STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Lane Nursing and Rehabilitation Center	**107 Magnolia Drive , Morganton, North Carolina, 28655**

(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 12/15/25 through 12/19/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DDECA-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/15/25 through 12/19/25. Event ID# 1DDECA-H1. The following intakes were investigated 2651849, 2624382, 2574483, 2570229, 823086, 823085, and 823084. 3 of the 14 complaint allegations resulted in deficiency.	F0000		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F0565	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/13/26, the Administrator and the Director of Nursing reviewed the Resident Council Meeting minutes for January 2025, March 2025, June 2025, July 2025, and August 2025. All areas of concern were addressed by the IDT (interdisciplinary) team members, and a resolution communicated and documented in writing by the Administrator of Director of Nursing during a follow-up Resident Council meeting that was held on 1/19/26 by the Activities Director and the Licensed Nursing Home Administrator. The IDT team members include: the Licensed Nursing Home Administrator, the Director of Nursing, the Staff Development Coordinator, and the Unit Manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/15/2026, the Administrator completed a 100% audit of Resident Council Meeting minutes from the past 60 days. All concerns were reviewed, addressed by the IDT	02/03/2026

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: 345219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

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F0565 SS = E	Continued from page 1 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to communicate the facility's efforts to address concerns and document in writing the facility's response and rationale to concerns voiced during Resident Council meetings for 5 of 10 Resident Council meetings reviewed (January 2025, March 2025, June 2025, July 2025, and August 2025). Findings included: The Resident Council minutes for December 2024 (no day listed) noted that residents voiced a concern regarding the daily menus were not being posted again. The Resident Council minutes for January 2025 (no day listed) revealed residents voiced they had noticed the daily menus were being posted but they would like more variety. There was no further details documented of the facility's response, actions and rationale taken to address of the facility concern. The Resident Council minutes for February 2025 (no day listed) revealed no documentation of the facility's response, actions and rationale taken to address the food concerns voiced during the previous meeting or if the concern was still ongoing. The Resident Council minutes for March 2025 (no day listed) revealed residents voiced they would like more consistency in who cooks and they were still unhappy with the menu. The Resident Council minutes for April 2025 (no day listed) revealed there was no documentation of the facility's response, actions and rationale taken to	F0565	Continued from page 1 team members, and a resolution communicated and documented in writing by the Licensed Nursing Home Administrator on 1/19/26. The IDT team members include: the Licensed Nursing Home Administrator, the Director of Nursing, the Staff Development Coordinator, and the Unit Manager. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: An in-service education was conducted by the Nursing Consultant for 100% of all IDT team members (the Licensed Nursing Home Administrator, the Director of Nursing, the Staff Development Coordinator, and the Unit Manager) on completing a Resident Council meeting monthly, ensuring follow-up and ensuring follow-up is documented and communicated with the person or persons reporting the grievance. The education began on 1/15/2026 and will be completed by 1/19/2026. Any IDT team members who have not received the education by 1/19/26 will receive it at their next scheduled shift. Any newly hired staff will be educated by the Licensed Nursing Home Administrator/Director of Nursing/Staff Development Director during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, Licensed Nursing Home Administrator will audit Resident Council Meeting minutes monthly x2 months to ensure all areas of concern are addressed, and a resolution is communicated and documented. All audits will be taken to Quality Assurance Performance Improvement monthly x2 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	

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F0565 SS = E	Continued from page 2 address the dietary concerns regarding food and menus voiced during the previous meetings. It was noted that residents had stated, “the food has been better, been worse” with no further details documented. The Resident Council minutes for May 2025 (no day listed) revealed the residents stated they had not noticed any concerns related to the food quality or temperature. There was no documentation of the facility’s response, actions and rationale taken to address the food concerns voiced during previous meetings. The Resident Council minutes for June 2025 (no day listed) revealed residents voiced concerns regarding Nurse Aides (NAs) not making beds even on bath days and not turning the light off after care was provided, residents were still unhappy with the corporate menu, and residents had to remind dietary staff to post the daily menus in all of the menu holders, not just some. The Resident Council minutes for July 2025 (no day listed) revealed residents voiced concerns that the menus were not being posted in all the menu holders, NAs were forgetting to turn the light out after care was provided and beds were still not being made satisfactorily. There was no documentation of the facility’s response, actions and rationale taken to address the concerns voiced during the previous meeting. Further review of the Resident Council minutes revealed a new document was utilized starting August 2025 for documentation of the minutes that included a sections for Old Business, New Business, Resident Rights Reviewed, Date of Next Meeting, and Signature Line for the staff member completing the minutes. The Resident Council minutes for August 13, 2025, revealed under old business residents voiced that menus were not to the residents’ liking and sometimes the menus were not posted in the menu holders. Under new business, it was noted the residents would like additional bath days. There was no documentation of the facility’s response, actions and rationale taken to address the concerns voiced during the previous meeting. The Resident Council minutes for September 10, 2025, revealed under old business the Administrator attended the meeting to introduce himself to the residents and to provide resolution to concerns voiced in the previous Resident Council meeting. The topics of resolution discussed with residents attending the	F0565		

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F0565 SS = E	Continued from page 3 meeting included special menu items, call light response times on evening and night shifts, and annual outing. There was no new business noted. There was no documentation of the facility's response, actions and rationale taken to address the dietary concerns and additional bath days voiced by residents during the previous meeting. The facility's grievance logs for the period December 2024 through September 2025 were reviewed and revealed no concerns were filed on behalf of the members of the Resident Council following the monthly meetings. A Resident Council group interview was conducted on 12/16/25 at 3:19 PM with Resident #9, Resident #32, Resident #44 (Resident Council President), and Resident #51 in attendance. Resident #9 stated when they voiced concerns during meetings they rarely received communication from facility staff regarding what was done to address the concerns. Resident #9 also stated they would like more communication regarding what the facility was doing to address the concerns they voiced and to be a part of the solution. When asked, Resident #32, Resident #44 and Resident #51 all stated they agreed with Resident #9. During an interview on 12/16/25 at 4:02 PM, the Activity Director revealed she had only been in her position for a few months and was still learning the process. She explained she had only facilitated two (2) resident council meetings, 10/17/25 and 11/03/25. She stated she had reviewed the minutes from previous meeting and during the meetings she facilitated she asked the residents if they had any grievances/complaints they would like to discuss. She stated the residents rarely mentioned any concerns during the Resident Council meetings but then would voice concerns during activities. The Activity Director explained when concerns were voiced by the residents either during the Resident Council meetings or activities, she didn't document the concerns on a resident grievance or group concern form, but she did share the concern(s) voiced by residents with the Administrator and other Department Managers during the daily team meetings. The Activity Director stated she would listen during the next team meeting to see what was done to address the concerns and if nothing was mentioned, she would ask what was done. The Activity Director stated once she received the resolution from the person who addressed the concern, she verbally provided the resolution to the individual resident voicing the concern the next time she saw the resident. During an interview on 12/19/25 at 3:17 PM, the	F0565		

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F0565 SS = E	Continued from page 4 Administrator revealed he started at the facility in August 2025. He confirmed the Activity Director would share with him any concerns voiced by residents during the Resident Council meetings. He explained the concern would be assigned to the appropriate Department Manager to investigate and provide a written response. He stated that once the concern had been addressed, it was discussed during the next daily team meeting that included the Activity Director and the Activity Director was the person responsible for communicating the resolution to the Resident Council. Other than the minutes of previous meetings, the Administrator was unable to provide any documentation of investigations or written resolutions for concerns voiced during Resident Council since starting his employment in August 2025.	F0565		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information	F0578	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/19/25, the Do Not Resuscitate (DNR) form was signed by the provider for Resident #2 and placed in the resident Medical Record by the Unit Manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/7/26, the Director of Nursing/Unit Manager/Staff Development Director completed a 100% audit of all resident Medical Records to ensure the physician's order has a corresponding Do Not Resuscitate (DNR) if applicable and is included in the Resident Medical Record. This audit was completed on 1/19/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was conducted by the Staff Development Coordinator (SDC) for 100% of all Licensed Nurses to include agency staff. The education included completing a DNR form to correlate with the physician's order and ensuring the DNR form is included in the Medical Record. The education began on 1/19/26 and will be completed by the Staff Development Coordinator by 1/23/26. Any newly hired Licensed Nurses who have not received the education by 1/23/26 will receive it at	02/03/2026

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F0578 SS = D	Continued from page 5 or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure the Do Not Resuscitate (DNR) form was signed by the physician and part of the medical record after the physician ordered for the resident to be Do Not Resuscitate for 1 of 21 residents reviewed for advanced directives (Resident #2). The findings included: Resident #2 was admitted to the facility on 7/25/25. Review of the physician's signed orders dated 10/13/25 revealed admission to Hospice with diagnosis of malignant neoplasm (a cancerous tumor) of the gallbladder. Review of the physician's signed orders dated 10/9/25 revealed an order for Resident #2 to be a Do Not Resuscitate (DNR). An interview with the former Assistant Director of Nursing (ADON) who entered the DNR order was attempted but unsuccessful. Review of Resident #2's electronic medical record revealed no evidence a DNR form was completed and signed by the physician. An attempt to contact Resident #2's Responsible Party (RP) was made but unsuccessful. Review of the quarterly Minimum Data Set (MDS) dated 12/10/25 revealed that Resident #2 was severely cognitively impaired. Resident #2 had a condition or chronic disease that may result in a life expectancy of less than 6 months and was on Hospice. Review of the care plan dated 12/11/25 revealed Resident #2 was documented as do not resuscitate (DNR) (lifesaving efforts such as Cardiopulmonary Resuscitation (CPR) were not to be conducted). Goals	F0578	Continued from page 5 their next scheduled shift. Any newly hired Licensed Nurse to include agency staff will be educated by the Director of Nursing/Staff Development Director during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, the Director of Nursing/Unit Manager/Staff Development Coordinator will audit 5 resident records weekly for 4 weeks to ensure the resident has a DNR that matches the corresponding physician's order and that the DNR form and order is in the Medical Record. Any areas of concern will be addressed with the provider immediately. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	

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F0578 SS = D	Continued from page 6 included advance directives will be honored per established documents/ documentation through next review. Interventions included do not resuscitate. A joint interview with the Administrator and the Corporate Consultant on 12/18/25 at 2:02 PM revealed that advanced directives were discussed in interdisciplinary team (IDT) daily meetings. The Administrator stated nursing should review the advanced directive orders and fill out the DNR or MOST form and have the physician review it with the resident or resident representative and sign the form. The Corporate Consultant further revealed that the facility had just completed an audit of advanced directives on 12/12/25 and Resident #2 was overlooked. The Corporate Consultant further stated that when an advanced directive was changed the medical record should be updated with all correct information and forms within 24 hours.	F0578		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably	F0582	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/15/26 and 1/16/26, the Business Office Manager notified and provided Resident #6, Resident #16, and Resident #76 or their Responsible Party with the Advanced Beneficiary Notice (ABN) which outlined services that may not be covered under Medicare prior to discharge from Medicare Part A skilled services. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 12/22/25, the Business Office Manager and the Business Office Consultant completed a 100% audit of all residents who have been discharged from Part A Medicare benefits in the previous 60 days. This audit was completed by 1/16/26. Any residents who were identified as not receiving an ABN, were notified and received in person or by mail by the Business Office Manager or the Business Office Consultant. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/2/26, the Business Office Consultant completed	02/03/2026

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F0582 SS = D	Continued from page 7 possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, a form used by skilled nursing facilities to inform residents about potential costs and coverage limitations for services that may not be covered by Medicare) to beneficiaries who intended to continue services and the SNF believed the services may not be covered under Medicare prior to discharge from Medicare Part A skilled services for 3 of 3 residents reviewed for beneficiary notification review (Residents #6, #16, and #76). Findings included: 1. Resident #6 was admitted to the facility on 08/26/25. A Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with and signed by Resident #6 on 09/19/25 which indicated his Medicare Part A coverage for skilled services would end on 09/23/25. Resident #6 remained in the facility. Resident #6's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #6.	F0582	Continued from page 7 in-service education with the Business Office Manager, the Licensed Nursing Home Administrator and the Therapy Director on issuing Advanced Beneficiary Notice of Non-Coverage (ABN). The in-service education was completed by 1/2/26. Any newly hired Business Office Manager, Administrator, or Therapy Director will be educated by the Business Office Consultant during orientation if applicable. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, the Business Office Manager will audit all residents who are discharged from Medicare Part A services to ensure an ABN is issued weekly x4 weeks. Any areas of concern will be addressed immediately and reported to the Licensed Nursing Home Administrator. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	

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F0582 SS = D	Continued from page 8 During an interview on 12/16/25 at 10:05 AM, the Business Office Manager revealed the therapy team reviewed the NOMNC with the resident or their Responsible Party (RP) when Medicare Part A services were ending, had them sign the form and then returned the form to her to keep. She stated due to a miscommunication between her and the therapy team; she was not aware that SNF ABNs were not being provided along with the NOMNC. The Business Office Manager stated she had since requested that the therapy team inform her when a resident's therapy services were ending so that she had time to provide a SNF ABN to the resident or their RP, if applicable. The Business Office Manager confirmed a SNF ABN was not issued to Resident #6 prior to Medicare Part A skilled services ending on 09/23/25. During an interview on 12/19/25 at 3:17 PM, the Administrator revealed he would have expected Resident #6 to have received a SNF ABN as required when his Medicare Part A services were ending. He stated going forward, the Social Worker would be responsible for ensuring a SNF ABN was provided to the resident or their RP as required. 2. Resident 16 was admitted to the facility on 06/09/25. A Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with and signed by Resident #16 on 08/15/25 which indicated his Medicare Part A coverage for skilled services would end on 08/18/25. Resident #16 remained in the facility. Resident #16's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #16. During an interview on 12/16/25 at 10:05 AM, the Business Office Manager revealed the therapy team reviewed the NOMNC with the resident or their Responsible Party (RP) when Medicare Part A services were ending, had them sign the form and then returned the form to her to keep. She stated due to a miscommunication between her and the therapy team; she was not aware that SNF ABNs were not being provided along with the NOMNC. The Business Office Manager stated she had since requested that the therapy team inform her when a resident's therapy services were ending so that she had time to provide a SNF ABN to the resident or their RP, if applicable. The Business Office Manager confirmed a SNF ABN was not issued to Resident #16 prior to Medicare Part A skilled services ending on 08/18/25.	F0582		

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F0582 SS = D	Continued from page 9 During an interview on 12/19/25 at 3:17 PM, the Administrator revealed he would have expected Resident #16 to have received a SNF ABN as required when his Medicare Part A services were ending. He stated going forward, the Social Worker would be responsible for ensuring a SNF ABN was provided to the resident or their RP as required. 3. Resident #76 was readmitted to the facility on 08/06/25. A Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with and signed by Resident #76 on 08/22/25 which indicated her Medicare Part A coverage for skilled services would end on 08/25/25. Resident #76 remained in the facility until her discharge on 11/28/25. Resident #76's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #76. During an interview on 12/16/25 at 10:05 AM, the Business Office Manager revealed the therapy team reviewed the NOMNC with the resident or their Responsible Party (RP) when Medicare Part A services were ending, had them sign the form and then returned the form to her to keep. She stated due to a miscommunication between her and the therapy team; she was not aware that SNF ABNs were not being provided along with the NOMNC. The Business Office Manager stated she had since requested that the therapy team inform her when a resident's therapy services were ending so that she had time to provide a SNF ABN to the resident or their RP, if applicable. The Business Office Manager confirmed a SNF ABN was not issued to Resident #76 prior to Medicare Part A skilled services ending on 08/25/25. During an interview on 12/19/25 at 3:17 PM, the Administrator revealed he would have expected Resident #76 to have received a SNF ABN as required when her Medicare Part A services were ending. He stated going forward, the Social Worker would be responsible for ensuring a SNF ABN was provided to the resident or their RP as required.	F0582		
F0645 SS = E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F0645	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/29/25, the Interim Social Worker began submitting PASARR screenings for level II PASARRs for Resident #7, Resident #52, and Resident #50. Resident #37 was not	02/03/2026

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F0645 SS = E	Continued from page 10 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and	F0645	Continued from page 10 submitted due to being discharged prior to audit. All submissions were completed by 12/30/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/6/26, the Interim Social Worker and the Director of Nursing initiated a 100% audit of all Resident records to ensure residents who were a level I PASARR were submitted for a level II PASARR if applicable. The criteria for submitting a level II PASRR screening includes suspicion of Serious Mental Illness or Intellectual/Developmental Disabilities, or a Related Condition, triggering a comprehensive assessment to confirm the condition and determine specialized needs before nursing placement and following a significant change. Any residents requiring submission for a level II PASARR were submitted to NC MUST by the Interim Social Worker during this time. The audit was completed by 1/16/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was conducted by the Nursing Consultant for the Interim Social Worker and the Director of Nursing on 1/15/2026. The education included the criteria for submitting a Level II PASARR screening for residents. Any newly hired team members who will be submitting PASARRS to NC MUST who have not received the education by 1/18/26 will be educated by the Interim Social Worker/Director of Nursing/Nurse Consultant after 1/18/26. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, the Interim Social Worker/Director of Nursing will audit 5 Resident records per week for 4 weeks to include new admissions to ensure any residents who meet the criteria for a level II PASARR but have a level I PASARR are submitted to NC MUST as applicable. The criteria for submitting a level II PASRR screening includes suspicion of Serious Mental Illness or Intellectual/Developmental Disabilities, or a Related Condition, triggering a comprehensive assessment to	

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F0645 SS = E	Continued from page 11 (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. 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 and Resident Review (PASRR) determination for residents who were admitted to the facility with serious mental health disorders for 4 of 4 residents reviewed for PASRR (Resident #37, Resident #7, Resident #52 and Resident #50). Findings included: 1. A PASRR Determination Notification letter dated 07/15/25 revealed Resident #37 had a Level I PASRR with no expiration date. Resident #37 was admitted to the facility on 09/29/25 with diagnoses that included atrial fibrillation, post-traumatic stress disorder (PTSD) and bipolar disorder. A staff progress note dated 10/01/25 at 1:44 PM written by the Social Worker (SW) revealed a baseline care plan meeting was held with Resident #37. The SW noted Resident #37 shared a history of significant trauma, including experiences related to war, and had diagnoses of PTSD and bipolar disorder. A physician's progress note dated 10/03/25 revealed Resident #37 had a diagnosis of chronic PTSD that was managed with divalproex sodium (anticonvulsant). The admission Minimum Data Set (MDS) assessment dated 10/05/25 revealed Resident #37 was not currently	F0645	Continued from page 11 confirm the condition and determine specialized needs before nursing placement and following a significant change. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	

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F0645 SS = E	Continued from page 12 considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #37's active psychiatric/mood disorder diagnoses included depression (other than bipolar) and PTSD. He received anticonvulsant medications during the MDS assessment period. A psychiatric note dated 10/09/25 revealed Resident #37 received divalproex sodium every night at bedtime for treatment of chronic PTSD with major depressive disorder. It was noted the medication was effective, Resident #37's mood had been stable and no changes to the medication was recommended. Resident #37 had a planned discharged home on 10/16/25. He was readmitted to the facility on 10/27/25 with diagnoses that included major depressive disorder, recurrent and PTSD. The October 2025 Medication Administration Record revealed Resident #37 received the following medications: *A physician order dated 10/28/25 for divalproex sodium 500 milligrams (mg) two tablets by mouth twice a day at 8:00 AM and 8:00 PM for mood disorder. *A physician order dated 10/28/25 for olanzapine (antipsychotic) 5 mg at bedtime for mood disorder. A physician progress note dated 10/29/25 revealed Resident #37 had diagnoses of major depressive disorder, recurrent episode and chronic PTSD. A Nurse Practitioner progress note dated 10/30/25 revealed Resident #37 had a diagnosis of major depressive disorder, recurrent episode with a plan to continue olanzapine and divalproex sodium for mood disorder. The admission Minimum Data Set (MDS) assessment dated 10/31/25 revealed Resident #37 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. He received antipsychotic and anticonvulsant medications during the MDS assessment period. Review of Resident #37's medical record revealed there was no documented evidence of a Level II PASRR evaluation. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR determination had been submitted for Resident #37.	F0645		

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F0645 SS = E	Continued from page 13 During an interview on 12/18/25 at 8:36 AM, the Admission Coordinator revealed if a resident was accepted for admission, she ensured they had a PASRR and if not, she would request one. The Admission Coordinator revealed she applied for PASRR evaluations by entering information into the North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) such as the resident's medications, mental health diagnoses, nursing notes and the Medicaid Long Term Care FL2 form (describes an individual's medical condition and the level of care needed). She revealed if a resident had a Level I PASRR determination and a mental health diagnosis, she informed the Social Worker (SW). The Admission Coordinator revealed she had been employed at the facility for two weeks and since starting her position, she had not requested any Level II PASRR evaluations. During an interview on 12/16/25 at 2:07 PM, the SW confirmed she had not been informed by the clinical team to submit a request for an evaluation for a Level II PASRR for Resident #37. The SW stated ideally when a resident admitted with a mental health diagnosis with a Level I PASRR, a request for a Level II evaluation should have been done and was overlooked. During an interview on 12/18/25 at 3:48 PM, the Administrator revealed PASRR was discussed during daily clinical meetings and if it was determined that a resident needed a Level II PASRR evaluation, the SW would be responsible for submitting a request for a Level II PASRR evaluation determination. The Administrator acknowledged a request for an evaluation for a Level II PASRR determination should have been submitted for Resident #37 and was overlooked. 2. A PASRR Determination Notification letter dated 07/05/10 revealed Resident #7 had a PASRR Level I with no expiration date. Resident #7 was admitted to the facility on 11/12/21 with diagnoses that included bipolar disorder and anxiety disorder. The most recent comprehensive Minimum Data Set (MDS) significant change in status assessment dated 04/28/25 revealed Resident #7 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #7's active psychiatric/mood disorder diagnoses included bipolar disorder and depression, and antidepressant and anticonvulsant	F0645		

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F0645 SS = E	Continued from page 14 medications were taken during the assessment lookback period. The care plan last revised on 09/09/25 revealed Resident #7 had diagnoses that included bipolar disorder, anxiety, and depression. Resident #7 received psychotropic antidepressant and antianxiety medications with the potential for side effects. Interventions included evaluate effectiveness and side effects of medications for possible reduction or elimination of psychotropic drugs. Review of Resident #7's medical records revealed there was no documented evidence that a request for an evaluation for a PASRR Level II determination was made. A Nurse Practitioner (NP) progress note dated 12/04/25 revealed Resident #7 was seen for ongoing medication management and symptom monitoring for bipolar disorder with anxiety. The NP noted Resident #7's bipolar disorder was in partial remission, and the most recent episode was depression and Resident #7 currently denied any anxiety or depression. The NP noted Resident #7's mood was stable and continued escitalopram (antidepressant) 10 milligrams (mg) daily for depression, depakote (anticonvulsant) 125 mg twice a day for mood stabilization, trazadone (antidepressant) 50 mg at hour of sleep for insomnia, and bupropion (antidepressant) extended release 100 mg daily for depression. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #7. During an interview on12/16/25 at 2:07 PM, the Social Worker (SW) revealed PASRR was discussed during the morning meetings and included review of psychotropic medications, and she would be informed if a request for a PASRR evaluation needed to be submitted. The SW revealed no request for a Level II PASRR evaluation had been completed for Resident #7 and stated ideally when a resident admitted with a mental health diagnosis and had a PASRR Level I, a request for re-evaluation should have been done. During an interview on 12/18/25 at 8:36 AM, the Admission Coordinator revealed if a resident was accepted for admission, she ensured they had a PASRR and if not, she would request one. The Admission Coordinator revealed she applied for PASRR evaluations by entering the resident's medications, mental health diagnoses, nursing notes, and the Medicaid Long Term Care FL2 form. She revealed if a resident had a PASRR	F0645		

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F0645 SS = E	Continued from page 15 Level I determination and a mental health diagnosis she informed the SW. The Admission Coordinator revealed she had not requested PASRR reevaluations since she had started her position. An interview was conducted on 12/18/25 at 3:48 PM with the Administrator. The Administrator revealed PASRR was discussed during morning meetings and the re-evaluation for Resident #7 was missed. The Administrator revealed the process for when a resident had a mental health diagnosis and a PASRR Level I, a request for reevaluation would need to be submitted and it was the SW's responsibility for requesting PASRR evaluations. 3. There was no PASRR Determination Notification letter included in Resident #52's medical records. A screenshot copy of the PASRR lookup and tracking included in the medical records revealed Resident #52 had a PASRR Level I with no expiration date. There was no date to show when Resident #52 was screened and the PASRR Level I remained valid. Resident #52 was admitted to the facility on 10/18/25 with cumulative diagnoses that included diabetes mellitus, bipolar disorder, moderate major depressive disorder, and toxic encephalopathy (exposure to toxic substances that alters brain function). The care plan initiated on 10/18/25 revealed Resident #52 received psychotropic medications for the diagnoses of depression and bipolar disorder that had the potential for cardiac and gastrointestinal side effects. Interventions included monitor for mood, behaviors, physical aggression, feeling unsafe and document and notify the physician, administer medications per physician's orders, and monthly and as ordered pharmacy review of medications. A Medical Doctor (MD) progress note dated 10/22/25 revealed Resident #52 was seen for a new patient admission and toxic encephalopathy. The MD noted Resident #52's past history of bipolar disorder, depression, anxiety, and insomnia and continued the current medications aripiprazole (antipsychotic) 10 mg daily for depression related to bipolar disorder, sertraline (antidepressant) 25 mg once a day and 100 mg at bedtime for depression, trazodone (antidepressant) 50 mg at bedtime for insomnia, divalproex sodium (anticonvulsant) 250 mg twice a day for mood. The MD noted Resident #52 had positive effects and the psychotropic medications were used to benefit mental and physical wellbeing and were without any reported or noted side effects.	F0645		

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F0645 SS = E	Continued from page 16 The admission MDS assessment dated 10/24/25 revealed Resident #52 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #52's active psychiatric/mood disorder diagnoses included bipolar disorder and depression, and antipsychotic, antidepressant and anticonvulsant medications were taken during the assessment lookback period. Review of Resident #52's medical records revealed there was no documented evidence that a request for an evaluation for a Level II PASRR was made. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #52. During an interview on 12/16/25 at 2:07 PM, the Social Worker (SW) revealed PASRR was discussed during the morning meetings and included review of psychotropic medications, and she would be informed if a request for a PASRR evaluation needed to be submitted. The SW revealed no request for a PASRR review had been done for Resident #52 and stated ideally when a resident admitted with a mental health diagnosis and had a PASRR Level I, a request for re-evaluation should have been done. During an interview on 12/18/25 at 8:36 AM, the Admission Coordinator revealed if a resident was accepted for admission, she ensured they had a PASRR and if not, she would request one. The Admission Coordinator revealed she applied for PASRR evaluations by entering the resident's medications, mental health diagnoses, nursing notes, and the Medicaid Long Term Care FL2 form. She revealed if a resident had a PASRR Level I determination and a mental health diagnosis she informed the SW. The Admission Coordinator revealed she had not requested PASRR reevaluations since she had started her position. An interview was conducted on 12/18/25 at 3:48 PM with the Administrator. The Administrator revealed PASRR was discussed during morning meetings and the re-evaluation for Resident #52 was missed. The Administrator revealed the process for when a resident had a mental health diagnosis and a PASRR Level I, a request for reevaluation would need to be submitted and it was the SW's responsibility for requesting PASRR evaluations. 4. A Pre-Admissions Screening and Resident Review (PASRR) Determination Notification letter dated	F0645		

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F0645 SS = E	Continued from page 17 10/14/23 revealed Resident #50 had a Level I PASRR with no expiration date. Resident #50 was admitted to the facility on 12/19/23 with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic kidney disease stage 4, and diabetes mellitus type 2, post-traumatic stress disorder (PTSD), major depressive disorder, obsessive-compulsive disorder (OCD), and anxiety. The annual Minimum Data Set (MDS) assessment dated 10/13/25 revealed Resident #50 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. He received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications during the MDS assessment period. Resident #50's active psychiatric/mood disorder diagnoses included anxiety disorder, major depressive disorder and PTSD. A Psychiatric progress note dated 12/04/25 revealed Resident #50 was seen for ongoing medication management and symptom monitoring of depression and anxiety with impulsivity and obsessive-compulsive symptoms, history of self-harm and inappropriate sexual actions toward staff. Resident #50 was taking sertraline (antidepressant) daily for OCD and depression, trazodone (antidepressant) for insomnia, and divalproex sodium (anticonvulsant) for mood stabilization. He was taking clonazepam for anxiety, which has changed from 0.5 mg three times per day as needed to 0.5 mg twice a day scheduled for 8:00 am and 2:00 pm as well as 0.5 mg once a day as needed. Review of Resident #50's medical record revealed there was no Level II PASRR evaluation. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #50. During an interview on 12/18/25 at 8:46 AM, the Admission Coordinator revealed she was responsible for verifying if a resident had a PASRR in the North Carolina Medicaid Uniform Screening Tool (NC MUST) before admission to the facility. If the resident had a valid PASRR in NC MUST she would accept the resident, if the resident did not have a valid PASRR she would submit the application for a Level I PASRR evaluation. She stated the PASRR application required the residents' diagnoses. If the resident had a mental health diagnosis the PASRR application would be elevated to a Level II PASRR which required additional information that included the resident's medications,	F0645		

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F0645 SS = E	Continued from page 18 history and physical, FL2 form (form used by medical providers to communicate health status and care requirements of a resident to care facilities), and medical provider notes provided to NC MUST. The Admission Coordinator also confirmed that Resident #50 had a Level I PASRR assigned before admission to the facility, therefore a request for a Level II PASRR evaluation had not been submitted. An interview was conducted with the Social Worker (SW) on 12/16/25 at 2:07 PM. The SW stated the PASRR process included the Admission Coordinator would confirm the residents had a Level I PASRR or Level II PASRR determination upon admission to the facility. During the clinical team meeting, the team reviewed psychotropic medications and the resident diagnoses and informed the SW if a PASRR re-evaluation or significant change request was needed. The SW also revealed she had not been asked to submit a request for an evaluation for a Level II PASRR for Resident #50 until 12/16/25, when she was asked to provide documentation of the Level II PASRR. An interview with the Administrator on 12/18/25 at 3:47 PM revealed residents were discussed in daily clinical team meetings and if it was determined that a resident needed an evaluation for a Level II PASRR the SW would be responsible for requesting the evaluation for a Level II PASRR. The Administrator acknowledged a request for a level II PASRR evaluation should have been submitted for Resident #50 by the SW due to Resident #50's mental health diagnoses.	F0645		
F0659 SS = D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to ensure a qualified staff member with the necessary skills and licensure inserted a peripheral intravenous (IV) catheter when a Medication Aide used the needle from an IV catheter kit and inserted it into a resident's arm (Resident #78). The deficient practice was identified for 1 of 5	F0659	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 6/1/25, the former Assistant Director of Nursing provided education following an incident where Medication Aide #1 used the needle from an IV (intravenous) catheter kit and inserted it into Resident #78's arm. The education outlined the scope of practice for a Medication Aide to Medication Aide #1. The incident was then reported to the Licensed Nursing Home Administrator. On 7/29/25, Medication Aide #1 was suspended pending investigation, and the incident was filed with the North Carolina Board of Nursing by the Director of Nursing. Address how the facility will identify other residents	02/03/2026

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(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
F0659 SS = D	Continued from page 19 nursing staff reviewed for sufficient and competent nurse staffing (Medication Aide #1). Findings included: Resident #78 was admitted to the facility on 05/02/25 with diagnoses that included arthritis, dementia, Alzheimer's disease, and diabetes mellitus. Resident #78 was discharged from the facility on 11/16/25. The admission Minimum Data Set assessment dated 05/08/25 revealed Resident #78 was severely impaired cognitively, was dependent or required substantial to maximum assistance with activities of daily living, and had taken antianxiety, antibiotic, antiplatelet medications during the lookback period of the assessment. Review of Resident #78's physician's order dated 06/01/25 to administer one (1) liter of 0.9% sodium chloride intravenously at 100 milliliters (ml) per hour for one day for hydration. Review of Nurse #1's progress note dated 06/01/25 revealed she had received a physician's order to administer one liter of 0.9% normal saline at 100 ml/hour intravenously to Resident #78. Nurse #1 noted attempts to start the IV were unsuccessful. An interview was conducted on 12/17/25 at 4:25 PM with Nurse #1. Nurse #1 stated she received a physician's order to administer IV fluids for Resident #78 on 06/01/25, but her attempt for intravenous access was unsuccessful. Nurse #1 stated she had left the room and did not observe Medication Aide #1 attempt to insert the IV catheter. She stated Medication Aide #2 was in the room and saw what happened and reported the incident to the former Assistant Director of Nursing (ADON) #2. Nurse #1 stated she was not made aware of the incident until the next day (06/02/25) when the former ADON #2 called her at home. Nurse #1 stated she had not witnessed a staff member attempt something out of their scope of practice but if she had she would immediately report it by following her chain of command. Review of Medication Aide #1's typed statement revealed she was in the room with Nurse #1 and was there to help calm Resident #78 and assist Nurse #1. The statement indicated Nurse #1 was successful in obtaining a blood draw but was unable to successfully get the IV started and had left the room. After Nurse #1 left the room Medication Aide #1's statement indicated she asked Resident #78 if she could try to start the IV and	F0659	Continued from page 19 having the potential to be affected by the same deficient practice: On 8/1/25, the Staff Development Director completed interviews for 100% of all Licensed Nurses and Medication Aides to include agency Nursing and Medication Aides to ensure compliance, review practice limits, and ethics training including practice limits. This was completed by 8/1/25. A 100% Medication Pass observations audit was completed with 100% of all Licensed Nurses and Medication Aides to include agency staff to ensure all medication aides and licensed nurses understand the scope of practice to include limitations of the Medication Aide. This audit began on 1/2/26 and was completed by 1/6/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was conducted by the Staff Development Coordinator of all 100% of all Licensed Nurses and Medication Aides to include agency staff to understand the scope of practice and limitations of the scope of practice of the Medication Aide. The education began on 1/19/2026 and will be completed by 1/23/2026. Any Licensed Nurses or Medication Aides to include agency staff who have not received the education by 1/23/26 will receive it at their next scheduled shift. Any newly hired Licensed Nurses or Medication Aides to include agency staff will be educated by the Staff Development Director during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, the Director of Nursing/Staff Development Coordinator will complete medication pass observations for 3 medication aides or licensed nurses per week for 4 weeks to include agency staff on various shifts to ensure compliance. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

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F0659 SS = D	Continued from page 20 Resident #78 stated, “yes that was fine.” The statement indicated Medication Aide #1 made one attempt to insert the peripheral IV catheter and was able to get blood return but unsuccessful in maintaining the IV when the vein collapsed. Medication Aide #1’s statement indicated she was attending nursing school and had practiced starting an IV and she meant no harm to Resident #78. The statement was signed on 07/29/25 by Medication Aide #1 and the former Administrator. Attempts to speak with Medication Aide #1 by phone on 12/17/25 at 2:26 PM were unsuccessful. The contact number provided by the facility was not a working number. Review of Medication Aide #2’s written statement revealed on 06/01/25 she observed Medication Aide #1 opening an IV catheter kit and stick Resident #78 in the arm in attempt to insert a peripheral IV catheter. The statement indicated the attempt was unsuccessful and Medication Aide #2 used gauze and a band aid to cover the area and stop the bleeding and had spoken to the nurse about what to do. A telephone interview was conducted with Medication Aide #2 on 12/18/25 at 9:00 AM. Medication Aide #2 stated she saw Medication Aide #1 attempt to start an IV on 06/01/25 and described what she saw was Medication Aide #1 stick Resident #78 in the left arm. After the attempt to start the IV, Medication Aide #2 recalled Resident #78 stated she was, “okay.” Medication Aide #2 stated she told the former ADON #2 about what happened and was asked to write a witness statement. Medication Aide #2 indicated she and Medication Aide #1 were interviewed by the former ADON #2 who discussed scope of practice and told Medication Aide #1 she could not start an IV. Medication Aide #2 stated she had received multiple educational in-services related to knowing your scope of practice and she knew not to attempt injections or attempt to insert an IV catheter. A telephone interview was conducted on 12/19/25 at 12:39 PM with the former ADON #2. The former ADON #2 stated she was not at the facility on 06/01/25 when Medication Aide #1 attempted to insert an IV catheter for Resident #78. She stated she was told there was no nurse in the room, but the incident was witnessed by Medication Aide #2. She questioned both Medication Aide #1 and Medication Aide #2 and Medication Aide #1 confirmed she attempted to start an IV for Resident #78. She reinforced Medication Aides do not start an IV and informed the former Administrator who took over the investigation.	F0659	Continued from page 20 The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	

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F0659 SS = D	Continued from page 21 A telephone interview was conducted on 12/19/25 at 1:53 PM with the former Administrator who stated after the incident was reported she spoke with Medication Aide #1 who confirmed she had attempted to start the IV. The former Administrator stated during her investigation Medication Aide #1 was suspended, and the Board of Nursing was called to report the incident. The former Administrator revealed she and the Staff Development Coordinator provided education to the nurses, medication aides, and nurse aides (NA) about scope of practice that included Medication Aides were not trained to start an IV. A telephone interview was conducted on 12/19/25 at 3:28 PM with the former Staff Development Coordinator. The Staff Development Coordinator revealed she had conducted a job skills fair approximately 2 months prior to her leaving her position in September 2025. She reviewed scope of practice, competency and skill checks for medication aides, nurses, and nurse aides. The skills check included medication administration, and she reinforced with the medication aides to ensure they understood scope of practice, and they were not competent or had the skills to start an IV. Review of a typed statement dated 8/1/25 revealed the former Director of Nursing (DON) had notified the state Board of Nursing on 8/6/25 to report Medication Aide #1. Attempt to interview the former DON on 12/19/25 at 1:47 PM was unsuccessful. An interview was conducted on 12/19/25 at 3:53 PM with the current Administrator revealed on 06/01/25, Medication Aide #1 attempted to insert an IV catheter into Resident #78's arm. The Administrator stated medication aides and/or nurse aides were not licensed for and did not have the required competency or skills to attempt to insert an IV catheter and must be immediately stopped and reported to the nurse, Director of Nursing (DON), or the Administrator.	F0659		
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:	F0677	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/18/26, the Director of Nursing and Nurse Aide #2 assisted Resident #31 and teeth were brushed. Resident #31 was satisfied, and no further concerns were identified.	02/03/2026

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F0677 SS = D	Continued from page 22 Based on record review, observations, and staff interviews, the facility failed to maintain oral hygiene for a dependent resident unable to brush their teeth for 1 of 3 residents reviewed for activities of daily living (Resident #31). The findings included: Resident #31 was admitted to the facility on 12/31/18 with diagnoses including autoimmune disease affecting the central nervous system, paralysis or severe weakness affecting the ability to move, and visual impairment. A review of the dental visit note dated 10/13/25 revealed Resident #31's periodontal health was documented as red tissue with a heavy buildup, plaque and calculus as heavy and oral hygiene as poor. The recommendations were for routine oral hygiene and follow up as needed. The quarterly Minimum Data Set (MDS) assessment dated 10/14/25 revealed Resident #31 was severely impaired cognitively, had upper extremity range of motion impairment on both sides, and was dependent on staff for oral hygiene. The care plan revised on 10/23/25 revealed Resident #31 required assistance with activities of daily living related to diagnoses and upper extremity contractures and was dependent on staff assistance for oral hygiene. During an interview on 12/16/25 at 9:32 AM, the Responsible Party (RP) stated Resident #31 required total care with oral hygiene and it was not routinely done. The RP revealed when family visited they had observed Resident #31's teeth were not clean and needed to be brushed, and they provided oral hygiene care. An interview and observation was conducted on 12/16/25 at 11:59 AM with Resident #31. When asked Resident #31 showed she had no lower teeth, and her upper front teeth had a white colored buildup of debris at the gum line and around several of her front teeth. When asked if staff brushed her teeth Resident #31 nodded her head as to say no. An observation on 12/17/25 at 3:41 PM revealed no change in Resident #31's front upper teeth and a white colored buildup of debris remained on the teeth and gums. An interview and observation was conducted on 12/18/25	F0677	Continued from page 22 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 12/31/25, the Unit Manager, Director of Nursing, and the Staff Development Director completed a 100% audit of all dependent resident's oral care. Any concerns identified were addressed immediately and reported to the Director of Nursing. This audit was completed on 12/31/25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/19/26, the Staff Development Coordinator began education for 100% of all nursing staff (Nurse Aides and Licensed Nurses) to include agency staff, on completing oral care daily and as needed for dependent residents. The education was completed by 1/23/26. Any nursing staff members (Nurse Aides and Licensed Nurses) to include agency who has not received this education by 1/23/26, will receive by their next scheduled shift. Any newly hired nursing staff members (Nurse Aides and Licensed Nurses) to include agency will receive in-service education during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, the Staff Development Coordinator/Director of Nursing will audit 5 dependent residents per week for 4 weeks to ensure oral hygiene has been completed. Any concerns will be addressed immediately and reported to the Director of Nursing of the Administrator. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed.	

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F0677 SS = D	Continued from page 23 at 11:40 AM with Nurse Aide (NA) #1. NA #1 revealed Resident #31 was dependent on staff and required total assistance with activities of daily living care. NA #1 revealed he had not offered or provided oral hygiene care for Resident #31 and stated he usually provided oral care during the afternoon. Upon request Resident #31 showed NA #1 her front upper teeth which continued to have the white colored buildup of debris on the teeth and along the gums and needed to be brushed. An observation and interview was conducted on 12/18/25 at 12:05 PM with the Director of Nursing (DON). The DON observed Resident #31's upper front teeth had a white colored buildup of debris and asked the resident if she wanted her teeth brushed. Resident #31 nodded her head as to say yes. The DON asked Resident #31 if she had been offered to have her teeth brushed and Resident #31 nodded her head as to say no. It was explained to the DON, Resident #31's teeth was observed to have a white colored buildup on 12/16/25, 12/17/25, and 12/18/25. The DON stated oral hygiene care should be done at least daily. During an interview and observation on 12/18/25 at 12:51 PM, NA #2 offered to brush Resident #31's upper teeth. NA #2 brushed Resident #31's upper teeth and the white colored buildup of debris was easily removed. NA #2 indicated oral hygiene care was done daily as part of the morning care. During an interview on 12/18/25 at 4:30 PM, the Administrator revealed oral hygiene care should be done at least daily.	F0677	Continued from page 23 Date of Compliance: 2/3/26	
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F0755	"Past Noncompliance - no plan of correction required"	06/26/2025

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F0755 SS = D	Continued from page 24 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Pharmacy Operation Manager and staff, the facility failed to have effective systems in place for the return of controlled medications to the pharmacy for 3 of 3 residents (Resident #15, Resident #25 and Resident #79). The findings included: a. The physician's order dated 03/19/25 revealed Resident #15 was to receive hydrocodone-acetaminophen (a combination of a narcotic opioid analgesic and a non-narcotic medication to relieve pain) 5-325 milligrams (mg) every 4 hours as needed (PRN) for left leg pain. The controlled substance count record dated 03/20/25 revealed Resident #15 had 30 tablets of hydrocodone-acetaminophen 5-325 mg with the RX# (prescription number) 17427852. Starting on 03/20/25, nurses signed the form indicating the medication was removed and administered to Resident #15 as follows: one dose on 3/20/25, one dose on 3/21/25, one dose on 3/24/25, one dose on 3/26/25, one dose on 3/31/25, one dose on 4/1/25, one dose on 4/8/25, one dose on 4/11/25, one dose on 4/12/25, one dose on 4/13/25, two doses on 4/14/25, one dose on 4/16/25, one dose on 4/17/25, two doses on 4/18/25, one dose on 4/21/25, two doses on 4/22/25, and one dose on 4/23/25. Following the last dose that was administered on 4/23/25, Resident #15 had 10 tablets left remaining.	F0755		

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F0755 SS = D	Continued from page 25 The March 2025 medication administration record (MAR) revealed starting on 03/20/25 Resident #15 received a total of 5 tablets of hydrocodone-acetaminophen 5-325 mg. The medication was documented as administered per physician order on 3/20/25 at 7:28 PM, 3/21/25 at 8:09 PM, 3/24/25 at 7:34 PM, 3/26/25 at 8:15 PM, and 3/31/25 at 8:24 PM. No further doses were documented as administered for the remainder of the month. The April 2025 MAR revealed Resident #15 received a total of 15 tablets of hydrocodone-acetaminophen 5-325 mg. The medication was documented as administered on 4/1/25 at 12:45 AM, 4/8/25 at 9:40 PM, 4/11/25 at 9:08 PM, 4/12/25 at 7:56 PM, 4/13/25 at 8:27 PM, 4/14/25 at 7:42 PM and 11:50 PM, 4/16/25 at 8:30 PM, 4/17/25 at 8:11 PM, 4/18/25 at 4:40 AM and 8:03 PM, 4/21/25 at 8:15 PM, 4/22/25 at 4:50 AM and 8:23 PM, and 4/23/25 at 8:03 PM. No further doses were documented as administered for the remainder of the month. The physician's order dated 03/19/25 for Resident #15's hydrocodone-acetaminophen 5-325 mg was discontinued on 04/28/25. The Pharmacy Return of Drugs form dated 4/28/25 and signed by Medication Aide #1 revealed Resident #15's RX #17427852 for hydrocodone-acetaminophen 5-325 mg with 10 tablets remaining was being returned due to the medication being discontinued. b. The physician's order dated 03/27/25 revealed Resident #25 was to receive one tablet of oxycodone (opioid) 5 milligrams (mg) by mouth every 8 hours as needed (PRN) for post-surgical pain. The controlled substance count record dated 03/27/25 revealed Resident #25 had 30 tablets of oxycodone 5 mg with the RX# (prescription number) 17469121. Starting on 04/13/25, nurses signed the form indicating the medication was removed and administered to Resident #25 starting as follows: one dose on 4/13/25, one dose on 4/14/25, one dose on 4/15/25, one dose on 4/16/25, one dose on 4/17/25, two doses on 4/18/25, one dose on 4/19/25, one dose on 4/21/25, two doses on 4/22/25, one dose on 4/23/25, and one dose on 4/24/25. Following the last dose that was administered on 4/24/25, Resident #25 had 17 tablets left remaining. The April 2025 MAR revealed Resident #25 received a total of 13 tablets of oxycodone 5 mg. The medication was documented as administered on 4/13/25 at 7:58 PM, 4/14/25 at 7:48 PM, 4/15/25 at 6:27 AM, 4/16/25 at 8:24 PM, 4/17/25 at 8:40 PM, 4/18/25 at 6:06 AM and 8:10 PM, 4/19/25 at 7:56 PM, 4/21/25 at 8:20 PM, 4/22/25 at 5:18	F0755		

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F0755 SS = D	Continued from page 26 AM and 8:03 PM, 4/23/25 at 7:51 PM, and 4/24/25 at 8:00 PM. No further doses were documented as administered for the remainder of the month. The physician's order dated 03/27/25 for Resident #25's oxycodone 5 mg was discontinued on 04/25/25. The Pharmacy Return of Drugs form dated 4/28/25 and signed by Medication Aide #1 revealed Resident #15's RX #17469121 for oxycodone mg with 17 tablets remaining was being returned due to the medication being discontinued. c. The physician's order dated 03/10/25 revealed Resident #79 was to receive one tablet of oxycodone-acetaminophen (a combination of a narcotic opioid analgesic and a non-narcotic medication to relieve pain) 5-325 milligrams (mg) one tablet every 4 hours as needed (PRN) for pain. The controlled substance count record dated 04/23/25 for the RX# (prescription number) 17508525 revealed Resident #79 had 30 tablets of oxycodone-acetaminophen 5-235 mg. There were no signatures indicating the medication was administered. The physician's order dated 03/10/25 for Resident #79's oxycodone-acetaminophen 5-235 mg was discontinued on 04/25/25. The Pharmacy Return of Drugs form dated 4/28/25 and signed by Medication Aide #1 revealed Resident #79's RX #17508525 for oxycodone-acetaminophen 5-235 mg with 30 tablets remaining was being returned due to the medication being discontinued. The initial allegation report dated 06/21/25 revealed on 06/20/25 at 10:45 AM the facility became aware that discontinued medications thought to have been sent back to the pharmacy at the end of April 2025 did not make it to the pharmacy. An investigation was initiated and law enforcement was notified. The investigative report dated 07/01/25 revealed the facility determined that 10 tablets of hydrocodone 5-325 mg and 47 tablets of oxycodone 5 mg that were presumed to have been sent to the pharmacy around 4/28/25 were unaccounted for. The facility's investigation included interviews with licensed nursing staff who reported no knowledge of the missing medications and a thorough search of the medication carts and medication rooms. The facility validated the medications were unaccounted for but were not able to substantiate that there was any drug diversion or	F0755		

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F0755 SS = D	Continued from page 27 misappropriation. Included in the facility's investigation documentation were statements dated 06/23/25 and 06/24/25 written and signed by Medication Aide (MA) #1. MA #1 indicated that on 04/29/25 she verified that Resident #15, Resident #25 and Resident #79 all had discontinued medication in an unsealed, controlled return bag stored in the narcotic drawer on the Main Hall medication cart. MA #1 indicated she had put the medications in the same bag, notified Unit Manager #1 and was standing at the medication cart when Unit Manager #1 started filling out a return of drug form, but she did not see what Unit Manager #1 wrote on the form. MA #1 noted she could not recall if she faxed the return of drug form to the pharmacy but did verify the medications remained on the Main Hall cart and were accounted for when she turned over the medication cart to Unit Manager #1 at 3:00 PM on 4/29/25. MA #1 was no longer employed and telephone attempts made on 12/17/25 at 2:26 PM and 3:59 PM for an interview were unsuccessful. During an interview on 12/17/25 at 2:30 PM, Unit Manager #1 explained the evening shift (7:00 PM to 7:00 AM) nurses were the ones who prepared medications for return to the pharmacy. She explained in April 2025, the process was the nurse would place the medications in a clear bag with a number stamped on the front of the bag, the number of the bag was written on the return of drugs form, the return of drug form was faxed to the pharmacy to arrange pick-up, and the bag was left unsealed and placed in the locked narcotic drawer in the Main Hall medication cart until picked up by the pharmacy. Unit Manager #1 revealed when the Administrator was informed by the pharmacy that they had not received the medication listed on the return of drug form dated 04/28/25, she was asked by the former Administrator to review all residents with physician orders for narcotic medications to determine if the residents actually needed it and if not, work with the provider to get the medication discontinued. Unit Manager #1 stated when reviewing residents narcotic substance count sheets and medication administration records, the only residents identified with medications unaccounted for were Resident #15, Resident #25 and Resident #79. Unit Manager #1 stated she personally saw the medication card for Resident #15 that had 10 tablets remaining. Unit Manager #1 stated the medication was placed in the unsealed bag to return to pharmacy and the only information she wrote on the return of drug form was Resident #15's name, RX number, name of the medication, reason for return and quantity.	F0755		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Lane Nursing and Rehabilitation Center	**107 Magnolia Drive , Morganton, North Carolina, 28655**

(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
F0755 SS = D	Continued from page 28 Unit Manager #1 stated she did not fill out the information for Resident #25 and Resident #79 that was listed on the return of drug form. She was not sure who placed the medications for Resident #25 and Resident #79 in the bag along with Resident #15's or filled out the information on the return of drugs form. She stated MA #1 confirmed it was not her handwriting. During a follow-up interview on 12/19/25 at 7:48 AM, Unit Manager #1 verified Resident #15's medications were in the bag to return to the pharmacy and stated the return of drug form must have been with the bag because the information for Resident #25 and Resident #79 were added to the form after the fact. Unit Manager #1 explained at the time (April 2025), when the pharmacy courier arrived at the facility for a scheduled pick-up, after the medication was counted, the pharmacy courier would seal the bag in front of the nurse and then sign the return of drug form. Telephone attempt on 12/19/25 at 1:47 PM for an interview with the former Director of Nursing (DON) was unsuccessful. During a phone interview on 12/19/23 at 2:13 PM, the former Administrator revealed in June 2025 (could not recall the exact date), she received an email from the pharmacy stating they had reason to believe that back in April 2025 medications were not returned to the pharmacy. The former Administrator stated she asked the pharmacy why they were reaching out 2 months later to inquire about the medications but didn't really get an answer. She stated on the same day she had received notification from the pharmacy, both she and the former DON looked through all the pharmacy forms. She stated they found the return of drug form dated 04/28/25 with the pharmacy courier's signature indicating the medications were picked up and she faxed the signed form to the pharmacy. The former Administrator explained when the return of drug form was placed in the DON's box with the nurse's and pharmacy courier's signatures, which was the process at the time, they would not have had any reason to think anything was wrong and the medications had been picked up by the pharmacy courier just like any other day. The former Administrator stated she didn't hear anything from the pharmacy until Wednesday the following week at which time she was informed by the pharmacy that when the courier signature was compared to other signed documents, the signature did not appear authentic. The former Administrator explained the pharmacy courier that signed the return of drug form was the main courier for the facility and if you pulled previous forms she had signed, her signatures were different	F0755		

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F0755 SS = D	Continued from page 29 each time. She stated when she and the former DON had looked at other forms the facility had that the pharmacy courier had signed, the signature appeared ok but since the pharmacy stated it wasn't the courier's signature, an investigation was initiated. The former Administrator stated as part of the facility's investigation, they had Corporate come to the facility to help with audits and interviews were conducted with nursing staff who had worked on the medication cart. She stated the nursing staff interviewed all recalled the medications were written up on the return of drug form and placed in the locked narcotic drawer of the medication cart, but they could not recall anything else. The former Administrator stated based on the facility's investigation, they could determine the medications were in fact missing but they were unable to determine how or what happened to the medications. The former Administrator stated the incident was discussed with the Medical Director and QAPI committee to develop a corrective action plan. During a phone interview on 12/18/25 at 2:30 PM, the Pharmacy Operation Manager revealed on 06/20/25, she received an envelope that contained a note from someone at the facility (did not state who) regarding a concern about narcotic medications for Resident #15, Resident #25 and Resident #79 that needed to be looked into. The Pharmacy Operation Manager stated she could not find any records of medication returns for the 3 residents, the pharmacy had not received a return of drug form from the facility and there was no record of receipt of returned medications. She stated she contacted the facility and had them fax her the return of drug form with the courier's signature. When she received the return of drug form dated 04/28/25, she looked through faxes, hard copies and emails but could not find any records that the medications were returned to the pharmacy or that the pharmacy had received the return of drug form request the facility provided. The Pharmacy Operation Manager stated she then pulled previous documents the courier had signed to compare with the signature on the return of drug form dated 04/28/25 and the signature did not appear authentic. She stated she also had her manager review the signatures who also agreed the courier's signature did not appear authentic. She then spoke with the courier who validated the signature on the return of drug form dated 04/28/25 was not hers. The Pharmacy Operation Manager stated at that point, she notified the facility and cooperated in the facility's investigation. The Pharmacy Operation Manager explained the process for medication returns was the facility fills out the return of drug form, faxes the form to the pharmacy and then the courier was notified to pick up the	F0755		

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F0755 SS = D	Continued from page 30 medications from the facility. If the form was faxed before 5:30 PM, the medications were picked up and brought back to the pharmacy the same day to be checked in and processed by the Pharmacist and Technician to make sure everything was accurate as indicated on the return of drug form. She stated for controlled substances (medications), it was the pharmacy's policy that couriers do not count the medications with facility nurses, and the courier does not seal the bag after the medications were counted. She stated the courier receives notification of the bag number to be picked up and once at the facility, the courier checks the number on the bag to confirm the number matches the number provided by the pharmacy and then signs the return of drug form. During interviews on 12/17/25 at 2:30 PM and 12/19/25 at 1:24 PM, the Corporate Consultant revealed they had determined through nurse interviews that the medications for Resident #15, Resident #25 and Resident #79 were prepared for return to the pharmacy per the facility process. The Corporate Consultant stated the facility believed the medication had been picked up by the pharmacy courier on 04/28/25 since the medications were no longer on the medication cart and at that time, the former DON had no reason to believe otherwise. She stated on 06/20/25 the facility was notified by the pharmacy they had concerns that the courier's signature on the return of drug form dated 04/28/25 was forged and the facility started an investigation. The Corporate Consultant stated Unit Manager #1 confirmed she only wrote the information on the return of drug form for Resident #15's medications that were being returned and MA #1 indicated the handwriting on the return of drug form that listed the medications being returned for Resident #25 and Resident #79 was not hers. She explained when they interviewed nursing staff that had worked on the medication cart 2 months after the medications were assumed to have been returned to the pharmacy, no one knew anything about the missing medications for Resident #15, Resident #25 and Resident #79. The Corporate Consultant stated during the investigation, there were some accusations that came up but nothing they could prove as there had been several nurses and medication aides who had worked on the medication cart and they just couldn't determine what had happened to the missing medications. She stated following this incident, they did a "company-wide" systematic change to the process for returning narcotic medications to the pharmacy. The facility provided the following corrective action plan with a completion date of 06/26/25:	F0755		

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F0755 SS = D	Continued from page 31 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 6/20/25 it was reported to the facility that medications were missing from the narcotic lock box for 3 residents. The medications had already been discontinued and prepared by the staff to be sent back to the pharmacy. The resident's and medications were as follows: Resident #79 had 30 tablets of oxycodone 5-325 milligrams (mg), Resident #25 had 17 tablets of Oxycodone 5mg, and Resident #15 had 10 tablets of Hydrocodone 5/325 for a total of 57 tablets. On 6/20/25, the pharmacy manager had a phone conversation with the Director of Nursing and the Licensed Nursing Home Administrator (LNHA) stating that the medications were not received from the pharmacy. The signature could not be confirmed as authentic upon review of the packing slip, during the facility investigation as the staff's signature. The pharmacy could not confirm during their investigation that the signature was the courier's authentic signature. An investigation was initiated by the Licensed Nursing Home Administrator (LNHA) immediately. The medications were written up to be sent to the pharmacy to be disposed of on 4/28/25. The courier picked up medications the following night on 4/29/25 from the facility. At the time of the reported incident, Resident #15 had 10 tablets of Hydrocodone 5/325 mg that had been discontinued on 4/28/25 and a return of drug sheet had been filled out and ready to return to the pharmacy. Resident #79 had 30 tablets of oxycodone 5-325mg that had been discontinued on 4/25/25 and a return of drug sheet had been filled out and ready to return to the pharmacy. Resident #25 had 17 tablets of Oxycodone 5mg tablets that had been discontinued on 4/25/25 and a return of drug sheet had been filled out and ready to return to the pharmacy. The medications were placed on the Main medication cart in narcotic lock box in an unsealed plastic bag. On 6/24/25 pain assessments were completed by the licensed nurses for Resident #79, Resident #15, and Resident #25. No concerns for pain were identified for these residents. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 6/20/25, the Administrator initiated an audit of 100% of all residents' Controlled Substance Count sheets in comparison to the narcotic medication blister	F0755		

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F0755 SS = D	Continued from page 32 packs in the medication cart to ensure there were no discrepancies in the count of the medications. The audit was completed on 6/22/25. There were no issues or concerns identified. On 6/20/25, the Administrator initiated an inspection of the narcotic blister pill packages for any tampering of medications. The inspection was completed on 6/22/25, and no issues or concerns were noted. On 6/23/25, the Clinical Consultant initiated an audit of the ordered narcotic medications since April 2025 to ensure the medications were in the medication cart, administered, or returned to pharmacy per protocol. The audit was completed on 6/25/25. The Administrator will initiate an investigation for any identified areas of concern. On 6/24/25, drug screenings were obtained for 100% of all Licensed Nurses/Medication Aides who had access to the medication cart. No positive screenings were noted. On 6/24/25, the Hall Nurses initiated assessment of all residents for pain. The Hall Nurses will initiate non-pharmacological interventions, pain medication, and/or physician notification for any identified areas of concern during the audit. The audit will be completed by 6/24/25. On 6/24/25, the Social Worker completed interviews with all alert and oriented residents regarding (1) Do you have any concerns with medication administration to include pain medication? (2) Do you have any concerns regarding misappropriation? A concern form will be completed for any identified area of concern and will be addressed by the Administrator. On 6/24/25, the Staff Development Coordinator initiated questionnaires with all Nurses and Medication Aides regarding: Do you have any concerns with medications being administered that have not been reported and addressed? The questionnaires will be completed by 6/24/25. Any Nurse or Medication Aide that has not completed the questionnaire by 6/24/25, will complete the questionnaire prior to their scheduled shift the Staff Development Director. Any issues or concerns reported will be addressed by the Administrator. On 6/24/25, the Payroll/Human Resources Bookkeeper completed an audit of all nurses and medication aides' license verification and Health Care Personnel Registry checks. All areas of concern will be addressed during the audit by the Administrator.	F0755		

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F0755 SS = D	Continued from page 33 On 6/23/25, the Clinical Consultant initiated an audit of packing slips since April 2025 to ensure all narcotic medications were checked in appropriately and accounted for. The audit was completed on 6/25/25. The Administrator will initiate an investigation for any identified areas of concern. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: On 6/23/25, the Staff Development Coordinator initiated an in-service with all nurses and medication aides regarding Controlled Substance Diversion to include: the definition, implications, and the new process for returning narcotic medications. The process for returning narcotic medications to the pharmacy is as follows: the nurse writes the narcotic medications on the return of medication form and has a second nurse verify the correct medication and amount. The form is then faxed to the pharmacy with only 2 medications per form/per bag. The purpose of only sending 2 cards per bag is so the pharmacy courier can verify the cards, and the nurse can continue to count with the cards placed back-to-back with the bag sealed. This is a new process. The medication is placed in a sealed clear/numbered bag supplied by the pharmacy and placed back in the narcotic lock box. The nurse on the cart will continue to count the medication as usual until the courier picks up the medication at their next delivery. At the time of pick-up, 1 nurse will verify the count with the courier prior to the medications being removed from the cart and the cards will be marked as removed from the cart on the declining count sheet, the courier and nurse will sign the form and 1 copy remains in the facility and remain in the Director of Nursing office. The other copy will leave with the courier and the medication. The in-service will be completed on 6/24/25. After 6/24/25, all nurses or medication aides to include contract or agency staff that have not worked and received the in-service will complete upon their next scheduled shift by the Staff Development Director. On 6/24/25, the Staff Development Coordinator initiated an in-service with all staff regarding Misappropriation and to report any concerns of misappropriation or diversion to the Administrator immediately. This in-service education also placed an emphasis on the following: the definition of misappropriation (the illegal use or redirection of prescription narcotics from their intended use). The in-service will be completed on 6/24/25. After 6/24/25, all staff to include contract and agency staff that have not worked	F0755		

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F0755 SS = D	Continued from page 34 and received the in-service will complete upon their next scheduled shift by the Staff Development Director. Any newly hired staff will receive the in-service upon hire by the Staff Development Director. At the conclusion of the investigation, it was determined that the facility failed to verify the medications being written on the return of drug form were correct in count by 2 nurses prior to placing the medications in the numbered bag, form faxed to the pharmacy, and being sealed to await pick-up by the courier. Indicate how will the facility plans to monitor its performance to make sure that solutions are sustained: Beginning on 6/30/25, a 100% audit of all ordered narcotic medications for all 3 medication carts to include an cart inspection was reviewed by the Staff Development Coordinator weekly x 4 weeks and compared to the Controlled Substance Count Sheets, medication administration record, and/or return of drug slips to ensure the narcotic medications were being administered or have been returned to the pharmacy as required per policy and there were no signs of drug diversion utilizing a Controlled Substance Audit tool. All areas of concern will be addressed during the audit including re-educating nurses. The Administrator will review and initial the audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed appropriately. The Administrator or Director of Nursing will present the findings of the audit tools to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will meet monthly for 2 months and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. The Quality Assurance Performance Improvement meetings were held on 10/08/25 for July and August. Date of Compliance: 6/26/25. Validation of the corrective action plan was completed onsite 12/19/25 by reviewing the staff education conducted along with the corresponding sign-in attendance sheets, interviews conducted with staff and residents, and monitoring tools put into place. Review of the monitoring tools revealed narcotic medications on all medication carts were audited weekly beginning 06/30/25 through 07/28/25 and were initialed	F0755		

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F0755 SS = D	Continued from page 35 as reviewed by the former Administrator with no concerns identified. The results were reported to the QAPI committee for suggestions and/or recommendations. Observations of medication administration revealed nurses and MAs reviewed the physician orders, the medication label, and MAR prior to administering resident medication. All the medications were administered as ordered without any issues. Residents with controlled narcotic medications had a declining count record that matched the remaining amounts. Interviews with nurses and MAs on various shifts revealed they had received in-service education related to Misappropriation of Resident's Property which included immediately reporting any discrepancies and were able to describe the process for returning discontinued medications to the pharmacy. Interviews with alert and oriented residents and family members of cognitively impaired residents revealed no concerns related to medication administration or uncontrolled pain. The corrective action plan completion date of 06/26/25 was validated.	F0755		
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and interviews with the Registered Dietitian (RD) and staff, the facility failed to follow the physician's diet order for double portions at breakfast and the enriched meal program for 1 of 5 residents reviewed for nutrition (Resident #52). Findings included: Resident #52 was admitted to the facility on 10/18/25 with diagnoses including adult failure to thrive and	F0808	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/16/25, Nurse Aide #3 notified the Dietary Manager of the error in the diet card that is included on the Resident's meal tray. The diet card/tray card is used to identify the Resident's physician ordered diet and the items that should be included on their meal tray. The dietary staff provided Resident #52 with a bowl of oatmeal and a chocolate milk that was missing from the meal tray and Nurse Aide #3 delivered it to Resident #52. No additional concerns were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 12/29/26/, the Dietary Manager completed a 100% audit of all resident meal tray cards/diet cards for all 3 meals to ensure 100% of all residents received the correct diet. The diet card/tray card is used to identify the Resident's physician ordered diet and the items that should be included on their meal tray. This audit was completed by 1/6/26. Any areas of concern	02/03/2026

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F0808 SS = D	Continued from page 36 moderate protein-calorie malnutrition. The admission Minimum Data Set assessment dated 10/24/25 revealed Resident #52 was severely impaired cognitively, required partial to moderate assistance with eating, had no swallowing disorders, weighed 101 pounds with no documented weight changes, and had a stage two (partial-thickness loss of skin with exposed dermis) pressure ulcer that was present on admission. Review of the RD progress note dated 10/27/25 included recommendations Resident #52 participated in the enriched meal program and received double portions at breakfast. Review of the physician's orders revealed a diet order dated 10/27/25 for double portions at breakfast and participation in the enriched meal program. The nutrition care plan initiated on 11/06/25 identified risk for weight changes related to varied intake and diagnoses. Interventions included to provide diet as ordered. During an observation on 12/16/25 at 8:12 AM, Resident #52 had received a breakfast meal that consisted of 2 pieces of bacon, 3 French toast sticks, a container each of orange and grape juice. Resident #52's diet card indicated, "Special diets: double portion breakfast, enhanced meal program, 8 ounces of chocolate milk, and 8 ounces of oatmeal and listed grits as a dislike." However, the tray did not include chocolate milk or oatmeal. An interview was conducted on 12/16/25 at 8:18 AM with Nurse Aide (NA) #3. NA #3 revealed he helped serve breakfast trays to the residents on the unit but did not serve Resident #52. NA #3 read the diet card instructions and confirmed Resident #52 was supposed to receive double portions and there was no oatmeal or chocolate milk on the tray. NA #3 did not know what the enriched meal plan meant. During an interview on 12/16/25 at 3:14 PM, the Dietary Manager revealed the dietary staff member who placed Resident #52's breakfast tray on the serving cart was responsible for ensuring the food served matched the instructions on the diet card. A second interview was conducted on 12/17/25 at 3:30 PM with the Dietary Manager. The Dietary Manager revealed for double portions, Resident #52 should have received four pieces of bacon and four French toast sticks. The Dietary Manager further revealed that on 12/16/25	F0808	Continued from page 36 identified were corrected immediately. No concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/19/26, the Staff Development Coordinator began education with 100% of all dietary and nursing staff to include agency staff on ensuring residents receive a therapeutic diet. This education included ensuring residents receive the recommended diet that is ordered by the resident's physician. The education began on 1/19/2026 and will be completed by 1/23/2026. Any dietary or nursing staff member to include agency staff who have not received the education by 1/23/26 will receive it at their next scheduled shift. Any newly hired staff will be educated by the Licensed Nursing Home Administrator/Director of Nursing/Staff Development Director during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, the Dietary Manager will audit 5 tray cards/diet cards weekly for 4 weeks to ensure resident tray cards/diet cards match the resident's diet card as ordered by the resident's physician. The diet card/tray card is used to identify the Resident's physician ordered diet and the items that should be included on their meal tray. Any areas of concern will be corrected immediately. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	

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(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
F0808 SS = D	Continued from page 37 cheese grits were served as the enhanced meal food item but was listed as a dislike on Resident #52's diet card. The Dietary Manager revealed Resident #52 should have received the substitute for the enriched meal plan which was fortified milk or an essential breakfast drink. An interview was conducted on 12/19/25 at 2:51 PM with the RD. The RD explained Resident #52 was underweight with a stage two pressure ulcer at admission. The RD explained the enriched meal program included food items like oatmeal that was made with sugar and milk for extra calories and double portions were ordered because Resident #52 consumed more at breakfast. The RD confirmed meals served should match the diet card. During an interview on 12/19/25 at 3:49 PM, the Administrator stated the food served to Resident #52 should match the physician's order and diet card.	F0808		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to discard food past its use-by date in	F0812	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/16/25, the Dietary Manager and the Dietician removed the frozen turkeys and the French toast sticks from the walk-in freezer floor and discarded the expired lemon-flavored thickener from the cooler. No further concerns were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/16/26, the Dietary Manager and the Licensed Nursing Home Administrator completed a 100% audit of all resident food storage areas in the kitchen to ensure all food products were within the use-by date. Any concerns were addressed immediately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was conducted by the Staff Development Director/Licensed Nursing Home Administrator/Dietary Consultant for 100% of all dietary staff on the guidelines for expired foods in the kitchen for both refrigerated and dry storage areas to include	02/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

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F0812 SS = E	Continued from page 38 1 of 1 walk-in cooler and store food off the floor in 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents. The findings included: a. During an initial observation of the facility's kitchen with the Dietary Manager on 12/15/25 at 9:59 AM, the walk-in cooler had two (2) one-quart sized containers of lemon-flavored thickener with a use-by date of 10/28/25. b. During an initial observation of the facility's kitchen with the Dietary Manager on 12/15/25 at 10:12 AM the walk-in freezer was noted to have the following concerns: -Three (3) boxes of frozen turkeys, four turkeys per box, placed on the floor in the center of the walk-in freezer. -One (1) box of french toast sticks placed on the floor in the center of the walk-in freezer. An interview with the Dietary Manager on 12/16/25 3:14PM revealed that food items should not be available to be served to residents past the use-by date and the turkeys and french toast sticks were not stored correctly in the walk-in freezer. The Dietary Manager discarded the food items from the walk-in cooler that were past the use-by date. The Dietary Manager stated that all dietary staff had the responsibility to check dates on food items weekly and food items past the used-by date should be discarded. He further stated that food items in the walk-in freezer should not be placed on the floor. He revealed the facility had given turkeys to the staff for the holidays and the freezer had limited space to store the extra turkeys. He stated staff had to move the turkeys and french toast sticks to get food items off the shelf and did not put the turkeys and french toast sticks back on the shelf. An interview with the Administrator on 9/25/2025 at 1:22 PM revealed that all dietary staff should have checked use-by dates on food items daily and that food items past the use-by date would be discarded. In addition, the dietary staff should report the food items past the use-by date to the Dietary Manager. The Administrator stated food items should not have been placed on the floor of the walk-in freezer and if dietary staff discovered food items placed on the floor of the walk-in freezer they should inform the Dietary Manager.	F0812	Continued from page 38 conducting routine audits of these areas, not storing food items on the floor, and discarding any food products that are expired immediately. The education began on 1/16/2026 and will be completed by 1/19/2026. Any dietary staff who have not received the education by 1/19/26 will receive it at their next scheduled shift. Any newly hired staff will be educated by the Dietary Manager/Licensed Nursing Home Administrator during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, Dietary Manager/Licensed Nursing Home Administrator will audit 2 food storage areas in the kitchen weekly for 4 weeks to ensure food products are within use-by date and no food products are stored on the floor. The Dietary Manager/Licensed Nursing Home Administrator/Dietary Aides will complete a weekly audit of all storage areas in the kitchen to include both refrigerated and dry storage areas to monitor for expired food products and food products on the floor. Any expired food products will be discarded immediately, and any foods noted on the floor will be removed immediately. This audit will begin on 1/19/26. This audit will continue indefinitely. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	
F0880 SS = D	Infection Prevention & Control	F0880	Address how the corrective action will be accomplished	02/03/2026

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F0880 SS = D	Continued from page 39 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0880	Continued from page 39 for those residents found to have been affected by the deficient practice: On 1/8/26, the facility Nurse Practitioner completed a health visit for Resident #45 to include a full assessment and noted no concerns or sign and symptoms of infection. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/19/26, the Staff Development Coordinator completed a 100% audit/assessment of all residents on Enhanced Barrier Precautions. No signs and symptoms of infection noted. On 1/5/26, the Staff Development Coordinator completed a 100% audit of all Nursing staff to include agency staff on how to properly don and doff Personal Protective Equipment (PPE) for residents on Enhanced Barrier Precautions. This audit was completed on 1/19/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was conducted by the Staff Development Coordinator with 100% of all licensed nurses and nurse aides members on donning and doffing Personal Protective Equipment (PPE) when providing direct care for a resident who has been placed on Enhanced Barrier Precautions as outlined in the Centers for Disease Control (CDC) guidelines. The education began on 1/15/2026 and will be completed by 1/18/2026. Any nursing staff members to include agency who have not received the education by 1/18/26 will receive it at their next scheduled shift. Any newly hired staff will be educated by the Director of Nursing/Staff Development Director during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 1/19/26, the Staff Development Coordinator will audit 5 staff per week for 4 weeks to ensure PPE	

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F0880 SS = D	Continued from page 40 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to implement their infection control policy and procedures for Enhanced Barrier Precautions (EBP) when Nurse #2 did not put on a protective gown prior to a high contact care activity that involved administering a nutritional supplement and water flushes through a resident's (Resident #45) feeding tube (a medical device inserted into the stomach). This occurred for 1 of 5 staff members reviewed for infection control practices (Nurse #2). Findings included: The facility's Infection Control Policy and Procedures guideline for initiation of precautions last revised on 6/13/24 read in part, "isolation precautions for EBP was utilized by staff for residents who had an implanted medical device when providing care and precautions included to wear a gown." A continuous observation on 12/15/25 at 12:04 PM through 12:27 PM revealed an EBP sign was posted on the door of Resident #45's room with instructions staff must wear a gown for high contact resident care	F0880	Continued from page 40 is donned and doffed properly when caring for residents with Enhanced Barrier Precautions. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 2/3/26	

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F0880 SS = D	Continued from page 41 activities. High contact care activities listed included use of a feeding tube. An over-the-door storage bin was in place and contained protective gowns available for use. Nurse #2 accessed Resident #45's feeding tube to administer water flushes and a nutritional supplement. Nurse #2 did not wear a protective gown during high-contact care of Resident #45's feeding tube. During an interview on 12/19/25 at 11:31 AM, Nurse #2 revealed Resident #45 had been on contact precautions, but she was told the precautions had been removed. Nurse #2 revealed she was not aware Resident #45 was under any type of precautions at the time she completed the tube feeding. An interview was conducted on 12/19/25 at 10:27 AM with the Staff Development Coordinator/Infection Preventionist in the presence of the Director of Nursing (DON). The Staff Development Coordinator/Infection Preventionist revealed she recently started at the facility, and she and the DON worked together on Infection Control. The Staff Development Coordinator/Infection Preventionist stated Nurse #2 should have put on a protective gown when she administered the water flushes and nutritional supplement for Resident #45's feeding tube. An interview was conducted on 12/19/25 at 10:27 AM with the DON. The DON revealed she worked with the Staff Development Coordinator/Infection Preventionist because she recently started her position at the facility. The DON revealed Nurse #2 should have put on a protective gown when she administered the water flushes and nutritional supplement for Resident #45's feeding tube.	F0880		