STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dahlia Gardens Center for Nursing and Rehabilitation	**915 Pee Dee Road , Aberdeen, North Carolina, 28315**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/1/25 through 12/4/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1DCBB5-H1.	E0000		12/30/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/1/25 through 12/4/25. Event ID# 1DCBB5-H1. The following intakes were investigated: 882426, 882439, 882442, 882447, 882450, 882451, 882454, 882456, 882460, 882461, 2581232, 2616368, 2663240, 2663864, 2668204, and 2682318. 8 of the 28 complaint allegations resulted in deficiency.	F0000		12/30/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584	On 12/2/25, Nursing Aide (NA) #3 emptied and discarded the urine collection hat in Resident #74's bathroom. On 12/24/25, the Director of Nursing (DON), Staff Development Coordinator (SDC), and unit manager completed an audit of resident bathrooms, including Resident #74, to ensure urine collection devices to include urine hats were labeled and stored correctly. Concerns identified during the audit were immediately addressed to include labeling and correctly storing urine collection devices. On 12/24/25, an in-service was initiated by the Director of Nursing (DON) and SDC for nurses and nurse aides regarding urine collection devices- correct labeling with resident names and storage of urine collection devices in plastic bags. The in-service will be completed by 12/30/25. After 12/30/25, any nurse or nurse aide that has not received the in-service will receive it prior to the next scheduled work shift. Newly hired nurses and nurse aides will receive the in-service during orientation by the SDC. The DON, SDC, and/or unit manager will conduct audits	12/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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F0584 SS = D	Continued from page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to dispose of a stained urine collection hat stored underneath a sink on the floor in a resident's bathroom. This deficient practice affected 1 of 7 residents on the 400 hall memory care unit who were reviewed for a safe, clean, comfortable, homelike environment (Resident #74). The findings included: An initial observation completed on 12/1/25 at 1:03 PM, and a follow-up observation on 12/2/25 at 11:28 AM, revealed a yellow stained white urine collection hat (a device placed inside the commode to collect urine for sampling) with a tissue inside lying on the floor underneath the sink in Resident #74's bathroom. The device was not labeled with a resident's name or stored in a bag. Resident #74 resided in the memory care unit and was in his room during both observations, and he was unable to state if the device belonged to him. On 12/2/25 at 11:32 AM an interview was conducted with Nurse Aide (NA) #3 who stated she was unaware there was a urine collection hat on the floor of Resident #74's bathroom and stated she would take care of it. NA #1indicated the hat was one used on the unit to collect	F0584	Continued from page 1 of 15 resident bathrooms to include Resident #74's bathroom weekly for 12 weeks to ensure urine collection devices including urine hats are labeled and stored correctly in a plastic bag with the resident's name. Any concerns identified during the audit will be corrected immediately by the DON, SDC, and/or unit manager to include retraining of staff. The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F0584 SS = D	Continued from page 2 urine samples for testing, and it should have been cleaned after use and labeled with the resident's name and stored in a closed bag if it was meant for reuse. NA #3 further stated it was the responsibility of the NA to remove urine collection hats from resident's rooms after use. The Unit Manager was interviewed on 12/3/25 at 2:11 PM and stated if a urine collection hat was used for obtaining a urine sample, then it should be thrown away. However, if one was kept for a resident then it should be labeled with the resident's name and stored in a plastic bag once cleaned after use. On 12/3/25 at 3:08 PM the Director of Nursing (DON) was interviewed and stated the urine collection hat should have been thrown away after use. The Administrator was interviewed on 12/4/25 at 1:42 PM and stated urine collection hats were typically used to obtain a sample for urine testing. She indicated once staff obtained the sample, the device should have been thrown away. The Administrator stated the used hat should not have been stored in the resident's bathroom, and she would expect the staff to obtain a new urine collection hat if the resident required a follow up sample.	F0584		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Nurse Practitioner, Pharmacist, and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication (methadone) prescribed to treat pain. This affected 1 of 3 residents reviewed for misappropriation (Resident #17). The findings included:	F0602	Resident #17 no longer resides in the facility. Resident #17 did not miss any doses of the ordered medication. Residents residing in the facility on narcotic medications have the potential to be affected by the deficient practice. On 12/24/25, an audit of all grievances for the past 30 days was initiated by the Administrator, Social Worker, and Admissions Coordinator to identify any concerns with misappropriation to include misappropriation of narcotic medication that had not been addressed. The audit will be completed by 12/29/25. All areas of concern identified will be immediately addressed by the Administrator, Social Worker, and Admissions Coordinator to include staff training as appropriate. On 12/3/25, the Administrator initiated an in-service for staff regarding the abuse policy of resident right to be free from exploitation and misappropriation of	12/30/2025

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F0602 SS = D	Continued from page 3 A review of the facility's policy entitled Abuse, Neglect, and Exploitation implemented 12/1/22 and revised 1/1/25 read in part . . . It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent. Resident #17 was admitted to the facility on 11/17/22 with diagnoses of diabetes mellitus type II with diabetic polyneuropathy and chronic pain due to trauma. A review of the quarterly Minimum Data Set (MDS) dated 1/13/25 assessed Resident #17 to be cognitively intact without behaviors. The active medication orders for Resident #17 during the month of 2/2025 revealed an order for methadone 10 mg (milligrams) with an ordered date of 1/1/25 given by mouth three times a day for pain. A review of the medication administration record (MAR) for the month of 2/2025 revealed Resident #17 was administered methadone 10 mg three times daily by the facility staff except for the leave of absence (LOA) from 2/24/25 to 2/27/25. The facility sent ten tablets of methadone with the party responsible for the resident during her LOA. Resident #17's ordered methadone was signed as being received at the facility by Medication Tech #1 on 1/28/25. The medication count sheets were listed as having 30 tablets of methadone on each medication card. A review of the narcotic count sheets for Resident #17's methadone filled on 1/28/25 indicated the pharmacy sent one count sheet for each 30-tablet card. A review of the methadone count sheets for Resident #17 revealed count sheet #1 and count sheet #3 were present but count sheet #2 was missing.	F0602	Continued from page 3 resident property to include narcotic medication. The education included the requirement to immediately report any known or suspected misappropriation of resident property including misappropriation of narcotic medication to the supervisor, Director of Nursing (DON), or Administrator. The in-service will be completed by 12/29/25. Any staff that has not received the in-service by 12/29/25 will do so prior to their next scheduled shift. Newly hired staff will receive the in-service during orientation by the Staff Development Coordinator (SDC). The Social Worker will conduct ten (10) resident questionnaires weekly for 8 weeks, then monthly for 1 month, to ensure any allegations of misappropriation of resident property including misappropriation of narcotic medication are addressed immediately. Any concerns identified during the questionnaires will be immediately addressed by the Social Worker and/or the Administrator to include staff retraining. The Social Worker, Admissions Coordinator, and Director of Nursing (DON) will review all grievances weekly for 8 weeks, then monthly for 1 month, to ensure any allegations misappropriation of resident property including misappropriation of narcotic medication are addressed immediately to include staff retraining. In addition, the Director of Nursing or designee will conduct three audits a week sampling random medication carts/narcotic books and comparing pharmacy narcotic delivery sheets to ensure pharmacy delivered items are found on the cart. This audit will continue for twelve weeks. The Social Worker, Director of Nursing and/or designee will forward the results of the audit to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F0602 SS = D	Continued from page 4 An initial allegation report was received by the State from the facility's Administrator on 2/25/25 at 7:05 PM. The report read that the facility initially became aware of the incident on 2/25/25 at 2:53 PM and alleged during reconciliation of Resident #17's medications post discharge, it was identified a methadone card was misplaced. Police were notified and the facility investigation was initiated. The incident was reported to local law enforcement on 2/25/25 at 6:46 PM. On 12/2/25 at 10:46 AM an interview was conducted with Resident #17 who stated she had become aware her methadone tablets were missing when the Director of Nursing (DON) and Administrator spoke with her about it. The resident stated as far as she knew, she received her methadone as she was supposed to and denied having uncontrolled pain during the month of 2/2025. Former Nurse Practitioner (NP) #1 was interviewed by phone on 12/3/25 at 1:18 PM. She stated on 2/22/25 she received a request from a nurse at the facility requesting a refill of methadone for Resident #17 (she was unsure of the nurse's name who called). NP #1 stated she submitted a refill request to pharmacy for the methadone, but later pharmacy notified her it was too soon to refill the medication. She stated she immediately notified the DON of a possible drug diversion. According to the NP, she had no previous cause for concern related to missing narcotic medications. Pharmacist #1 was interviewed by phone on 12/3/25 at 1:32 PM and stated he was notified of the missing methadone at the facility. He stated the pharmacy confirmed with the facility that no methadone had been returned for Resident #17, and he played a support role as the facility worked through their investigation regarding possible drug diversion. The Pharmacy Supervisor was interviewed by phone on 12/3/25 at 2:48 PM and stated the pharmacy filled a 90-tablet methadone prescription for Resident #17 on 1/28/25. She indicated the facility tried to submit a refill request around 2/22/25 for methadone 10 mg for Resident #17, but it was too soon to refill the medication. She stated the record showed the pharmacy did fill and deliver 10 tablets of methadone on 2/22/25 to the facility. The Pharmacy Supervisor stated their role was to support the facility as they investigated	F0602		

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F0602 SS = D	Continued from page 5 possible drug diversion. On 12/3/25 at 3:08 PM an interview was conducted with the Director of Nursing (DON) who stated she completed an investigation into possible drug diversion when the NP notified her on 2/25/25 of a refill request for Resident #17's methadone 10 mg being denied by pharmacy as being too soon to refill. The DON explained after researching the discrepancy it was found to have occurred when Nurse #1 last worked on 2/13/25. Nurse #1 had administered the last dose of methadone to Resident #17 from card #1. During the investigation she learned Resident #17's methadone card #2 was missing along with the methadone narcotic count sheet #2. She stated Nurse #1 had begun administering the methadone from card #3 and count sheet #3. The DON indicated the end of shift narcotic count came out correct due to both methadone medication card #2 and count sheet #2 being missing. The DON stated Nurse #1 stopped coming into work once the facility began investigating the incident, and Nurse #1 was terminated. Medication Tech #1 who received the methadone from pharmacy on 1/28/25 was interviewed on 12/3/25 at 3:28 PM and stated she was off the weekend the methadone went missing and had no first-hand knowledge of the incident. Multiple attempts were made to contact Nurse #1 by phone for an interview. Voice mail messages left requesting a return call were not returned. The Administrator was interviewed on 12/4/25 at 11:18 AM and stated the DON informed her on 2/25/25 that she believed there was a drug diversion due to the NP notifying her an order to refill methadone for Resident #17 was denied by pharmacy for being too early. She stated the DON investigation found a card of methadone was missing along with the count sheet for Resident #17's medication. The Administrator affirmed there was never a time when the resident went without the medications that were ordered for her by the Nurse Practitioner. The facility provided a plan of correction that was not acceptable to the State Agency as the facility did not include a systemic approach to prevent future incidents of misappropriation of residents' property. The audits included in the corrective action plan would not	F0602		

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F0602 SS = D	Continued from page 6 prevent further misappropriation.	F0602		
F0641 SS = B	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of rejection of care (Resident #35) for 1 of 19 MDS assessments reviewed. The findings included: Resident #35 was admitted to the facility on 12/1/23	F0641	On 12/24/25, the Regional Nurse Consultant & Minimum Data Set (MDS) Coordinator completed a modification to prior comprehensive assessment for Resident #35 to reflect accurate coding of refusal of medication. On 12/24/25, the Regional Nurse Consultant & Director of Nursing initiated an audit for residents' most current MDS assessment, to include Resident #35 to ensure MDS assessments completed are coded accurately for refusal of medication. The MDS Coordinator will complete modifications for concerns identified during the audit. The audit will be completed by 12/30/25. On 12/24/25, the administrator completed an in-service with the social worker regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely to include refusals of medication. Newly hired social workers will be in-serviced by the Administrator and/or the Director of Nursing (DON) during orientation regarding MDS Assessments and Coding. The DON will review 10 residents most recent MDS assessments weekly for 8 weeks, then monthly for 1 month, for accuracy to include accurate coding of refusal of medication. This audit will be completed to ensure accurate coding of refusals of medication on the MDS assessment. The social worker, MDS Coordinator, Administrator and/or DON will address all areas of concern identified during the audit to include completion of resident assessment and/or providing retraining when indicated. The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	12/30/2025

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F0641 SS = B	Continued from page 7 with diagnoses that included anxiety disorder. A review of Resident #35's medical record revealed that she had refused medications a total of seven days prior to 10/27/25 for medication administration times of 6:30 AM, 8:00 AM and 8:00 PM. Review of the October 2025 Medication Administration Record (MAR) from 10/27/25 to 10/31/25, revealed that Resident #35 was marked as refused for the following: • 10/27/25 at 8:00 PM for Ferrous Sulfate 220 milligrams (mg) per 5 milliliters (ml). Give 5 ml via feeding tube every morning and at bedtime for supplementation. • 10/27/25 at 8:00 PM for Sennosides 8.6 mg. Give two tablets by mouth two times a day for constipation. • 10/28/25 at 8:00 PM for inspection of surrounding skin to feeding tube area every morning and at bedtime. A MDS assessment dated 10/31/25 indicated Resident #35 had moderately impaired cognition and was not coded for rejection of care. Resident #35's active care plan, last reviewed 11/10/25, included a focus area for having a behavior problem related to attention seeking behaviors, noncompliance with tube feedings and ordered oral diet. The focus area was initiated on 12/15/23. Attempts to call Nurse #1 occurred during the survey but were unsuccessful. She was scheduled to care for Resident #35 on 10/27/25 and 10/28/25 when refusals were noted on the MAR. An interview with Nurse #2 occurred on 12/3/25 at 10:45 AM and stated that she frequently cared for Resident #35 during the day shift. Nurse #2 stated that Resident #35 would refuse care and medication. An interview with the MDS Nurse was conducted on 12/4/25 at 11:22 AM and stated that the Social Worker (SW) was responsible for completing the section of the MDS assessment that addressed rejection of care. On 12/4/25 at 11:29 AM, an interview occurred with the SW, who explained that she had been in the role for about two and half months and was responsible for completing the section addressing rejection of care on the MDS assessment. She explained that she looked at the nurses' notes only for this information and didn't review the MARs to see if a resident refused	F0641		

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F0641 SS = B	Continued from page 8 medications or treatments. The SW stated she wasn't sure where to look in the medical records for rejection of care. She reviewed Resident #35's MDS assessment dated 10/31/25 as well as the October 2025 MAR and verified that Resident #35 was marked as refusing medications and care on 10/27/25 and 10/28/25 which would have been during the MDS seven-day look back period and should have been coded on the 10/31/25 MDS assessment as rejection of care occurring one to three days. The Administrator was interviewed on 12/4/25 at 12:51 PM and stated she expected the MDS assessment to be coded accurately.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening Resident Review (PASRR) determination for a resident with a newly diagnosed serious mental illness for 1 of 2 residents reviewed for PASRR (Resident #4). The findings included: Resident #4 was admitted to the facility on 11/29/24 with diagnoses of generalized anxiety disorder and unspecified depression. A level I PASRR was completed	F0644	On the 12/24/25, the administrator submitted a Preadmission Screening and Resident Review (PASARR) for Resident #4. On 12/3/25, the Business Office Manager, Minimum Data Set Nurse (MDS), and Administrator initiated an audit of residents with a newly diagnosed serious mental illness for the past 30 days to ensure a request had been submitted for a Level II Preadmission Screening Resident Review (PASARR). had a current and accurate PASARR. The administrator will address concerns identified during the audit to include submitting a request for a PASARR evaluation for any resident with a newly diagnosed serious mental illness. The audit will be completed by 12/30/25. On 12/24/25, the administrator initiated an in-service regarding PASARRs with the admission director, social worker, Minimum Data Set Nurse (MDS), and Director of Nursing (DON) with emphasis on submitting a request for a PASARR evaluation following a newly diagnosed serious mental illness. The in-service will be completed by 12/30/25. Newly hired admission directors, social workers, Minimum Data Set nurses (MDS), and DONs will receive the in-service during orientation regarding PASARR submissions from the Administrator. The Director of Nursing (DON), and/or designee will review 10 resident charts to weekly for 8 weeks then monthly for 1 month to ensure a submission to request a PASARR evaluation following a newly diagnosed serious mental illness was completed. The DON and/or administrator will address all concerns identified during the audit to include	12/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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F0644 SS = D	Continued from page 9 on 5/8/24 prior to admission. A review of a psychiatric assessment note dated 3/20/25 indicated Resident #4 was seen by the psychiatrist and diagnosed with bipolar disorder. A review of a psychiatry note dated 6/3/25 indicated a new medication order for Risperidone 0.25 milligrams (mg) by mouth once daily for behaviors related to psychosis based off the resident's self-reported mood swings, confusion, and crying. Resident #4's Representative provided informed verbal consent by phone on 6/3/25 for the psychiatric provider to begin the medication. A psychiatry note dated 6/9/25 indicated the staff reported Resident #4 continued to have mood swings, and the psychiatric provider included in his note an increase of Risperidone to 0.5 mg once daily. Review of the electronic medical record revealed there was no evidence that a level II PASRR screening was requested. A review of the quarterly Minimum Data Set (MDS) dated 6/12/25 indicated Resident #4 was severely cognitively impaired without behavioral concerns. Resident #4 was coded with bipolar disorder. On 12/4/25 at 12:01 PM the MDS Nurse was interviewed and stated she usually saw new mental health diagnoses and medication orders when she reviewed the providers' notes for gradual dose reductions of certain medications. She stated when she completed the quarterly MDS for Resident #4 she saw the new diagnosis of bipolar disorder for Resident #4 when she reviewed her orders and entered the diagnosis into the electronic medical record but clarified "it did not dawn on me" that she needed to notify the Administrator needed to submit a request for a Level II PASRR evaluation for Resident #4. She stated, "I just missed it." Resident #4's annual Minimum Data Set dated 11/17/25 assessed the resident was severely cognitively impaired and revealed she was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. The MDS coded Resident #4 with bipolar disorder. An interview was conducted with the Social Worker (SW) on 12/4/25 at 10:46 AM, and she stated she did not have access to North Carolina's MUST (Medicaid Uniform	F0644	Continued from page 9 referral for evaluation/re-evaluation of PASRR for any resident newly diagnosed with a serious mental illness. The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F0644 SS = D	Continued from page 10 Screening System) system since being hired almost two months ago. The SW indicated the Administrator had been submitting PASRR requests to NCMUST during that timeframe. The Director of Nursing (DON) was interviewed on 12/4/25 at 11:40 AM and stated the facility's providers entered their own orders for medication changes and new diagnoses in the electronic medical record, and she confirmed the new orders once they were entered. The DON stated she tried to catch new orders and new diagnoses to inform the MDS Nurse. She further stated she kept a list of residents who needed a level II PASRR screening and thought Resident #4 already had a level II PASRR determination. On 12/4/25 at 11:07 AM, the Administrator was interviewed and affirmed she had been submitting requests for PASRR evaluations since the previous SW left. The Administrator stated the last PASRR for Resident #4 was completed prior to her admission on 5/8/24, and she had not submitted a request for a level II PASRR screening. She stated she was not aware Resident #4 needed a level II PASRR assessment, and the Administrator indicated she relied on the Director of Nursing and the Minimum Data Set (MDS) nurse to notify her of changes in a resident's condition so she could submit requests for PASRR screenings when needed.	F0644		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and resident and staff interview, the facility failed to ensure a resident who was dependent on staff assistance for nail care received assistance when needed for 1 of 5 residents reviewed for activities of daily living (ADL) (Resident #14). The findings included: Resident #14 was admitted to the facility on 06/11/13 with diagnoses that included a permanent neurological disorder affecting movement, posture, and coordination, contracture of left arm, and vascular dementia.	F0677	On 12/3/25, Resident #14 received nail care to include trimming. On 12/3/25, an audit of current residents was completed by the Director of Nursing/SDC/Unit Managers to ensure nail care was received to include trimmed fingernails. Any concerns found were addressed immediately by the Director of Nursing (DON). On 12/24/25, an in-service was initiated by the Administrator for nurses and nursing assistants related to the requirement to assist residents with nail care including trimming fingernails and to immediately notify the nurse if the task cannot be performed for any reason. The in-service will be completed by 12/23/2025. After 12/23/2025, any nurses and/or nursing assistants that have not received the in-service, will be educated prior to the next scheduled shift. Newly hired nurses and nursing assistants will be in-serviced during orientation by the DON or SDC regarding the requirement to assist residents with nail care to include trimming fingernails and to immediately notify the nurse if the	12/30/2025

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F0677 SS = D	Continued from page 11 The quarterly Minimum Data Set (MDS) assessment dated 10/10/25 indicated Resident #14's cognition was severely impaired. He exhibited behaviors that occurred for 1 to 3 days during the look-back period that included behavioral symptoms not directed towards others. He required moderate assistance with eating and was dependent on staff with personal hygiene, dressing, toilet hygiene, oral hygiene, shower/bath, bed mobility, and transfers. He was not coded for rejection of care. Resident #14 had range of motion impairment to both sides of his upper and lower extremities. Resident #14's active care plan, last revised on 10/10/25, included the focus area of an activity of daily living (ADL) self-care deficit and required assistance with ADL. Interventions included Resident required total assistance from staff for bathing and for staff to check nail length, trim, and clean on bath day and as necessary. Report any changes to the nurse. A review of Resident #14's nursing progress notes from 11/01/25 to 12/02/25 revealed no refusals of nail care documented. Record review revealed Resident #14's shower/bathing were scheduled for Wednesday and Saturday on night shift. Resident #14's shower schedule revealed no refusals from 11/01/25 through 12/02/25. Unsuccessful attempts were made to contact Resident #14's direct care NA for 11/29/25 (Resident #14's last scheduled shower day). An observation and interview were conducted on 12/01/25 at 11:10 AM with Resident #14. The observation revealed Resident #14's fingernails on his left and right hands extended approximately 1/4 to 1/2 of an inch beyond his fingertips and were jagged. A brown substance was observed under the pointer fingernail on the right hand. Resident #14 held his right hand up and stated, "they need to be cut". When asked if he had asked anyone to cut his fingernails he did not respond. An observation of Resident #14 was conducted on 12/02/25 at 12:01 PM. He was observed sitting in his wheelchair watching television. The observation revealed Resident #14's fingernails were still long and jagged. A brown substance was observed under the pointer fingernail on the right hand. An observation of Resident #14 was conducted on 12/02/25 at 2:25 PM. Resident #14 was observed sitting in his wheelchair watching television. The observation	F0677	Continued from page 11 task cannot be performed for any reason. The Unit Manager, Quality Assurance (QA) nurse, and RN supervisor will monitor 10 residents weekly for 8 weeks, then monthly for 1 month to ensure residents who nail care including trimming fingernails were provided these necessary services to maintain good grooming. Any concerns identified during the audit will be immediately addressed by the Unit Manager, QA Nurse, and RN Supervisor to include providing additional re-training. The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F0677 SS = D	Continued from page 12 revealed Resident #14's fingernails were still long and jagged. A brown substance was observed under the pointer fingernail on the right hand. An interview was conducted on 12/03/25 at 1:45 PM with Nursing Assistant (NA) #1. He verified he was the direct care NA for Resident #14 from 7:00 AM to 7:00 PM that day. He confirmed Resident #14's fingernails on his right and left hands were long, jagged, and the pointer fingernail had a brownish substance under it. He stated he did not realize Resident #14's nails needed to be cleaned and cut. An interview was conducted on 12/03/25 at 2:02 PM with the Director of Nursing (DON). She verified Resident #14's fingernails on his right and left hands were long, jagged, and the pointer fingernail had a brownish substance under it. She stated his showers are on 2nd shift however nailcare was everyone's responsibility. Staff normally performed nailcare on shower days, during morning care, and as needed. She indicated Resident #14's fingernails needed to be cut, filed, and cleaned. She indicated there was no reason his nails had not been tended to. An interview was conducted on 12/03/25 at 2:10 PM with Medication Aide (MA) #1. She verified she had been the direct care MA for Resident #14 since 12/01/25. She stated staff normally perform nailcare on shower days and as needed. She also stated she did not notice Resident #14's fingernails needed to be cut, filed, and cleaned. She indicated Resident #14 did not refuse nail care or showers.	F0677		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F0732	On 12/5/25, the receptionist posted the daily staffing form with the correct date and staffing information. The Administrator confirmed. On 12/5/25, the administrator initiated an audit of nurse staffing forms for the past 30 days to ensure information was correct and consistent with the staff schedule. The audit was completed on 12/8/25 and corrective action was taken if needed. On 12/5/25, the Administrator initiated an in-service with the Scheduler, Receptionist, and Director of Nursing (DON) regarding nursing staff posting requirements with emphasis on posting the correct date and ensuring the information is consistent with the staff schedule and updated as necessary. The in-service was completed on 12/24/25. Newly hired Scheduler, Receptionist, and Director of Nursing (DON)	12/30/2025

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F0732 SS = C	Continued from page 13 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to post accurate staffing information as compared to the daily staff schedule for 32 out of 32 days (11/01/25 through 12/02/25) reviewed. The findings included: a) A review of the facility's daily posting for nursing staff for the past 32 days (11/01/25 through 12/02/25) as compared to the daily staffing schedule revealed the total of actual hours worked for day shift, evening shift, and night shift, for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Aides were blank. b) A review of the facility's daily posting for nursing staff for the past 32 days as compared to the daily staffing schedule included an inaccurate total number	F0732	Continued from page 13 will receive the in-service regarding nursing staff posting requirements during orientation by the Administrator. The Administrator and/or the DON will audit the nurse staffing forms 4 times weekly for 8 weeks, then 3 times weekly for 1 month, to ensure the correct date is posted and the information provided is consistent with the staff schedule. Any concerns identified during the audit will be immediately addressed by the administrator and/or the DON. The Administrator or designee will forward the results of the audit to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F0732 SS = C	Continued from page 14 of licensed staff working. These included the following: -The number of licensed staff on 1st shift was incorrect for the following dates: 11/03/25-11/07/25, 11/10/25-11/14/25, 11/17/25-11/22/25, and 11/24/25-12/02/25. -The number of licensed staff on 2nd shift was incorrect for the following dates: 11/23/25 and 12/02/25. -The number of licensed staff on 3rd shift was incorrect for the following dates: 11/01/25, 11/11/25, 11/19/25, 11/24,25, and 11/30/25. c) A review of the facility's daily posting for nursing staff for the past 32 days as compared to the daily staffing schedule included an inaccurate total number of unlicensed staff working. These included the following: -The number of unlicensed staff on 1st shift was incorrect for the following dates: 11/04/25-11/12/25, 11/14/25, 11/17/25, and 11/24/25-12/02/25. -The number of unlicensed staff on 2nd shift was incorrect for the following dates: 11/07/25-11/06/25, 11/12/25-11/10/25, 11/19/25, 11/24/25-11/26/25, and 11/28/25-11/30/25. -The number of unlicensed staff on 3rd shift was incorrect for the following dates: 11/01/25, 11/02/25, 11/07/25, and 11/25/25. An interview was conducted on 12/03/25 at 3:16 PM with the Receptionist. She stated she completed the daily nurse staffing summary sheets that were posted daily. She stated she did not complete the area of total hours for licensed or unlicensed staff because the facility got a new time clock system and she did not have access to the totals anymore. She explained that was how she added the hours up. It was an oversite that she forgot to add the census total on some of the sheets. She stated she was unaware she was to add the wound nurse and nurse supervisors to the licensed staff totals for each shift or the medication aide (MA) to the unlicensed staff totals. An interview was conducted on 12/04/25 at 11:22 AM with the DON. She reviewed and confirmed the daily Posted Nurse Staffing Information sheets were inaccurate and did not reflect the actual working hours or the correct number of staff. She stated the time totals should have	F0732		

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F0732 SS = C	Continued from page 15 been added to the total hours worked columns for each shift. She explained that the hours should have been calculated with 12 or 8 hours for each working employee, not the actual punch time totals. The census also should have been added and if a member of staff called out the sheet should have been adjusted to reflect the correct number of employees working. She explained she was unaware the posting sheets were not correct or completed accurately. An interview was conducted on 12/03/25 at 3:16 PM with the Administrator. She was unaware the staff sheets were not being filled out completely or correctly as the Director of Nursing (DON) oversees the task. A follow-up interview was conducted on 12/04/25 at 12:35 PM with the Administrator. She stated she was not involved in the staff posting sheets however she would expect them to display the correct information.	F0732		