STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345315	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Lumberton	**1170 Linkhaw Road , Lumberton, North Carolina, 28358**

(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 The survey team entered the facility on 2/10/26 to conduct a recertification and complaint investigation survey and exited on 2/13/26. Additional information was obtained on 2/19/26. Therefore, the exit date was changed to 2/19/26. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID # 1E3727-H1.	E0000		
F0000	INITIAL COMMENTS The survey team entered the facility on 2/10/26 to conduct a recertification and complaint investigation survey and exited on 2/13/26. Additional information was obtained on 2/19/26. Therefore, the exit date was changed to 2/19/26. Event ID# 1E3727-H1 The following intakes were investigated 2661762, 2656216, 2568684, 2723758, 2584263, 2699720, 2620665, and 2738055. 3 of the 17 complaint allegations resulted in deficiency.	F0000		
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices	F0561	Immediate action(s) taken for the resident(s) found to have been affected include: Upon notification by the surveyor to the facility Administrator (LNHA), the facility immediately implemented Carrolton Policy #15.2 Use and Storage of Food Brought on by Family or Visitors on 2/12/26. Residents #28, #48, and #71 were educated by the LNHA on the new food storage policy on 2/12/26. Resident #28 was discharged home from the facility on 2/19/26. Identification of other residents having the potential to be affected was accomplished by: An Ad-Hoc Quality Assessment Performance Improvement (QAPI) was completed on 2/12/26, led by the facility administrator (LNHA) regarding the new policy and the plan of correction for F 561.	03/13/2026

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

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F0561 SS = D	Continued from page 1 about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and Registered Dietician (RD) and staff interviews, the facility failed to honor residents' choices to have food items stored in the refrigerator and reheated for later consumption for 3 of 9 residents reviewed for self-determination (Resident #28, Resident #48, Resident #71). The findings included: a. Resident #28 was admitted to the facility on 12/8/2025 with diagnoses to include acute unspecified protein calorie malnutrition. Review of Resident #28's admission Minimum Data Set (MDS) assessment dated 12/14/2025 revealed she was moderately cognitively impaired and was coded independent for eating. The care plan dated 12/8/2025 for Resident #28 revealed a plan of care for risk for malnutrition related to weight loss, acute on chronic illness, and impaired mobility. The goal of care was for her intake of nutrients to meet her metabolic needs. Interventions included she was to receive her diet and supplements as prescribed. An interview with Resident #28 was completed on 2/10/2026 at 11:25 AM. Resident #28 stated she really didn't like the food provided by the facility. She further stated she would prefer to eat foods provided to her by her husband from home or local restaurants. Resident #28 indicated the facility would not allow her to store any cooked foods in the refrigerator or reheat the food for her. She stated that she would like to store food items brought to her in the refrigerator, but she was told by the facility that it was not allowed.	F0561	Continued from page 1 The facility has determined that all residents have the potential to be affected when resident choices regarding food storage, refrigeration, and reheating are not honored. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary team (IDT) members were educated on 2/12/26 by the LNHA on the new refrigeration storage policy (Carrolton Policy #15.2) for outside food brought in for residents. Newly hired IDT members will be educated on policies related to food brought in for residents during the orientation process by the LNHA/DON. IDT members provided the updated policy to all facility residents with a Brief Interview from Mental Status (BIMS) of 13 or higher on 2/12/26. The Business Office Manager (BOM) notified all facility residents' responsible parties of the new policy (Carrolton Policy #15.2 Use and Storage of Food Brought on by Family or Visitors) via mail on 2/12/26. The Admission Director added the new policy (Carrolton Policy #15.2 Use and Storage of Food Brought on by Family or Visitors) to the admission packet on 2/12/26. How the corrective action(s) will be monitored to ensure the practice will not recur: The LNHA and/or designee will complete random weekly audits for two (2) consecutive weeks, consisting of: Interviewing five (5) Residents at random with a BIMS of 13 or higher to ensure they can store food per policy Interviewing two (2) residents' responsible parties of residents with a BIMS of 12 or less at random to ensure the residents can store food per policy.	

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F0561 SS = D	Continued from page 2 b. Resident #48 was admitted on 12/16/22 with diagnosis to include stroke. Review of Resident #48's annual Minimum Data Set (MDS) assessment dated 11/12/25 revealed he was cognitively intact and was coded as independent for eating. An interview with Resident #48 was completed on 2/10/26 at 11:14 AM. Resident #48 stated he did not like the food provided by the facility. He further stated that in the past he enjoyed ordering a pizza once per month and would eat some of the pizza for dinner and save the rest in the refrigerator and have it reheated for his lunch and dinner the following day. Resident #48 stated that recently he was told that he was not allowed to store any cooked food items in the refrigerator or reheat the food and the pizza that he ordered and purchased was thrown away by the staff. Resident #48 stated that he would like to store food items in the refrigerator, but he was told that the facility did not allow this. c. Resident #71 was admitted on 1/31/23 with diagnosis to include stroke and diabetes. Resident #71's quarterly Minimum Data Set (MDS) dated 11/11/25 revealed that he was cognitively intact. An interview with Resident #71 was completed on 2/10/26 at 1:28 PM. Resident #71 stated that he did not like the food provided by the facility. He further stated that he would prefer to eat foods including healthy, diabetic foods provided by his family. Resident #71 stated that he was told that the facility would not allow him to store any cooked foods in the refrigerator or reheat the food for him. He stated that he would like to store food items brought in by his family in the refrigerator but was told by the facility that it was not allowed and the facility did not allow residents to have a personal refrigerator in their room. An observation of the 300-hall nourishment room was completed on 2/10/2026 at 10:35 AM. A sign on the refrigerator for residents read in part, "No cooked food may be stored in refrigerator. No stored foods per Carrolton policy." An interview with the Dietary Manager was conducted on 1/10/2026 at 10:38 AM. The Dietary Manager stated that it was the facility's policy not to allow residents to store food in the nourishment room refrigerator to prevent any potentially hazardous food illnesses from	F0561	Continued from page 2 The Activity Director and/or designee will ask about the new policy at the next scheduled Resident Council meeting to ensure compliance. Audit records will be reviewed by the QAPI committee on a bi-weekly basis until consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 2026.	

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F0561 SS = D	Continued from page 3 leftover food or foods that were prepared someplace else. She indicated that residents were allowed to keep drinks and nutritional supplements in the nourishment room refrigerator. An interview with the Registered Dietician (RD) was conducted on 2/12/2026 at 1:47 PM. The RD stated that one of his recommendations to facilities was that previously cooked food items could usually be safely stored in the refrigerator for up to 3 days. An interview with the Director of Nursing (DON) was completed on 2/13/2026 at 2:40 PM. The DON stated she expected residents to be allowed to make choices about their food. She further stated that residents should be given the choice to store leftovers in the refrigerator for later consumption. An interview with the Administrator was completed on 2/10/2026 at 11:30 AM. The Administrator stated the facility policy was not to allow residents to store food in the refrigerator and not to reheat foods. He indicated that any cooked foods that were not eaten within 4 hours were discarded. The Administrator stated that residents were not allowed to have personal refrigerators in their rooms.	F0561		
F0602 SS = E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with resident, staff, Pharmacy Director and Nurse Practitioner, the facility failed to protect the residents' right to be free from misappropriation of narcotic pain medications (Tramadol, Hydrocodone-Acetaminophen, Oxycodone, and Oxycodone-Acetaminophen) for 9 of 9 residents reviewed for misappropriation of controlled medications (Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87).	F0602	Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing (DON) was notified by the surveyor of excess narcotic medications being present on two medication carts. Immediately, all controlled substances in the facility were checked, including the narcotic pain medications for residents #2, # 16, #21, #34, #43, #52, #69, and #71. Twenty-two medications were removed from the carts and returned to the pharmacy. No signs of drug diversion were found. Identification of other residents having the potential to be affected was accomplished by: Facility leaders, including the Administrator, Director of Nursing (DON), Facility Nurse Consultant (FNC), Chief Clinical Officer (COO), and Chief Operating Officer (COO), met on February 19, 2026, to discuss the results of the recent survey and the need to re-examine all pharmacy procedures surrounding the monitoring of controlled substances. As a result of this meeting:	03/13/2026

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F0602 SS = E	Continued from page 4 Findings included: a.) Resident #21 was admitted to the facility on 12/22/22 with diagnoses including adult failure to thrive and debility. A physician's order with a start date of 10/16/23 which remained as an active order for Resident #21 revealed Tramadol 50 milligrams (mg) tablets, one tablet by mouth two times a day for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/27/25 at 7:09 PM a total of 30 Tramadol 50 mg tablets for Resident #21 were delivered to the facility. The delivery receipt was signed off as received by Nurse #1, a night shift nurse, on 10/28/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet (an inventory log used to record a running total for each controlled medication) found for the 30 Tramadol 50 mg tablets that were delivered to the facility on 10/27/25 for Resident #21. The Minimum Data Set (MDS) quarterly assessment dated 2/3/26 revealed Resident #21 was cognitively intact. During an observation on 2/13/26 at 4:30 PM Resident #21 was observed sitting in her room in a wheelchair with her eyes closed. She showed no signs or symptoms of distress/pain. b.) Resident #2 was admitted to the facility on 12/14/22 with diagnoses including peripheral vascular disease (narrowed or blocked blood vessels, typically affecting legs and feet, that can cause pain and cramping in the leg muscles). A physician's order with a start date of 1/1/25 which remained as an active order for Resident #2 revealed oxycodone 5 mg tablets, one tablet by mouth every six	F0602	Continued from page 4 Plans were made to re-educate all nursing staff, including all licensed nurses and medication aides, on facility procedures surrounding controlled substances. Audit tools and processes for monitoring controlled substances were revised by the Facility Nurse Consultant and Chief Clinical Officer. Medication Room Inspection Medication Cart Audits Medication Pass Audit DON/ADON Controlled Substance Process Audit Facility Nurse Consultant Audit The facility's Quality Assessment and Performance Improvement (QAPI) plans were revised on 2/19/26 to reflect changes to the processes for monitoring controlled substances. The facility has determined that all residents who receive controlled medications have the potential to be affected when the facility does not maintain procedures that protect the residents' right to be free from misappropriation of narcotic pain medications. An Ad-Hoc QAPI was completed on 2/26/26, led by the facility administrator (LNHA), regarding the plan of correction for F 602. Actions taken/systems put into place to reduce the risk of future occurrence include: The Facility Nurse Consultant/Pharmacy Nurse Consultant/DON re-educated facility nursing staff on pharmacy procedures and systems for the receipt and disposition of all controlled drugs, and for maintaining accurate accounts and reconciliations of all controlled substances 2/18/26 through 2/27/26. These in-services covered the following information: Identifying and Reporting Suspected Drug Diversion Controlled Substance Accountability	

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F0602 SS = E	Continued from page 5 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/10/25 at 5:04 PM a total of 60 oxycodone 5 mg tablets for Resident #2 were delivered to the facility. The delivery receipt was signed as received by Nurse #15. The delivery receipt was not signed off as received by a second nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on 8/10/25 for Resident #2. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/19/25 at 7:11 PM a total of 60 oxycodone 5 mg tablets for Resident #2 were delivered to the facility. The delivery receipt was not signed off as received by a nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on 10/19/25 for Resident #2. The MDS quarterly assessment dated 2/11/26 revealed Resident #2 had severely impaired cognition. During an observation on 2/13/26 at 4:30 PM Resident #2 was lying in bed. She was not oriented and could not engage in conversation. She showed no signs or symptoms of distress/pain. c.) Resident #16 was admitted to the facility on 4/11/24 with diagnoses including cancer and heart failure. A physician's order with a start date of 5/8/24 which remained as an active order for Resident #16 revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/19/25 at 7:34 PM a total of 30 Tramadol 50 mg tablets were delivered to the facility for Resident #16. The delivery receipt was signed by Nurse #1 on 8/19/25. There was no signature	F0602	Continued from page 5 Carrolton Policy 12.10- Controlled Substance Procedures and Recordkeeping, including: Delivery of Controlled Substances Facility receipt of controlled substances must include a two-person verification by the pharmacy delivery driver and the facility receiving nurse Adding Controlled Substances to the medication cart inventory must include a two-nurse verification Shift Change Count A thorough count of controlled substances must be performed each time the possession of the medication cart changes. Shift Change Count Sheets must be completed accurately with two nurse confirmations for all counts, and each time a declining count sheet is added or subtracted from the cart inventory Completed Declining Count Sheets will be placed in the DON locked box after being removed from the cart inventory Return of Drugs Review of processes and required documentation All discontinued medications are to be removed from the inventory and processed for return to the pharmacy at the time of discontinuation or at the time of resident discharge from the facility or death. Record Retention and Filing Pharmacy Delivery Sheets are to be filed daily by delivery date DEA Power of Attorney (processes and retaining)- these are never to be destroyed.	

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F0602 SS = E	Continued from page 6 on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 30 Tramadol 50 mg tablets that were delivered to the facility on 8/19/25 for Resident #16. The MDS comprehensive assessment dated 1/23/26 revealed Resident #16 was cognitively intact. During an observation and interview on 2/13/26 at 4:40 PM with Resident #16 she was observed lying in bed and voiced no concerns about her care or pain medications. d.) Resident #34 was admitted to the facility on 11/11/24 with diagnoses including cerebral vascular accident (CVA) and heart failure. A physician's order with a start date of 2/12/25 which remained as an active order for Resident #34 revealed Tramadol 50 mg tablets, one tablet by mouth every 6 hours as needed for moderate and severe pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/12/25 at 5:09 PM a total of 60 Tramadol 50 mg tablets were delivered to the facility for Resident #34. There was no nurse signature on the delivery sheet. There was no declining count sheet found for the 60 Tramadol 50 mg tablets that were delivered to the facility on 10/12/25 for Resident #34. The MDS comprehensive assessment dated 12/2/25 revealed Resident #34 had severely impaired cognition. During an observation on 2/12/26 at 4:00 PM Resident #34 was observed sitting in his room in his wheelchair with his Responsible Party present. Resident #34 could not engage in conversation. Resident #34's Responsible Party was interviewed and voiced no concerns regarding Resident #34's pain medication. e.) Resident #43 was admitted to the facility on	F0602	Continued from page 6 Documentation All controlled substance administrations must be documented at the time of administration on the declining count sheet and the medication administration record (MAR) All waste must include a two-nurse (or med aide) verification Licensed nurses and certified medication aides who were not present for these training sessions were educated prior to returning to work. Newly hired licensed nurses and medication aides will receive training during orientation from the Director of Nursing or Unit Managers on policies and procedures regarding controlled substances, accountability, and drug diversion. The FNC met with the DON/ADON/UM from 2/23/26 to 2/25/26 to review revised audit tools and monitoring processes to ensure accurate accounts and reconciliations for all controlled substances. This education covered the following: Review of the facility's plan of correction for F 755 (Pharmacy Services) Daily responsibilities of the DON/ADON Reconciling delivery sheets Review and filing of declining count sheets Daily rounding to check the medication room and medication carts to ensure that controlled substance security is maintained. Daily responsibilities of the UM Running the discharged medication report to ensure that all discontinued controlled substances are returned to the pharmacy in a timely manner Daily rounding to check the medication room and	

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F0602 SS = E	Continued from page 7 2/19/25 with diagnoses including deep vein thrombosis (blood clot in deep veins). A physician's order with a start date of 2/25/25 which remained as an active order for Resident #43 revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/6/25 at 8:50 PM a total of 90 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/7/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 90 Tramadol 50 mg tablets that were delivered to the facility on 10/7/25 for Resident #43. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 45 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 45 Tramadol 50 mg tablets that were delivered to the facility on 10/30/25 for Resident #43. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. f.) Resident #52 was admitted to the facility on 1/16/25 with diagnoses including arthritis and diabetes. A physician's order with a start date of 10/29/25 which remained as an active order for Resident #52 revealed oxycodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 60 oxycodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #52. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse.	F0602	Continued from page 7 medication carts to ensure that controlled substance security is maintained. Review of revised audit schedules and audit tools Medication Room Inspection Medication Cart Audits Medication Pass Audit DON/ADON Controlled Substance Process Audit Facility Nurse Consultant Audit The FNC, along with the DON/ADON, rounded to each medication cart in the facility on 2/25/26 to verify that all discharged and/or excess controlled substances had been removed from each cart. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/ADON/UM will complete Medication Room Audits weekly for four (4) weeks to ensure that all expired/discharged medications have been removed and that security procedures for maintaining controlled substances are followed: All controlled Substances are secured, both refrigerated and in the Nexsys Automated Dispensing Cabinet (Nexsys) Review five (5) entries on Nexsys, match the MAR to ensure accuracy in documentation Review of Nexsys alerts- all must be reconciled and cleared The ADON/UM will audit all Medication Carts each week for four (4) weeks to ensure that all expired/discharged and excess controlled medications have been removed and that security procedures for maintaining controlled substances are followed: Controlled Substances Locked, Cart keys with the nurse	

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F0602 SS = E	Continued from page 8 There was no declining count sheet found for the 60 oxycodone-acetaminophen 5-325 mg tablets that were delivered to the facility on 10/30/25 for Resident #52. The MDS comprehensive assessment dated 1/15/26 revealed Resident #52 had severely impaired cognition. During an observation on 2/11/25 at 2:00 PM Resident #52 was lying in bed and could not engage in conversation. She was smiling and showed no signs or symptoms of distress/pain. g.) Resident #69 was admitted to the facility on 1/18/23 with diagnoses including diabetes and renal disease. A physician's order with a start date of 10/24/24 which remained as an active order for Resident #69 for hydrocodone–acetaminophen 10-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 9/3/25 at 7:18 PM a total of 45 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #69. The delivery receipt was signed by Nurse #1 on 9/4/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 45 hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on 9/3/25 for Resident #69. The MDS comprehensive assessment dated 11/20/25 revealed Resident #69 was cognitively intact. During an interview on 2/11/25 at 2:00 PM Resident #69 voiced no concerns about receiving her pain medications. h.) Resident #79 was admitted to the facility on 2/1/24 with diagnoses including heart failure and renal disease. A physician's order with a start date of 4/5/24 that remained as an active order for Resident #79 for	F0602	Continued from page 8 D/Cd and expired controlled substances removed Excess medications have been removed from the cart Review Shift Count sheets for at least 24 hrs. to ensure the appropriate signatures are in place for all shifts (counts and additions/removals of declining count sheets) Review declining count sheets to ensure appropriate signatures are in place for administrations/wastes Review five (5) entries on the declining count sheet, match the MAR to ensure accuracy in documentation Random Medication Pass Audits will be conducted by the DON/ADON/UM weekly for four (4) weeks (1 nurse/medication aide per week), then monthly for two (2) months (2 nurses/medication aides per month) to ensure that medication passes are free from medication errors and that security procedures for maintaining controlled substances are being followed. Med cart is locked when unattended/controlled substances are secured properly Meds administered within timeframe on MAR (and declining count sheet if controlled) Have all discontinued/expired/excess medications been removed from the cart The DON/ADON will complete the Controlled Substance Process Audit daily for four (4) weeks to ensure security procedures for maintaining controlled substances are being followed. Reconciliation of controlled substance delivery sheets Verification of two-nurse signatures for controlled substance deliveries Verification of two-nurse signatures changes in the declining count sheet cart inventory (adding controlled substances and removing completed count sheets) Controlled Substance security is maintained (locked carts)	

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F0602 SS = E	Continued from page 9 hydrocodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/23/25 at 7:41 PM a total of 60 hydrocodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #79. The delivery receipt was signed by Nurse #1 on 10/24/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 60 hydrocodone-acetaminophen 5-325 mg tablets that were delivered to the facility on 10/23/25 for Resident #79. The MDS quarterly assessment dated 11/24/25 revealed Resident #79 had moderate cognitive impairment. During an observation on 2/11/26 at 2:45 PM Resident #79 was observed lying on bed. Resident #79 could not engage in conversation. She showed no signs or symptoms of distress/pain. i.) Resident #87 was admitted to the facility on 1/21/23 with diagnoses including heart failure. A physician's order with a start date of 1/20/23 which remained as an active order for Resident #87 for hydrocodone–acetaminophen 10-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/5/25 at 5:02 PM a total of 60 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #87. The delivery receipt was signed by the weekend Nurse Supervisor and by Nurse #5 on 10/5/25. There was no declining count sheet found for the 60 hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on 10/5/25 for Resident #87. The MDS quarterly assessment dated 12/8/25 revealed Resident #87 had severely impaired cognition. During an observation on 2/11/25 at 2:30 PM Resident	F0602	Continued from page 9 The Facility Nurse Consultants will complete a corporate-controlled substance audit by March 12, 2026, to verify compliance with controlled substance procedures. This audit will include: Audit declining count sheets against the corresponding MARs for thirty (30) residents Audit of 20 random delivery sheets for two-person verification A review audit of 10 completed shift-change count sheets for two-nurse verifications Count the controlled substances on two (2) medication carts to verify accuracy Audit records will be reviewed by the Quality Assessment and Performance Improvement (QAPI) Committee biweekly until the committee determines that consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 2026.	

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F0602 SS = E	Continued from page 10 #87 was lying in bed and showed no signs or symptoms of distress or pain. During an interview on 2/12/26 at 9:30 AM the Director of Nursing (DON) stated on Monday morning 11/3/25 she was notified by the weekend supervisor that they could not find Resident #21's Tramadol. The DON stated she called the pharmacy and was told that 30 tablets of Tramadol 50 mg for Resident #21 were sent to the facility on 10/27/25. The DON stated she checked all of the medication carts to see if it had been put on another cart by mistake. The DON stated that all 8 medication carts in the facility were checked and the Tramadol for Resident #21 delivered on 10/27/25 was never found and the declining count sheet for the Tramadol for Resident #21 was never found. The DON stated she immediately notified the Administrator and the facility's Chief Nursing Officer. She stated the Pharmacy Director and the Medical Director were also notified. The DON stated that she, the Chief Nursing Officer, and the facility's Nurse Consultant began auditing all controlled medications that included current and discharged residents from 8/1/25 through 11/4/25. During the audit they discovered that eight additional residents (Residents #2, #16, #34, #43, #52, #69, #79, and #87) were found to have missing controlled medications for active orders. The DON stated that during the medication cart audits they were able to determine that the missing controlled medications were mainly from the 200-hall medication cart. She indicated that they started interviewing the 200-hall staff and were told during staff interviews that there was a Medication Aide (Medication Aide #1) who had been acting "suspicious". The DON stated they drug tested all nursing staff, and Medication Aide #1 tested positive for the missing medications. Medication Aide #1 was terminated, and Health Care Personnel Registry was notified. The DON stated the process used before the missing controlled medications in November 2025 included that when controlled medications were delivered to the facility one nurse would go through the delivery tote that held the medications and distribute the medications to the medication carts. The DON stated there was no assigned nurse to distribute the medications to the carts, it was whichever nurse was available when the delivery driver came in. The nurse would distribute the medications to the carts then sign the delivery sheet. The DON stated the medication delivery sheet had two signature lines and the nurse that checked the medication in was to sign and the nurse who received the medication on the medication cart was to sign. The DON stated during their investigation they discovered that two nurses were not signing off on the medication delivery sheets.	F0602		

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F0602 SS = E	Continued from page 11 The DON stated once the nurses signed the delivery sheets, the delivery sheets were placed in her box outside of her office. The DON stated she was responsible for reviewing the declining count sheets and the delivery sheets once they were completed. The DON stated she did not identify a problem with the declining count sheets until the missing medications were identified on 11/3/25 because the declining counts sheets were missing, the missing controlled medications were not recorded in the narcotic book, and she did not verify delivery sheets to ensure the medications were actually on the medication carts. The DON stated the new process was for the delivery sheets and declining counts sheets to be placed in a lockbox once completed and she would review the sheets for accuracy. The DON stated that prior to the identification of the missing medications on 11/3/25, she or Unit Manager #1 would do periodic audits of the controlled medications, and the Consultant Pharmacist also conducted periodic audits of controlled medications. The DON stated they had not identified any concerns with controlled medications until this occurred with Resident #21's medications. The DON stated that Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87 continued to receive their medications as ordered due to having extra refills on the cart. During an interview on 2/12/26 at 2:00 PM the facility's Chief Nursing Officer stated she was notified on 11/3/25 of the missing controlled medications for Resident #21. She stated an investigation was initiated at that time. The Chief Nursing Officer stated once they determined that the controlled medications were missing, they began auditing all controlled medications and identified eight additional residents (Residents #2, #16, #34, #43, #52, #69, #79, and #87) with missing medications. She stated the Drug Enforcement Agency (DEA) and law enforcement were notified, and Health Care Personnel Registry was notified regarding Medication Aide #1. The Chief Nursing Officer indicated they reported a total of 660 missing controlled tablets for active orders to the DEA. She stated they identified during their investigation that Nurse Practitioner #2 would order refills of the controlled medications for residents on her visits without checking to see if the order needed to be refilled first which caused controlled medications to accumulate on the medication carts. The Chief Nursing Officer stated they had changed the process, and the Nurse Practitioner and the Medical Director now checked with a nurse to determine if a refill was needed before writing the refill orders. The Chief Nursing Officer stated this would help to reduce	F0602		

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F0602 SS = E	Continued from page 12 the number of controlled medications stored on the medication carts and reduce the risk of diversion. During an interview on 2/12/26 at 2:30 PM the facility's Nurse Consultant stated during the investigation of the missing controlled medications in November 2025, they found that there were excessive controlled medications being stored on the medication carts. The Nurse Consultant stated they determined that Nurse Practitioner #2, who was interim while Nurse Practitioner #1 was out on leave, was evaluating residents and writing orders for refills for the controlled medications without first determining if a refill was needed at that time. This led to excessive amounts of the controlled medications being delivered and stored on the medication carts. The Nurse Consultant stated that Nurse Practitioner #2 was no longer working at the facility. The Nurse Consultant stated the facility worked with the pharmacy and changed the process to where the pharmacy would not fill the order until a staff nurse confirmed that a refill was needed. The Nurse Consultant stated due to having excessive amounts of the controlled medications stored on the medication carts the residents continued to receive their medications. During a phone interview on 2/12/26 at 4:00 PM Nurse Practitioner #2 stated she was no longer evaluating residents in the facility due to Nurse Practitioner #1 no longer being on leave. Nurse Practitioner #2 stated when she evaluated residents for pain assessments, which was usually once a month, she would go ahead and order pain medication refills. She stated she did not necessarily check with a nurse to see if a refill was needed at the time. Nurse Practitioner #2 stated she had spoken to the facility's Nurse Consultant during the investigation of the missing medications in November 2025 and was made aware of the new process for refilling controlled medications. During a phone interview on 2/13/26 at 1:05 PM the Pharmacy Director stated he was made aware of the nine residents (Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87) who were identified in November 2025 as having missing controlled medications. The Pharmacy Director stated they audited their system, their delivery sheets and the returned medications that were sent back to the pharmacy and confirmed that the medications missing for the nine residents were filled by the pharmacy, delivered to the facility, and none of the missing controlled medications had been returned to	F0602		

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F0602 SS = E	Continued from page 13 the pharmacy. The Pharmacy Director stated when medications were delivered to the facility they sent two copies of the delivery sheets, one copy went with the delivery driver, and the second copy was to be signed by a nurse and should be sent back to the pharmacy by fax. The Pharmacy Director stated that when refill orders for controlled medications were received in the pharmacy and they had not filled it in a while they would go ahead and refill the medication. He stated due to the number of missing controlled medications from the facility, the pharmacy had changed their process and now before refilling controlled medications, including as needed medications, the nurse from the facility must call to request the refill. This new process would help to ensure excessive controlled medications were not sent if they were not needed. During an interview on 2/13/26 at 1:30 PM Nurse Practitioner #1 stated she and the Medical Director were made aware of the nine residents (Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87) who had missing controlled medications in November 2025. Nurse Practitioner #1 stated she was aware of the new ordering process for controlled medications and now checked with the nurse to see if a refill was needed before she wrote refill orders. Nurse Practitioner #1 stated there had been no reports made to her regarding Resident #21, Resident #2, Resident #16, Resident #34, Resident #43, Resident #52, Resident #69, Resident #79, or Resident #87 having unrelieved pain. The facility provided a corrective action plan that was not able to be validated.	F0602		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed	F0684	Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing (DON) obtained orders on 2/12/2026 to access and flush the port-a-cath for resident #1. Identification of other residents having the potential to be affected was accomplished by: The Director of Nursing verified that there were no other residents in the facility with port-a-caths on 2/12/2026.	03/13/2026

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F0684 SS = E	Continued from page 14 to obtain orders to access and manage a port-a-cath (an implantable device placed under the skin, usually in the chest, to provide long-term, easy access to veins for chemotherapy, medications, blood draws, or intravenous fluids) for 1 of 1 sampled resident with a port-a-cath (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/13/2023 with diagnoses to include personal history of traumatic brain injury with persistent vegetative state. The hospital discharge summary completed on 12/20/2024 for Resident #1 revealed a left chest port-a-cath was placed by vascular surgery on 12/18/2024 for future access, but it was not yet mature (approximately 7 to 14 days for the site to heal to allow for use). A progress note written by the NP on 12/4/2025 revealed Resident #1 was admitted to the hospital on 8/26/2025 for pneumonia and sepsis (a serious condition in which the body responds improperly to an infection), and 10/14/2025 for seizure like activity. It further listed a port-a-cath was placed surgically on 12/18/2024. The quarterly Minimum Data Set (MDS) assessment dated 12/5/2025 for Resident #1 indicated he had no speech, was rarely/never understood and rarely/never understood others. His cognitive skills for daily decision making indicated, “severely impaired-never/rarely made decisions.” The care plan for Resident #1 last revised 1/7/2026 did not reveal a plan of care regarding a port-a-cath. The hospital physician’s history and physical dated 1/30/2026 revealed Resident #1 was admitted to the hospital on 1/29/2026 with seizures and a catheter associated urinary tract infection. It further read that the resident had a left upper chest port-a-cath that was available for medication administration. The hospital discharge summary for Resident #1 dated 2/5/2026 revealed he was being discharged to the facility following treatment for seizures and a urinary tract infection with sepsis. It indicated that the resident’s left chest port-a-cath was last flushed with normal saline (sterile solution of salt and water) and heparin (an anticoagulant) on 2/5/2026. A review of Resident #1’s physician orders from 12/20/2024 through 2/11/2026 revealed no orders related to accessing and maintaining the resident’s	F0684	Continued from page 14 The facility has determined that all residents have the potential to be affected when orders are not obtained to cover medications, treatments, and services required, including orders to access and manage port-a-caths. An Ad-Hoc Quality Assessment Performance Improvement (QAPI) was completed on 2/26/26, led by the facility administrator (LNHA) regarding the plan of correction for F 684. Actions taken/systems put into place to reduce the risk of future occurrence include: The Facility Assessment was updated on 2/13/2026 by the LNHA and the Facility Nurse Consultant to address the care required for the population of residents with a port-a-cath and the staff training necessary to completely provide port-a- cath care. The Chief Nursing Officer and Facility Nurse Consultant reviewed/revised the following documents on 2/17/2026: Carrolton Policy 8.26 Accessing and De-accessing an Implanted Vascular Access Port Skills Validation Checklist- Accessing Implanted Vascular Access Port Skills Validation Checklist- De-accessing Implanted Vascular Access Port The facility Nurse Practitioner (NP) assessed and flushed the port-a-cath for resident #1 on 2/18/2026. The DON and Assistant Director of Nursing (ADON) were educated by the NP on accessing, flushing, and de-accessing a port-a-cath during this encounter. Facility leaders, including the Administrator, Director of Nursing, Facility Nurse Consultant, Chief Nursing Officer, and Chief Operating Officer, met with the Nurse Practitioner on 2/19/2026 to discuss the care of resident #1’s implanted vascular port. The NP verified the DON's and ADON's competencies for accessing, flushing, and de-accessing an implanted	

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F0684 SS = E	Continued from page 15 port-a-cath. An observation of Resident #1 was completed with Nurse #4 on 2/12/2026 at 3:53 PM. The observation revealed a left chest port-a-cath. An interview with Nurse #4 was completed on 2/12/2026 at 3:55 PM. Nurse #4 stated she didn't know if there were orders to access and maintain the port-a-cath, because she was a licensed practical nurse (LPN), and only registered nurses (RN) could access and flush a port-a-cath. An interview was completed with the Unit Manager on 2/13/2026 at 8:12 AM. The Unit Manager stated that she was the nurse responsible for Resident #1's readmission from the hospital on 2/5/2026. She stated she did not realize there should have been orders to access and flush the port-a-cath, because she was an LPN and the care of a port-a-cath was not in her scope of practice. The Unit Manager indicated that the second nurse that reviewed the orders was also an LPN. An interview with the Director of Nursing (DON) was conducted on 2/13/2026 at 7:50 AM. The DON stated Resident #1 had a port-a-cath due to poor vascular access. She further stated that when the resident returned from the hospital on 12/20/2024 the discharge summary had noted the port-a-cath was too immature to access at that time. The DON indicated that typically orders should have been obtained regarding the care and maintenance for the port-a-cath upon admission. She stated she was unsure of how long it took for a port-a-cath to heal, but that it would not take a year. The DON further stated that the facility had never accessed Resident #1's port-a-cath or provided any maintenance or care for it. She stated the hospital discharge summary dated 2/5/2026 indicated the port had been flushed at the hospital on 2/5/2026. She stated she thought there should have been orders in place to access and flush the port-a-cath routinely to keep it patent and prevent it from clotting off (ensuring it is open, unobstructed, and working properly). The DON indicated that accessing the port had to be done with a special needle and then flushed with normal saline and heparin for maintenance. She stated the facility didn't have a policy for routinely flushing a port-a-cath and that it would be ordered on an individual basis. She indicated that usually a port-a-cath was accessed monthly or every 6 weeks by an RN to maintain patency. The DON stated that accessing and flushing a port-a-cath was not on the list of competencies for nurses at the facility, and that training and education would have to be provided by the NP.	F0684	Continued from page 15 vascular access port via return demonstration on 3/3/2026. Competency verification via return demonstration will be completed on any licensed nurse prior to being asked to perform access, de-access, or flush an implanted vascular access port. All Licensed Nurses (Registered Nurses and Licensed Practical Nurses) were in-serviced on ensuring that orders for residents admitted to the facility are complete and accurate. This education was provided by the DON and Facility Nurse Consultant from 2/24/26 through 2/27/26 and covered the following items: Completing a thorough review of all medical records (including admission documents, histories, and physicals, and physicians' visit documentation) for all residents who are admitted to the facility and upon return from a visit to the physician. Completing a thorough admission assessment on all residents who are admitted or re-admitted to the facility Ensuring that orders for all residents are obtained to cover medications, treatments, and services required, including orders to access and manage port-a-caths. Licensed nurses who were not present for these training sessions were educated prior to returning to work. Newly hired licensed nurses will receive training during orientation from the Director of Nursing or Unit Managers on policies and procedures regarding ensuring that orders for all residents are obtained to cover medications, treatments, and services required, including orders to access and manage port-a-caths. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The DON/ADON/Unit Manager will audit all resident admissions for the next four (4) weeks to ensure that orders are obtained to cover all medications, treatments, and services required (including orders for implanted ports). This audit will include a review of the medical records and a physical assessment.	

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F0684 SS = E	Continued from page 16 An interview with the NP was completed on 2/13/2026 at 1:42 PM. The NP stated that she was aware Resident #1 had a port-a-cath for administration of intravenous (IV) fluids, medications, and blood draws, because he had poor vascular access. She further stated that she was not exactly sure how long it took a port-a-cath to heal, but they were usually able to be used approximately 2 weeks after placement. The NP indicated Resident #1's port-a-cath had not been accessed or flushed at the facility since it was placed in December 2024. The NP indicated she was aware a port-a-cath should be accessed and flushed routinely and that there had not been orders to access and maintain the port-a-cath after it was placed in December 2024. She stated that Resident #1 was admitted to the hospital at least 2 times in 2025 and she assumed that the hospital was accessing it and flushing it during the hospital stays must have been enough to keep it patent. The NP indicated she had mentioned ordering the special needles used to access a port-a-cath while speaking to nursing staff in the nurses' station on 2/9/2026, but the nursing staff indicated they did not access the port-a-cath. She could not recall which nurses made that statement. She further stated she was going to discuss care for the port-a-cath with the physician, but she had not done it yet. The NP indicated that the port-a-cath should be accessed monthly to maintain patency and she was going to write the orders and educate the registered nurse staff.	F0684	Continued from page 16 Audit records will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee on a bi-weekly basis until consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 2026.	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and Nurse Practitioner interviews, the facility failed to provide effective supervision of a cognitively impaired resident (Resident #91) who was known to exhibit wandering behavior and rummaging. This failure resulted in	F0689	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #91 discharged from the facility on 1/9/2026. On 12/27/25, Resident # 91 ingested the contents of one Dayquil over the counter capsule that she retrieved from the desk drawer of the receptionist. She was immediately assessed by the facility nurse and the Nurse Practitioner (NP), who recommended she be sent to the emergency department for further assessment. There were no adverse outcomes associated with capsule consumption, but to be safe, the patient was sent to the emergency department. The receptionist was immediately educated about maintaining the safety of our residents and ensuring that no medications were stored (personal or otherwise) in her desk drawer. All receptionists were educated by the DON/designee about the importance of not leaving personal	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345315	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

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F0689 SS = D	Continued from page 17 Resident #91 obtaining and ingesting one gel capsule of an over-the-counter cold and flu medication containing acetaminophen, dextromethorphan (cough suppressant) and phenylephrine (nasal decongestant) that was in an unlocked drawer in the receptionist's desk located in the lobby area of the facility. This deficient practice was identified for 1 of 4 residents reviewed for supervision to prevent accidents (Resident #91). Findings included: Resident #91 was admitted on 2/10/23 with a diagnosis which included Lewy body dementia, atrial fibrillation (irregular heart rate), hypertension, diabetes, chronic obstructive pulmonary disease, heart failure, thyroid disease and kidney disease. Resident #91's care plan dated 3/10/24 and currently active indicated that the resident was at risk for cognitive decline related to history of delirium and diagnosis of neurocognitive disorder with Lewy Body dementia. The intervention for this problem indicated to monitor, document and report any changes in cognitive function. Resident #91's quarterly Minimum Data Set dated 11/9/25 indicated that the resident had moderate cognitive impairment, wandering was not exhibited during the look back period and the resident used a wheelchair for mobility. A review of Resident # 91's electronic health record revealed a nursing progress note dated 12/27/25 at 2:51 PM written by the Unit Coordinator which indicated that Resident #91 went through the unattended receptionist's desk in the lobby and found an over-the-counter cold capsule. Resident #91 ingested the contents. The on-call provider was notified, and the staff were advised to monitor the resident and encourage fluids. The on-call provider was to be notified of any new or worsening symptoms. The note stated that Resident #91 was symptomatic with no description of the symptoms exhibited. A review of the manufacturer's instructions for the cold and flu relief gel capsule indicated to ask a doctor before use if you have: liver disease, heart disease, high blood pressure, thyroid disease or diabetes. Common side effects include but are not limited to confusion, dizziness, nervousness, and nausea. An interview was conducted with the Unit Coordinator on 2/12/26 at 2:55 PM. The Unit Coordinator stated that	F0689	Continued from page 17 medications in the facility – anywhere that is unlocked. Identification of other residents having the potential to be affected was accomplished by: A review of incident/accident reports by the Administrator (LNHA) and Director of Nursing (DON) for the last 90 days did not reveal any similar situations. No others were impacted. The facility has determined that all residents (100%) have the potential to be negatively affected by ingesting drugs not prescribed to them. If medications are stored in desks accessible to patients, patients are at risk for negative outcomes. An Ad-Hoc Quality Assessment Performance Improvement (QAPI) was completed on 2/26/26, led by the facility administrator (LNHA) regarding the plan of correction for F 689. Actions taken/systems put into place to reduce the risk of future occurrence include: All employees were in-serviced on 2/23/26 – 2/28/26 by the LNHA on maintaining the facility free of hazards at all times. Staff members were instructed to leave personal items locked in the employee lounge and not in offices, desks, or the nursing station. Employees who were not present for these training sessions were educated prior to returning to work. Newly hired employees will receive training during orientation from the LNHA/DON/ADON on policies and procedures to ensure the facility is free of hazards at all times. All incident/accident reports will be monitored daily by the DON to identify root causes and interventions. The DON or designee will immediately educate staff if problems are identified. All incident/accident reports will be monitored daily by the LNHA to ensure they are complete and accurate and that appropriate follow-up and interventions are taken. Additional education will be provided by the DON	

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F0689 SS = D	Continued from page 18 she was assigned to Resident #91 on 12/27/25 from 7:00 AM to 7:00 PM. The Unit Coordinator stated that on the afternoon of 12/27/25, she was in the nurse's station which is adjacent to the lobby when the Receptionist informed her that as she was returning to her desk, the Receptionist witnessed from across the room, Resident #91 ingesting a cold and flu gel capsule from the unlocked unattended desk drawer at the Receptionist's desk. The Receptionist informed the Unit Coordinator that she was unable to get to the resident in time to prevent her from taking the medication. The Unit Coordinator stated the Receptionist observed Resident #91 go into the receptionist's desk drawer, obtain one gel capsule of the cold and flu medication that was loose in the drawer and ingested it before staff could stop her. The Unit Coordinator stated that the Receptionist stated that she had the cold and flu medication loose in the desk drawer and Resident #91 opened the desk drawer, found the medication and ingested it. The Unit Coordinator indicated that throughout the day, residents were frequently in the common area in the front of the building where the receptionist's desk was and most of the residents don't wander or go into things. The Unit Coordinator stated that staff tried to supervise the residents in the common area the best they could but there was no system in place to ensure that the residents in the area were continuously monitored. The Unit Coordinator stated that the lobby area was an open area with television and seating that the residents were free to sit in and can propel wheelchairs throughout the area unrestricted with the receptionist's desk at the front of the area by the door to the facility. The Unit Coordinator indicated that Resident #91 exhibited behaviors of wandering throughout the facility, entering other resident rooms and common areas and rummaging through other residents' belongings. The Unit Coordinator stated that prior to this incident, Resident #91 would take items from other resident rooms, and it was difficult to redirect her. The Unit Coordinator stated that staff tried to monitor Resident #91 and redirect her when she wandered or rummaged through other residents' belongings. The Nurse Coordinator stated that initially after Resident #91 ingested the medication, she seemed okay but then she became drowsy and lethargic, so she was sent to the emergency room. A message was left on the Receptionist's voicemail on 2/13/26 at 2:12 PM with no return call received. A nursing progress note dated 12/27/25 at 5:51 PM written by the Weekend Supervisor revealed that the on-call provider and emergency medical services were called at 5:15 PM. Resident #91 was lethargic and not	F0689	Continued from page 18 if problems are identified. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The LNHA will complete five (5) random audits per week for four (4) weeks in general areas and desks to ensure that no medications (personal or otherwise) are stored in unlocked desks or areas. Random audits by the administrator will be included in the bi-weekly QAPI committee meeting to track and trend, ensuring no problems are present. Audit records and incident reports will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee biweekly until consistent, substantial compliance is achieved. Corrective action completion date: March 13, 2026.	

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F0689 SS = D	Continued from page 19 responding after she ingested over-the-counter cold medication. Resident #91 was sent to the emergency department for evaluation. An interview was conducted with the Weekend Supervisor on 2/13/26 at 1:55 PM. The Weekend Supervisor stated that Resident #91 had dementia and was confused with wandering and rummaging behaviors. The Weekend Supervisor stated that while she was on duty on 12/27/25 from 7:00 AM to 7:00 PM, the Unit Coordinator reported that Resident #91 went into the unlocked, unattended receptionist's desk drawer and obtained a cold and flu gel capsule and ingested it. The Weekend Supervisor indicated that Resident #91 was cognitively impaired with a diagnosis of dementia, propelled her wheelchair independently throughout the facility and at times was agitated and difficult to redirect with increased confusion. The Weekend Supervisor stated that after Resident #91 ingested the cold medication Resident #91 was drowsy and lethargic, so the supervisor stated she informed the on-call provider. The Weekend Supervisor stated that she obtained an order to send Resident #91 to the emergency department for altered mental status. The Weekend Supervisor stated that Resident #91 was evaluated in the emergency department and returned to the facility the same day? with no new orders. A review of the emergency department discharge summary dated 12/28/25 at 6:18 AM indicated that Resident #91 arrived in the emergency department on 12/27/25 at 5:51 PM with vital signs which were blood pressure 151/89 millimeters of Mercury (mm/Hg) (normal range is below 120/80 mmm/Hg) pulse 61 (normal range is 60-110), respirations 17 (normal range 16-20 breaths per minute), temperature 97.4 degrees (normal range is 97 to 99 degrees Fahrenheit) and oxygen saturation 96 percent (normal range is 96-100 percent). Resident #91 presented to the emergency department with altered mental status that began earlier in the day after she ingested a dose of over-the-counter cold and flu medication that she took from the receptionist's desk drawer. The discharge summary indicated that the supervisor at the facility reported that after taking the cold and flu medication, Resident #91 was very confused, not responding to her name, and was wandering into other residents' rooms at the facility. While in the emergency department, lab work, electrocardiogram, computed tomography (CT) scan of the head and urinalysis were obtained with the results being unremarkable. The note indicated that Resident #91's condition remained stable with no changes in vital signs or mental status while in the emergency department and the resident was discharged to the	F0689		

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F0689 SS = D	Continued from page 20 facility at 6:18 AM on 12/28/25 with no new physician orders. The discharge summary indicated that the facility was to follow up with the primary care physician if Resident #91 exhibited any worsening or change in symptoms. An interview was conducted with the Nurse Practitioner on 2/11/26 at 1:50 PM. The Nurse Practitioner stated that Resident #91 should not have had access to the medication and that the resident was confused with impaired cognition, wandering and rummaging behavior. The Nurse Practitioner stated that ingesting the medication had the potential for an adverse effect but Resident #91 did not suffer harm due to this incident. The Nurse Practitioner stated that one dose of the over-the-counter cold medication containing acetaminophen, dextromethorphan and phenylephrine wouldn't normally cause lethargy but the effect of a medication, even an over-the-counter medication, is individual. The Nurse Practitioner stated that it was her professional opinion that the gel capsule was not related to Resident #91's change in status with increased lethargy. The Nurse Practitioner stated that she had no concern that the cold medication was related to Resident #91's change in status and thought that it was related to the resident's diagnosis of Lewy Body Dementia which can cause waxing and waning cognition. An interview was conducted with the Director of Nursing (DON) on 2/13/26 at 2:30 PM. The DON stated that the incident should not have happened, and the resident should have been supervised and kept free from hazards. The DON indicated that all staff were responsible for supervising the residents but there was no system in place to ensure that a staff member was continuously monitoring the residents in the common areas, including the lobby area. The DON stated that staff are frequently passing in and out of the lobby area. Prior to this incident, the facility had not considered unlocked drawers to be a potential hazard to the residents. An interview with the Administrator on 2/13/26 at 4:15 PM revealed that he expected that the residents would be kept free from hazards and supervised to prevent accidents. The Administrator stated that all staff were responsible for supervising the residents in common areas including the lobby area. Prior to this incident, the facility had not considered unlocked drawers to be a potential hazard to a cognitively impaired resident.	F0689		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F0755	Immediate action(s) taken for the resident(s) found to have been affected include:	03/13/2026

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F0755 SS = E	Continued from page 21 §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. §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 staff, Consultant Pharmacist, Pharmacy Nurse Consultant, and Pharmacy Director, the facility failed to have effective safeguards and systems in place for the accounting of controlled medications and the return of discontinued controlled medications to the pharmacy to prevent drug diversion for 9 of 9 residents reviewed for misappropriation of medications (Resident #69, #43, #2, #21, #16, #34, #52, #79, and #87). Findings included: a. A physician's order for Resident #69 with a start date of 8/8/25 revealed Lorazepam 0.5 milligrams (mg)	F0755	Continued from page 21 The Director of Nursing was notified by the surveyor of excess narcotic medications being present on two medication carts. Immediately, all controlled substances in the facility were checked, including the narcotic pain medications for residents #2, # 16, #21, #34, #43, #52, #69, and #71. Twenty-two medications were removed from the carts and returned to the pharmacy. No signs of drug diversion were found. Identification of other residents having the potential to be affected was accomplished by: Facility leaders, including the Administrator, Director of Nursing (DON), Facility Nurse Consultant (FNC), Chief Clinical Officer (COO), and Chief Operating Officer (COO), met on February 19, 2026, to discuss the results of the recent survey and the need to re-examine all pharmacy procedures surrounding the monitoring of controlled substances. As a result of this meeting: Plans were made to re-educate all nursing staff, including all licensed nurses and medication aides, on facility procedures surrounding controlled substances. Audit tools and processes for monitoring controlled substances were revised by the Facility Nurse Consultant and Chief Clinical Officer. Medication Room Inspection Medication Cart Audits Medication Pass Audit DON/ADON Controlled Substance Process Audit Facility Nurse Consultant Audit The facility's Quality Assessment and Performance Improvement (QAPI) plans were revised on 2/19/26 to reflect changes to the processes for monitoring controlled substances. The facility has determined that all residents who receive controlled medications have the potential to be affected when the facility does not maintain adequate pharmacy procedures that protect the residents' right	

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F0755 SS = E	Continued from page 22 tablets, one tablet by mouth every 24 hours as needed for anxiety for 14 days. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/8/25 at 7:13 PM a total of 14 Lorazepam 0.5 mg tablets were delivered to the facility for Resident #69. The delivery receipt was signed by Nurse #1 on 8/8/25. There was no signature on the delivery sheet from a second nurse There was no declining count sheet (an inventory log used to record a running total for each controlled medication) found for the 14 tablets of Lorazepam 0.5 mg that were delivered to the facility on 8/8/25 for Resident #69. Review of Resident #69's Medication Administration Record (MAR) for August 2025 revealed the as needed Lorazepam 0.5 mg order showed no documentation that the medication was administered to Resident #69 after the delivery on 8/8/25 at 7:13 PM. A review of Resident #69's physician's orders included an order (start date of 10/24/24) for hydrocodone–acetaminophen 10-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. This order remained active. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 9/3/25 at 7:18 PM a total of 45 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #69. The delivery receipt was signed by Nurse #1 on 9/4/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 45 hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on 9/3/25 for Resident #69. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. b. A physician's order for Resident #43 with a start date of 2/25/25 which remained as an active order revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours for pain.	F0755	Continued from page 22 to be free from misappropriation of narcotic pain medications. An Ad-Hoc QAPI was completed on 2/26/26, led by the facility administrator (LNHA), regarding the plan of correction for F 755. Actions taken/systems put into place to reduce the risk of future occurrence include: The Facility Nurse Consultant/Pharmacy Nurse Consultant/DON re-educated facility nursing staff on pharmacy procedures and systems for the receipt and disposition of all controlled drugs, and for maintaining accurate accounts and reconciliations of all controlled substances 2/18/26 through 2/27/26. These in-services covered the following information: Identifying and Reporting Suspected Drug Diversion Controlled Substance Accountability Carrolton Policy 12.10- Controlled Substance Procedures and Recordkeeping, including: Delivery of Controlled Substances Facility receipt of controlled substances must include a two-person verification by the pharmacy delivery driver and the facility receiving nurse Adding Controlled Substances to the medication cart inventory must include a two-nurse verification Shift Change Count A thorough count of controlled substances must be performed each time the possession of the medication cart changes. Shift Change Count Sheets must be completed accurately with two nurse confirmations for all counts, and each time a declining count sheet is added or subtracted from the cart inventory	

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F0755 SS = E	Continued from page 23 A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/6/25 at 8:50 PM a total of 90 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/7/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 90 Tramadol 50 mg tablets that were delivered to the facility on 10/7/25 for Resident #43. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 45 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 45 Tramadol 50 mg tablets that were delivered to the facility on 10/30/25 for Resident #43. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. c. A physician's order for Resident #2 with a start date of 1/1/25 which remained as an active order revealed oxycodone 5 mg tablets, one tablet by mouth every six hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/10/25 at 5:04 PM a total of 60 oxycodone 5 mg tablets for Resident #2 were delivered to the facility. The delivery receipt was signed as received by Nurse #15. The delivery receipt was not signed off as received by a second nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on 8/10/25 for Resident #2. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/19/25 at 7:11 PM a total of 60 oxycodone 5 mg tablets for Resident #2 were delivered to the facility. The delivery receipt was not	F0755	Continued from page 23 Completed Declining Count Sheets will be placed in the DON locked box after being removed from the cart inventory Return of Drugs Review of processes and required documentation All discontinued medications are to be removed from the inventory and processed for return to the pharmacy at the time of discontinuation or at the time of resident discharge from the facility or death. Record Retention and Filing Pharmacy Delivery Sheets are to be filed daily by delivery date DEA Power of Attorney (processes and retaining)- these are never to be destroyed. Documentation All controlled substance administrations must be documented at the time of administration on the declining count sheet and the medication administration record (MAR) All waste must include a two-nurse (or med aide) verification Licensed nurses and certified medication aides who were not present for these training sessions were educated prior to returning to work. Newly hired licensed nurses and medication aides will receive training during orientation from the Director of Nursing or Unit Managers on policies and procedures regarding controlled substances, accountability, and drug diversion. The FNC met with the DON/ADON/UM from 2/23/26 to 2/25/26 to review revised audit tools and monitoring processes to ensure accurate accounts and reconciliations for all controlled substances. This education covered the following:	

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F0755 SS = E	Continued from page 24 signed off as received by a nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on 10/19/25 for Resident #2. d. A physician's order for Resident #21 with a start date of 10/16/23 which remained as an active order revealed Tramadol 50 milligrams (mg) tablets, one tablet by mouth two times a day for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/27/25 at 7:09 PM a total of 30 Tramadol 50 mg tablets for Resident #21 were delivered to the facility. The delivery receipt was signed off as received by Nurse #1, a night shift nurse, on 10/28/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet (an inventory log used to record a running total for each controlled medication) found for the 30 Tramadol 50 mg tablets that were delivered to the facility on 10/27/25 for Resident #21. e. A physician's order for Resident #16 with a start date of 5/8/24 which remained as an active order revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/19/25 at 7:34 PM a total of 30 Tramadol 50 mg tablets were delivered to the facility for Resident #16. The delivery receipt was signed by Nurse #1 on 8/19/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 30 Tramadol 50 mg tablets that were delivered to the	F0755	Continued from page 24 Review of the facility's plan of correction for F 755 (Pharmacy Services) Daily responsibilities of the DON/ADON Reconciling delivery sheets Review and filing of declining count sheets Daily rounding to check the medication room and medication carts to ensure that controlled substance security is maintained. Daily responsibilities of the UM Running the discharged medication report to ensure that all discontinued controlled substances are returned to the pharmacy in a timely manner Daily rounding to check the medication room and medication carts to ensure that controlled substance security is maintained. Review of revised audit schedules and audit tools Medication Room Inspection Medication Cart Audits Medication Pass Audit DON/ADON Controlled Substance Process Audit Facility Nurse Consultant Audit The FNC, along with the DON/ADON, rounded to each medication cart in the facility on 2/25/26 to verify that all discharged and/or excess controlled substances had been removed from each cart. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/ADON/UM will complete Medication Room Audits	

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F0755 SS = E	Continued from page 25 facility on 8/19/25 for Resident #16. f. A physician's order for Resident #34 with a start date of 2/12/25 which remained as an active order for revealed Tramadol 50 mg tablets, one tablet by mouth every 6 hours as needed for moderate and severe pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/12/25 at 5:09 PM a total of 60 Tramadol 50 mg tablets were delivered to the facility for Resident #34. There was no signature on the delivery sheet. There was no declining count sheet found for the 60 Tramadol 50 mg tablets that were delivered to the facility on 10/12/25 for Resident #34. g. A physician's order for Resident #52 with a start date of 10/29/25 which remained as an active order revealed oxycodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 60 oxycodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #52. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 60 oxycodone-acetaminophen 5-325 mg tablets that were delivered to the facility on 10/30/25 for Resident #52. h. A physician's order for Resident #79 with a start date of 4/5/24 that remained as an active order revealed hydrocodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/23/25 at 7:41 PM a total of 60 hydrocodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #79. The delivery receipt was signed by Nurse #1 on 10/24/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response.	F0755	Continued from page 25 weekly for four (4) weeks to ensure that all expired/discharged medications have been removed and that security procedures for maintaining controlled substances are followed: All controlled Substances are secured, both refrigerated and in the Nexsys Automated Dispensing Cabinet (Nexsys) Review five (5) entries on Nexsys, match the MAR to ensure accuracy in documentation Review of Nexsys alerts- all must be reconciled and cleared The ADON/UM will audit all Medication Carts each week for four (4) weeks to ensure that all expired/discharged and excess controlled medications have been removed and that security procedures for maintaining controlled substances are followed: Controlled Substances Locked, Cart keys with the nurse D/Cd and expired controlled substances removed Excess medications have been removed from the cart Review Shift Count sheets for at least 24 hrs. to ensure the appropriate signatures are in place for all shifts (counts and additions/removals of declining count sheets) Review declining count sheets to ensure appropriate signatures are in place for administrations/wastes Review five (5) entries on the declining count sheet, match the MAR to ensure accuracy in documentation Random Medication Pass Audits will be conducted by the DON/ADON/UM weekly for four (4) weeks (1 nurse/medication aide per week), then monthly for two (2) months (2 nurses/medication aides per month) to ensure that medication passes are free from medication errors and that security procedures for maintaining controlled substances are being followed. Med cart is locked when unattended/controlled substances are secured properly	

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F0755 SS = E	Continued from page 26 There was no declining count sheet found for the 60 hydrocodone-acetaminophen 5-325 mg tablets that were delivered to the facility on 10/23/25 for Resident #79. i. A physician's order for Resident #87 with a start date of 1/20/23 which remained as an active order revealed hydrocodone–acetaminophen 10-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/5/25 at 5:02 PM a total of 60 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #87. The delivery receipt was signed by the weekend Nurse Supervisor and by Nurse #5 on 10/5/25. There was no declining count sheet found for the 60 hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on 10/5/25 for Resident #87. During an interview on 2/12/26 at 9:30 AM the Director of Nursing (DON) stated on 11/3/25 she was notified by the weekend supervisor that they could not find Resident #21's Tramadol for an active order. She reported that they began auditing the medication carts and identified there were missing controlled medications including Resident #69's discontinued Lorazepam that was delivered on 8/8/25. The DON stated she called the pharmacy and was told that 14 Lorazepam 0.5 mg tablets were delivered to the facility for Resident #69 on 8/8/25. She stated that the 14 Lorazepam tablets delivered on 8/8/25 and the declining count sheet were never found. The DON indicated she confirmed with the pharmacy that 14 Lorazepam 0.5 mg tablets were sent to the facility on 8/8/25 and none were returned back to the pharmacy. The DON stated that Resident #69's MAR was reviewed and there was no documentation that Lorazepam was administered from the 8/8/25 delivery. The DON added that there was no declining count sheet for the 8/8/25 delivery of Lorazepam for Resident #69 and it was not recorded in the narcotic book. The DON stated she immediately notified the Administrator and the facility's Chief Nursing Officer. She stated the Pharmacy Director and the Medical Director were also notified. The DON stated that she, the Chief Nursing Officer, and the facility Nurse Consultant began auditing all controlled medications that included current and discharged residents from 8/1/25 through 11/4/25. The DON stated that during the medication cart audits they were able to determine that the missing controlled medications	F0755	Continued from page 26 Meds administered within timeframe on MAR (and declining count sheet if controlled) Have all discontinued/expired/excess medications been removed from the cart The DON/ADON will complete the Controlled Substance Process Audit daily for four (4) weeks to ensure security procedures for maintaining controlled substances are being followed. Reconciliation of controlled substance delivery sheets Verification of two-nurse signatures for controlled substance deliveries Verification of two-nurse signatures changes in the declining count sheet cart inventory (adding controlled substances and removing completed count sheets) Controlled Substance security is maintained (locked carts) The Facility Nurse Consultants will complete a corporate-controlled substance audit by March 12, 2026, to verify compliance with controlled substance procedures. This audit will include: Audit declining count sheets against the corresponding MARs for thirty (30) residents Audit of 20 random delivery sheets for two-person verification A review audit of 10 completed shift-change count sheets for two-nurse verifications Count the controlled substances on two (2) medication carts to verify accuracy Audit records will be reviewed by the Quality Assessment and Performance Improvement (QAPI) Committee biweekly until the committee determines that consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 2026.	

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F0755 SS = E	Continued from page 27 were mainly from the 200 hall medication cart. She reported that the facility then started interviewing 200 hall staff and were told during staff interviews that there was a Medication Aide (Medication Aide #1) who had been acting “suspicious”. The DON stated they drug tested all nursing staff, and Medication Aide #1 tested positive for the missing Lorazepam. Medication Aide #1 was terminated, and Health Care Personnel Registry was notified. The DON stated the process used before the missing Lorazepam was identified in November 2025 included that when controlled medications were delivered to the facility one nurse would go through the delivery tote and distribute the medications to the medication carts. The DON stated there was no assigned nurse to distribute the medications to the carts, it was whichever nurse was available when the delivery driver came in. The nurse would distribute the medications to the carts then sign the delivery sheet. The DON stated the medication delivery sheet had two signature lines and the nurse that checked the medication in was to sign and the nurse who received the medication on the medication cart was to sign. The DON stated during their investigation they discovered that two nurses were not signing off on the medication delivery sheets. The DON stated once the nurses signed the delivery sheets, the delivery sheets were placed in her box outside of her office. The DON stated she was responsible for reviewing the declining count sheets and the delivery sheets once they were completed. The DON explained that she did not identify a problem with the declining count sheet until 11/3/25 because the declining count sheet was missing, the Lorazepam was not recorded in the narcotic book, and she did not verify delivery sheets to ensure the medications were actually on the medication carts. The DON stated that they verified during their investigation that the declining count sheets were missing for nine residents (Resident #69, #43, #2, #21, #16, #34, #52, #79, and #87). The DON added that the new process was the delivery sheets and declining counts sheets would now be placed in a lockbox once completed and she would review the sheets for accuracy. The DON stated that prior to the identification of the missing medication on 11/3/25, she or Unit Manager #1 would do periodic audits of the controlled medications, and the Consultant Pharmacist also conducted periodic audits of controlled medications. The DON stated they had not identified any concerns with controlled medications until this was found in November 2025. The DON stated discontinued controlled medication declining count sheets were to be removed from the narcotic book with the witness of another staff member and the declining count sheet placed in her box. Then she would place the medication in a sealed bag and complete a return drug	F0755		

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F0755 SS = E	Continued from page 28 form then fax the form to the pharmacy. The sealed bag would be locked in the narcotic box on the medication cart until the pharmacy delivery driver picked it up. The DON indicated that process did not occur for Resident #69's Lorazepam because she did not receive a discontinued declining count sheet notifying her the Lorazepam order was discontinued for Resident #69. During an interview on 2/12/26 at 1:00 PM Unit Manager #1 stated she was responsible for checking medication orders, but she did not audit controlled medications on the medication carts, and she thought the DON was responsible for the controlled medications. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she was in the facility for monthly medication regimen reviews. She stated she was made aware of the missing controlled medications, including the discontinued Lorazepam, in November 2025. The Consultant Pharmacist stated that she did not conduct medication cart audits including auditing the controlled medications. She stated the pharmacy employed a Nurse Consultant that checked the medication carts and she thought he did random controlled medication audits, but she was not certain of this. The Consultant Pharmacist stated the Pharmacy Nurse Consultant had not reported any concerns to her regarding controlled medications. During a phone interview on 2/13/26 at 1:05 PM the Pharmacy Director stated in November 2025 he was made aware of Resident #69's missing Lorazepam that was delivered to the facility on 8/8/25. He stated the pharmacy audited their system, their delivery sheets and the returned medications that were sent back to the pharmacy and confirmed that the missing Lorazepam for Resident #69 was filled by the pharmacy, delivered to the facility on 8/8/25, and had not been returned to the pharmacy. The Pharmacy Director stated when medications were delivered to the facility they sent two copies of the delivery sheets, one copy went with the delivery driver, and the second copy was to be signed by a nurse and should be sent back to the pharmacy through fax. He stated medications should be returned to the pharmacy when the orders were discontinued. The Pharmacy Director stated the pharmacy did not track discontinued medication orders including controlled medications. He stated it was the facility's responsibility to remove the controlled medications from the medication cart when the order was discontinued and return any remaining medication to the	F0755		

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F0755 SS = E	Continued from page 29 pharmacy. During a phone interview on 2/19/26 at 3:00 PM the facility's Pharmacy Nurse Consultant stated he conducted random medication cart audits, but he was not responsible for conducting audits of the controlled medications. He stated he only checked that the narcotic box was locked when he did medication cart audits, but he never reviewed the controlled medications or the declining count sheets, and it was not a part of his medication cart audits. During a follow up interview on 2/13/26 at 2:00 PM the DON indicated she was not aware the Consultant Pharmacist did not conduct random audits of the controlled medications. She indicated she was not aware that Unit Manager #1 did not check the controlled medications. The DON stated Resident #69's discontinued Lorazepam should have been removed from the medication cart and returned to the pharmacy when the order was discontinued after 14 days, and that did not occur.	F0755		
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F0756	Immediate action(s) taken for the resident(s) found to have been affected include: Nurse #2 was re-educated on 2/13/26 by the Director of Nursing (DON) on medication administration, specifically preventing significant medication errors by following the physician-ordered parameters for blood pressure medication administration for residents, including resident #12. Identification of other residents having the potential to be affected was accomplished by: The Director of Nursing (DON) reviewed the February Pharmacy Report on 2/25/2026 to identify all follow-up actions needed, including staff education. The facility has determined that all residents of the facility who receive medications have the potential to be affected when pharmacy recommendations are incomplete or lack adequate follow-up. An Ad-Hoc Quality Assessment Performance Improvement (QAPI) was completed on 2/26/26, led by the facility administrator (LNHA) regarding the plan of correction	03/13/2026

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F0756 SS = E	Continued from page 30 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Consultant Pharmacist's interviews, the facility failed to a.) act on the Consultant Pharmacist's recommendation to address a residents (Resident #12) diuretic medication Metolazone (used to treat high blood pressure and fluid retention caused by heart failure or kidney disease) that was prescribed for increased edema. The Consultant Pharmacist reported during the monthly medication regimen review in October 2025 and November 2025 that Resident #12 was receiving Metolazone outside of the physician ordered parameters which were to hold the medication if the residents systolic blood pressure was less than 110 or the diastolic blood pressure was less than 60. b.) the Consultant Pharmacist failed to identify and address during the December 2025 and January 2026 monthly medication regimen reviews that Metolazone continued to be administered to Resident #12 outside of the ordered blood pressure parameters. This resulted in Resident #12 continuing to receive the medication when it should have been held. This occurred for 1 of 6 residents reviewed for medication administration (Resident #12). Findings included. a.) Resident #12 was admitted to the facility on 4/14/25 with diagnoses including heart failure, hypertension, and kidney disease. A physician's order dated 9/5/25 for Resident #12 revealed Metolazone 5 milligram (mg) tablets. Give 1 tablet by mouth one time a day every Monday, Wednesday,	F0756	Continued from page 30 for F 756. Actions taken/systems put into place to reduce the risk of future occurrence include: The Chief Clinical Officer met with the Consulting pharmacist on February 23, 2026, to discuss the action plan for ensuring that pharmacy recommendations address all identified and unresolved issues. The action plan will include: The consultant pharmacist will track all recommendations made during monthly medication regimen reviews utilizing the existing pharmacy monitoring software. Each recommendation will remain in "open" status in the monitoring software until resolution is confirmed. During each subsequent monthly review, any unresolved recommendations will be re-addressed and documented within the report until compliance is confirmed. Any unaddressed recommendations will be communicated to the Director of Nursing in each monthly report to ensure proper follow-up. This process will begin with the February report and continue with each subsequent monthly report. The Facility Nurse Consultant re-educated the DON, Assistant Director of Nursing (ADON), and the Unit Manager (UM) on processes to follow up on pharmacy recommendations on 2/23/2026 and 2/24/2026. This education included: Carrolton Policy # 12.13, "Addressing Medication Regimen Review Irregularities/Recommendations." Expectations regarding follow-up timeframes outlined in policy 12.13 Expectations regarding follow-up, including education with nursing staff Newly hired administrative nurses will receive training on Addressing Medication Regimen Review during orientation, led by the DON/Facility Nurse Consultant.	

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F0756 SS = E	Continued from page 31 and Friday for edema (swelling caused by excessive fluid trapped in body tissues). Hold for systolic blood pressure less than 110, or diastolic blood pressure less than 60. Review of the Medication Administration Record (MAR) dated September 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 9/10/25 administered by Nurse #2 with blood pressure 103/62 9/12/25 administered by Nurse #2 with blood pressure 77/60 9/15/25 administered by Nurse #2 with blood pressure 99/54 9/17/25 administered by Nurse #2 with blood pressure 98/66 9/19/25 administered by Nurse #2 with blood pressure 103/68 9/22/25 administered by Nurse #2 with blood pressure 99/56 9/24/25 administered by Nurse #2 with blood pressure 89/64 9/26/25 administered by Nurse #2 with blood pressure 106/78 9/29/25 administered by Nurse #2 with blood pressure 110/53 Review of the Medication Administration Record (MAR) dated October 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 10/01/25 administered by Nurse #2 with blood pressure 89/56 10/03/25 administered by Nurse #2 with blood pressure	F0756	Continued from page 31 The DON met with the ADON and the UM on February 25, 2026, to discuss the follow-up areas identified in the February Pharmacy Report, including staff education and training needs. All identified areas of follow-up will be completed and documented no later than 7 days of receiving the report (March 1, 2026). Nurse Managers will address any irregularities/recommendations and all staff education/re-education identified in the medication regimen review within 7 days of receipt of the pharmacy report. Documentation will be provided of all actions taken to address each irregularity/recommendation, including documentation of staff education noted. Physician recommendations will be scanned into the medical record within 15 days of the report date. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing will audit the pharmacy report and corresponding documentation for the next two (2) months to ensure compliance with follow-up on all pharmacy recommendations, including: Nurse Managers will address any irregularities/recommendations and all staff education/re-education identified in the medication regimen review within 7 days of receipt of the pharmacy report. Documentation will be provided of all actions taken to address each irregularity/recommendation, including documentation of staff education noted. Physician recommendations will be scanned into the medical record within 15 days of the report date. The Pharmacy Director will audit the Pharmacy Consultant's reports monthly for the next two (2) months to ensure accuracy. Audit results will be reviewed by the QAPI Committee	

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F0756 SS = E	Continued from page 32 89/61 10/06/25 administered by Nurse #2 with blood pressure 96/64 10/08/25 administered by Nurse #2 with blood pressure 98/61 10/15/25 administered by Nurse #2 with blood pressure 105/64 10/17/25 administered by Nurse #2 with blood pressure 110/53 10/20/25 administered by Nurse #2 with blood pressure 108/80 10/22/25 administered by Nurse #2 with blood pressure 91/71 10/29/25 administered by Nurse #2 with blood pressure 104/68 10/31/25 administered by Nurse #2 with blood pressure 93/64 Review of the Consultant Pharmacist's medication regimen review dated 10/9/25 revealed a note informing the Director of Nursing (DON) that Resident #12 had received Metolazone outside of the ordered blood pressure parameters on several occasions in September 2025 and in October 2025. Record review revealed Unit Manager #1 noted on the Consultant Pharmacist's medication regimen review dated 10/9/25 that nursing staff was educated. Unit Manager #1 did not specify if Nurse #2 received the education or what education was provided. Review of the Medication Administration Record (MAR) dated November 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 11/03/25 administered by Nurse #2 with blood pressure 98/58 11/05/25 administered by Nurse #2 with blood pressure	F0756	Continued from page 32 biweekly until the committee determines that consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 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
F0756 SS = E	Continued from page 33 97/69 11/07/25 administered by Nurse #2 with blood pressure 103/60 11/12/25 administered by Nurse #2 with blood pressure 99/61 11/14/25 administered by Nurse #2 with blood pressure 97/62 11/17/25 administered by Nurse #2 with blood pressure 102/72 11/19/25 administered by Nurse #2 with blood pressure 100/61 11/21/25 administered by Nurse #2 with blood pressure 97/60 11/24/25 administered by Nurse #2 with blood pressure 101/63 11/26/25 administered by Nurse #2 with blood pressure 100/58 11/28/25 administered by Nurse #2 with blood pressure 103/60 Review of the Consultant Pharmacist's medication regimen review dated 11/6/25 revealed a note informing the DON that Resident #12 had received Metolazone outside of the ordered blood pressure parameters. Record review revealed Unit Manager #1 noted on the Consultant Pharmacist's medication regimen review dated 11/6/25 that nursing staff was educated regarding the Metolazone. Unit Manager #1 did not specify if Nurse #2 received the education or what education was provided. During an interview on 2/11/26 at 1:15 PM Nurse #2 stated she did administer Metolazone to Resident #12 on the above dates. She stated she was a new nurse and thought the order to hold the medication was if both the systolic and the diastolic blood pressure was less than 110/60. Nurse #2 stated she misunderstood the parameters that were ordered and the Metolazone was given in error. Nurse #2 stated she was consistently assigned to Resident #12 and did not realize that she had been administering Metolazone to Resident #12 in error on so many occasions since September 2025. Nurse	F0756		

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F0756 SS = E	Continued from page 34 #2 indicated the medication error had not been brought to her attention until now. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she completed monthly medication reviews for the facility. She stated she did see that Resident #12's Metolazone was administered outside of the parameters and included that in her monthly reports that were sent to the DON in October 2025 and November 2025. The Consultant Pharmacist indicated that she typically did not go back and review the previous months recommendations that were sent to the DON and just expected that the nursing recommendations would be followed. During an interview on 2/13/26 at 2:40 PM the DON stated she and Unit Manager #1 shared the responsibility for reviewing and acting on the monthly pharmacy reports. She was not aware that Metolazone continued to be administered to Resident #12 outside of the parameters. The DON stated the Consultant Pharmacist did address the medication error in her monthly reports in October and November 2025. The DON stated Unit Manager #1 noted on the October 2025 and November 2025 pharmacy reports that education was provided to nursing staff. The DON stated all nursing staff should have been included in the education provided by Unit Manager #1 including Nurse #2. The DON stated Unit Manager #1 was not in the facility at the time, and she was not certain where the documentation was regarding the education that was provided by Unit Manager #1 or if Nurse #2 received education regarding following blood pressure parameters. The DON stated further education would be provided to all nursing staff including Nurse # 2, regarding medication administration including following blood pressure parameters. b.) Review of the Medication Administration Record (MAR) dated December 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 12/01/25 administered by Nurse #2 with blood pressure 99/63 12/03/25 administered by Nurse #2 with blood pressure 102/70	F0756		

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F0756 SS = E	Continued from page 35 12/05/25 administered by Nurse #2 with blood pressure 106/69 12/08/25 administered by Nurse #2 with blood pressure 99/65 12/10/25 administered by Nurse #2 with blood pressure 95/68 12/12/25 administered by Nurse #2 with blood pressure 95/62 12/15/25 administered by Nurse #2 with blood pressure 105/69 12/17/25 administered by Nurse #2 with blood pressure 97/62 12/19/25 administered by Nurse #2 with blood pressure 96/65 12/22/25 administered by Nurse #2 with blood pressure 108/61 12/24/25 administered by Nurse #2 with blood pressure 95/56 12/26/25 administered by Nurse #2 with blood pressure 108/62 12/29/25 administered by Nurse #2 with blood pressure 105/68 Review of the Consultant Pharmacist's medication regimen review dated 12/3/25 revealed no recommendations regarding Resident #12's Metolazone. Review of the Medication Administration Record (MAR) dated January 2026 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 1/02/26 administered by Nurse #2 with blood pressure 98/64 1/07/26 administered by Nurse #2 with blood pressure 107/61	F0756		

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F0756 SS = E	Continued from page 36 1/09/26 administered by Nurse #2 with blood pressure 94/63 1/14/26 administered by Nurse #2 with blood pressure 101/62 1/16/26 administered by Nurse #2 with blood pressure 102/61 1/19/26 administered by Nurse #2 with blood pressure 102/57 1/21/26 administered by Nurse #2 with blood pressure 99/68 1/26/26 administered by Nurse #2 with blood pressure 105/60 1/30/26 administered by Nurse #2 with blood pressure 109/55 Review of the Consultant Pharmacist's medication regimen review dated 1/27/26 revealed no recommendations were made regarding Resident #12's Metolazone. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she completed monthly medication reviews for the facility. She stated she did not address Metolazone for Resident #12 in the December 2025 or January 2026 monthly pharmacy reports, and she had previously reported the discrepancy to the DON. The Consultant Pharmacist indicated this was missed on the December 2025 and January 2026 medication regimen reviews. During an interview on 2/13/26 at 2:40 PM the Director of Nursing (DON) stated the Consultant Pharmacist did address the medication error in her monthly reports in October and November 2025 regarding Resident #12's Metolazone. The DON stated Resident #12's Metolazone was not addressed by the Consultant Pharmacist on the December 2025 or the January 2026 pharmacy reports. The DON indicated she did not review Resident #12's Metolazone in December 2025 or January 2026 to ensure the medication was not administered outside of the parameters.	F0756		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F0760	Immediate action(s) taken for the resident(s) found to have been affected include:	03/13/2026

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F0760 SS = E	Continued from page 37 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff, resident, Nurse Practitioner and the Consultant Pharmacist interviews, the facility failed to hold the medication Metolazone (a diuretic medication used to treat high blood pressure and fluid retention caused by heart failure or kidney disease) when a resident's blood pressure was less than 110 systolic or less than 60 diastolic according to the parameters ordered by the physician. This resulted in a significant medication error as Resident #12 received 57 doses when the medication should have been held. Resident #12 experienced no significant outcome from receiving the medication. This occurred for 1 of 6 residents reviewed for medication administration (Resident #12). Findings included. Resident #12 was admitted to the facility on 4/14/25 with diagnoses including heart failure, hypertension, and kidney disease. A physician's order dated 9/5/25 for Resident #12 revealed Metolazone 5 milligram (mg) tablets. Give 1 tablet by mouth one time a day every Monday, Wednesday, and Friday for edema (swelling caused by excessive fluid trapped in body tissues). Hold for systolic blood pressure less than 110, or diastolic blood pressure less than 60. Review of the Medication Administration Record (MAR) dated September 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 9/10/25 administered by Nurse #2 with blood pressure 103/62 9/12/25 administered by Nurse #2 with blood pressure 77/60	F0760	Continued from page 37 Nurse #2 was re-educated on 2/13/26 by the Director of Nursing (DON) on medication administration, specifically preventing significant medication errors by following the physician-ordered parameters for blood pressure medication administration for residents, including resident #12. Identification of other residents having the potential to be affected was accomplished by: The Chief Clinical Officer (CCO) audited the medication administration records for 50% of active residents (20 residents) who had antihypertensive medication orders on 2/22/26 to ensure compliance with the physician-ordered administration parameters. Five (5) residents were found to have one or more medication administrations outside of the physician-ordered parameters. Five (5) records were found to need some clarification of the parameters. The staff members were re-educated by the DON on 2/23/26. Needed clarification orders were obtained by the Assistant Director of Nursing (ADON) and the Unit Manager (UM). Findings from this audit were used to develop the training sessions for licensed nurses and medication aides as a part of this plan of correction to prevent significant medication errors. The facility has determined that all residents receiving medications have the potential to be affected by medication errors. An Ad-Hoc Quality Assessment Performance Improvement (QAPI) was completed on 2/26/26, led by the facility administrator (LNHA) regarding the plan of correction for F 760. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing personnel, including all Licensed Nurses and Medication Aides, were in-serviced on medication administration, including following the physician-ordered blood pressure parameters prior to administering blood pressure medication, from 2/24/26 through 2/27/26, by the DON and Facility Nurse	

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F0760 SS = E	Continued from page 38 9/15/25 administered by Nurse #2 with blood pressure 99/54 9/17/25 administered by Nurse #2 with blood pressure 98/66 9/19/25 administered by Nurse #2 with blood pressure 103/68 9/22/25 administered by Nurse #2 with blood pressure 99/56 9/24/25 administered by Nurse #2 with blood pressure 89/64 9/26/25 administered by Nurse #2 with blood pressure 106/78 9/29/25 administered by Nurse #2 with blood pressure 110/53 Review of the Medication Administration Record (MAR) dated October 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 10/01/25 administered by Nurse #2 with blood pressure 89/56 10/03/25 administered by Nurse #2 with blood pressure 89/61 10/06/25 administered by Nurse #2 with blood pressure 96/64 10/08/25 administered by Nurse #2 with blood pressure 98/61 10/15/25 administered by Nurse #2 with blood pressure 105/64 10/17/25 administered by Nurse #2 with blood pressure 110/53 10/20/25 administered by Nurse #2 with blood pressure 108/80 10/22/25 administered by Nurse #2 with blood pressure 91/71	F0760	Continued from page 38 Consultant (FNC). This in-service covered the following items: Carrolton Policy 12.14- Medication Administration Policy, including: Rights of Medication Administration Following physician ordered parameters when administering medications Documentation Licensed nurses and certified medication aides who were not present for these training sessions were educated prior to returning to work. Newly hired licensed nurses and medication aides will receive training during orientation from the DON/ADON/UM on policies and procedures for medication administration and adherence to vital sign parameters. On 3/5/2026, facility leaders (including the LNHA, DON, FNC, CCO, and Chief Operating Officer (COO) met with the facility Nurse Practitioner (NP) to review the results of the week 1 audit for Medication Errors related to the following of blood pressure administration parameters (F 760). As a result of the week one audit, the following actions were added to the QAPI plan of improvement for F 760: Licensed nurses and medication aides found to be out of compliance with parameters for blood pressure administration were individually counseled and re-educated by the DON and the FNC on 3/5/26 and 3/6/26. The NP reviewed the residents' blood pressure readings and made needed adjustments to parameters. Administrative nurses, including the DON/ADON/Unit Manager, will complete a daily audit of medication administration records (MARs) 3/5/26 through 3/9/26, to ensure compliance with the physician-ordered administration parameters. Licensed nurses/medication aides will be re-educated as needed to address any negative findings.	

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F0760 SS = E	Continued from page 39 10/29/25 administered by Nurse #2 with blood pressure 104/68 10/31/25 administered by Nurse #2 with blood pressure 93/64 Review of the Medication Administration Record (MAR) dated November 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 11/03/25 administered by Nurse #2 with blood pressure 98/58 11/05/25 administered by Nurse #2 with blood pressure 97/69 11/07/25 administered by Nurse #2 with blood pressure 103/60 11/12/25 administered by Nurse #2 with blood pressure 99/61 11/14/25 administered by Nurse #2 with blood pressure 97/62 11/17/25 administered by Nurse #2 with blood pressure 102/72 11/19/25 administered by Nurse #2 with blood pressure 100/61 11/21/25 administered by Nurse #2 with blood pressure 97/60 11/24/25 administered by Nurse #2 with blood pressure 101/63 11/26/25 administered by Nurse #2 with blood pressure 100/58 11/28/25 administered by Nurse #2 with blood pressure 103/60 Review of the Medication Administration Record (MAR) dated December 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood	F0760	Continued from page 39 How the corrective action(s) will be monitored to ensure the practice will not reoccur: Random medication pass audits will be conducted by the DON/ADON/UM weekly for four (4) weeks (1 nurse/medication aide per week), then monthly for two (2) months (2 nurses/medication aides per month) to ensure medication passes are free of medication errors. Licensed nurses/medication aides will be re-educated as needed to address any negative findings. The FNC will conduct a weekly audit of medication administration records for four (4) weeks, reviewing ten (10) active residents with antihypertensive medication orders, to ensure compliance with the physician-ordered administration parameters. Negative findings will be forwarded to the DON immediately, who will provide retraining as needed. Audit records will be reviewed by the QAPI committee on a bi-weekly basis until consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 2026.	

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F0760 SS = E	Continued from page 40 pressure less than 60: 12/01/25 administered by Nurse #2 with blood pressure 99/63 12/03/25 administered by Nurse #2 with blood pressure 102/70 12/05/25 administered by Nurse #2 with blood pressure 106/69 12/08/25 administered by Nurse #2 with blood pressure 99/65 12/10/25 administered by Nurse #2 with blood pressure 95/68 12/12/25 administered by Nurse #2 with blood pressure 95/62 12/15/25 administered by Nurse #2 with blood pressure 105/69 12/17/25 administered by Nurse #2 with blood pressure 97/62 12/19/25 administered by Nurse #2 with blood pressure 96/65 12/22/25 administered by Nurse #2 with blood pressure 108/61 12/24/25 administered by Nurse #2 with blood pressure 95/56 12/26/25 administered by Nurse #2 with blood pressure 108/62 12/29/25 administered by Nurse #2 with blood pressure 105/68 Review of the Medication Administration Record (MAR) dated January 2026 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 1/02/26 administered by Nurse #2 with blood pressure 98/64	F0760		

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F0760 SS = E	Continued from page 41 1/07/26 administered by Nurse #2 with blood pressure 107/61 1/09/26 administered by Nurse #2 with blood pressure 94/63 1/14/26 administered by Nurse #2 with blood pressure 101/62 1/16/26 administered by Nurse #2 with blood pressure 102/61 1/19/26 administered by Nurse #2 with blood pressure 102/57 1/21/26 administered by Nurse #2 with blood pressure 99/68 1/26/26 administered by Nurse #2 with blood pressure 105/60 1/30/26 administered by Nurse #2 with blood pressure 109/55 Review of the Medication Administration Record (MAR) dated February 2026 for Resident #12 revealed Metolazone 5 milligram (mg) tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 2/02/26 administered by Nurse #2 with blood pressure 93/58 2/04/26 administered by Nurse #2 with blood pressure 102/58 2/06/26 administered by Nurse #2 with blood pressure 102/63 2/09/26 administered by Nurse #2 with blood pressure 103/59 2/11/26 administered by Nurse #2 with blood pressure 107/67 Review of Resident #12's progress notes from 9/10/25 through 2/11/26 revealed no documentation indicating Resident #12 had a change in her condition.	F0760		

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F0760 SS = E	Continued from page 42 The Minimum Data Set (MDS) quarterly assessment dated 2/11/26 revealed Resident #12 was cognitively intact. She required staff assistance with activities of daily living and received diuretic medications. During an interview on 2/11/26 at 1:15 PM Nurse #2 stated she did administer Metolazone to Resident #12 on the above dates. She stated she was a new nurse and thought the order to hold the medication was if both the systolic and the diastolic blood pressure was less than 110/60. Nurse #2 stated she misunderstood the parameters that were ordered and the Metolazone was given in error. Nurse #2 stated she was consistently assigned to provide care to Resident #12. Nurse #2 stated Resident #12 was alert and oriented to person, and place, and was out of bed and in her wheelchair this morning and has had no change in her condition. An observation and interview conducted on 2/11/26 at 1:30 PM revealed Resident #12 was in her room sitting in her wheelchair. She was in no distress. Resident #12 voiced no concerns with her care. During an interview on 2/11/26 at 1:39 PM the Nurse Practitioner stated Resident #12 was prescribed Metolazone due to increased edema and was also on another diuretic medication each day. The Nurse Practitioner stated that Resident #12 had heart failure and her blood pressure did run low which was why the parameters were in place for the diuretics. She stated the order was to hold the Metolazone if either the systolic was less than 110 or if the diastolic was less than 60. The Nurse Practitioner stated she was not aware that Resident #12 had received Metolazone outside of the parameters. The Nurse Practitioner indicated she recently evaluated Resident #12 and although Resident #12 had received the Metolazone when it should have been held she has had no change in her condition. She stated the hold parameters were put in place for a reason and the nurse should have followed the parameters and held the dose when Resident #12's blood pressure was outside of the parameters. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she completed monthly medication reviews for the facility. The Consultant Pharmacist stated that taking Metolazone when it was not indicated could cause hypotension and contribute to an increased risk of falls.	F0760		

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F0760 SS = E	Continued from page 43 During an interview on 2/13/26 at 2:40 PM the Director of Nursing (DON) stated she was not aware that Metolazone continued to be administered to Resident #12 outside of the parameters. The DON stated Resident #12 has had no falls and no change in her condition. The DON stated further education would be provided to all nursing staff regarding medication administration including following blood pressure parameters.	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to discard expired medications and record an opened date on ophthalmic drops that had shortened expiration dates on 2 of 6 medication carts that were reviewed for medication storage (200 hall medication cart #1 and medication cart #2). Findings included.	F0761	Immediate action(s) taken for the resident(s) found to have been affected include: The expired ophthalmic drops were immediately discarded from cart #1 and cart #2 (200 hall) after the surveyor notified the Director of Nursing (DON) that they were expired and had no recorded opening date. Identification of other residents having the potential to be affected was accomplished by: All medication carts and the medication room were checked for expired medications on 2/11/26 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Unit Manager (UM). No other expired medications were found in the facility. The facility has determined that 100% of residents who receive medication have the potential to be affected when expired medications are not disposed of in a timely manner. An Ad-Hoc Quality Assessment Performance Improvement (QAPI) was completed on 2/26/26, led by the facility administrator (LNHA) regarding the plan of correction for F 761. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing personnel (Licensed Nurses and Certified Medication Aides) were in-serviced 2/18/26 through 2/27/26 by the Pharmacy Nurse Consultant/DON/ADON/Facility Nurse Consultant (FNC). The in-services included the following information:	03/13/2026

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F0761 SS = D	Continued from page 44 a.) An observation of the 200-hall medication cart #1 on 2/10/26 at 2:50 PM along with Nurse #1 revealed the following medications: One bottle of Latanoprost .005% ophthalmic drops that was opened with no opened date labeled on the bottle. Review of the manufacturer's guidelines for Latanoprost ophthalmic solution instructed that once a bottle was opened for use, it may be stored at room temperature for 6 weeks then discarded. One bottle of Rocklatan ophthalmic drops that was opened with no opened date labeled on the bottle. Review of the manufacturer's guidelines for Rocklatan ophthalmic solution (a combination of two medications) instructed that once a bottle was opened for use, it may be stored at room temperature for 6 weeks then discarded. b.) An observation of the 200-hall medication cart #2 on 2/10/26 at 3:00 PM along with Nurse #1 revealed the following medications: Pyridium (phenazopyridine) 95 milligram tablets, a urinary analgesic, with an expiration date of March 2025. One bottle of Dorzolamide 2% ophthalmic drops with an expiration date of 11/30/25. During an interview on 2/10/26 at 2:05 PM Nurse #1 stated she was the assigned nurse today for medication cart #1 and medication cart #2. Nurse #1 stated all nurses were responsible for checking the medication carts for expired medications and recording opened dates on the eye drops. Nurse #1 indicated she had not administered any of the expired medications today and she had not checked for expiration dates on either medication cart. Nurse #1 further stated she did not open the eye drops on medication cart #1 and the eye drops should have been dated when opened.	F0761	Continued from page 44 Medication Labeling and Storage Labeling everything with an open date Expiration dates for commonly used medications after opening, including Eye drops (6 weeks after opening) Checking for expired medications Medication disposal of expired medications Nursing staff (Licensed nurses and certified medication aides) will not be allowed to work until they receive education on Medication Labeling and Storage. The DON and supervisory nursing personnel will continue to include Medication Labeling and Storage in the orientation process for newly hired licensed nurses and certified medication aides. The Medication Room and Medication Cart audit tools were revised by the Chief Clinical Officer (CCO) on 2/21/2026. The DON/ADON and UM were educated on the use of these audit tools by the FNC on 2/23/2026. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/ADON/UM will complete medication room audits weekly for four (4) weeks to ensure that all expired medications have been removed. The ADON/UM will audit all medication carts each week for four (4) weeks to ensure that all expired medications have been removed. The medication room audits and medication cart audits will be reviewed by the facility nurse consultant for	

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F0761 SS = D	Continued from page 45 During an interview on 2/13/26 at 2:34 PM the Director of Nursing (DON) stated the assigned nurse was responsible for checking medication carts for expired medications and to ensure all medications with shortened expiration dates were labeled with an opened date. The DON stated the expired medications should have been discarded and the eye drops should have been labeled with opened dates.	F0761	Continued from page 45 four (4) weeks. Medication Storage audits will continue to be conducted monthly by the pharmacy nurse consultant. Audit records will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee on a bi-weekly basis until consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 2026.	
F0838 SS = D	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;	F0838	Immediate action(s) taken for the resident(s) found to have been affected include: The Facility Assessment was updated immediately on 2/13/2026 upon notification from the surveyor by the facility Administrator (LNHA) and the Facility Nurse Consultant (FNC) to address the care required for the population of residents, including resident #1, with a port-a-cath, and the staff training necessary to completely provide port-a- cath care. Identification of other residents having the potential to be affected was accomplished by: The Director of Nursing verified that there were no other residents in the facility with port-a-caths on 2/12/2026. The facility has determined that all facility residents requiring the use of a port-a-cath have the potential to be affected. An Ad-Hoc Quality Assessment Performance Improvement (QAPI) was completed on 2/26/26, led by the facility administrator (LNHA) regarding the plan of correction for F 838. Actions taken/systems put into place to reduce the risk of future occurrence include: Facility Nurse Consultant educated the LNHA and DON on the facility policy for updating the Facility	03/13/2026

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F0838 SS = D	Continued from page 46 (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of	F0838	Continued from page 46 Assessment on 2/13/2026. The Chief Nursing Officer and Facility Nurse Consultant reviewed/revised the following documents on 2/17/2026: Carrolton Policy 8.26 Accessing and De-accessing an Implanted Vascular Access Port Skills Validation Checklist- Accessing Implanted Vascular Access Port Skills Validation Checklist- De-accessing Implanted Vascular Access Port The facility Nurse Practitioner (NP) assessed and flushed the port-a-cath for resident #1 on 2/18/2026. The DON and Assistant Director of Nursing (ADON) were educated by the NP on accessing, flushing, and de-accessing a port-a-cath during this encounter. Facility leaders, including the Administrator, Director of Nursing, Facility Nurse Consultant, Chief Nursing Officer, and Chief Operating Officer, met with the Nurse Practitioner on 2/19/2026 to discuss the care of resident #1's implanted vascular port. The NP verified the DON's and ADON's competencies for accessing, flushing, and de-accessing an implanted vascular access port via return demonstration on 3/3/2026. Competency verification via return demonstration will be completed on any licensed nurse prior to being asked to perform access, de-access, or flush an implanted vascular access port. How the corrective action(s) will be monitored to ensure the practice will not recur: The LNHA and/or designee will audit the Facility Assessment to match the facility's 802 weekly for two (2) weeks and monthly for two (2) months. Results will be taken to QAPI to ensure compliance. Audit records will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee on a bi-weekly	

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F0838 SS = D	Continued from page 47 nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure the facility assessment identified and addressed the care required for the population of residents with a port-a-cath (a small implanted device placed under the skin in the chest to provide easy, long-term access to a vein for chemotherapy, medication, intravenous (IV) fluids, or blood sampling), and to address the staff training	F0838	Continued from page 47 basis until consistent, substantial compliance has been achieved. Corrective action completion date: March 13, 2026.	

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F0838 SS = D	Continued from page 48 necessary to competently provide port-a-cath care for residents for 1 of 1 resident (Resident #1). Findings included: Review of the facility assessment revealed the assessment was last updated on 9/8/2025. The document indicated the facility had completed education, training and competencies with staff specific to resident care needs; however, the document lacked training and competency to care for residents who required a port-a-cath. Resident #1 was admitted to the facility on 10/13/2023. Review of the electronic medical record (EMR) revealed Resident #1's port-a-cath was placed 12/18/2024 during a hospitalization for pneumonia. An interview with the Director of Nursing (DON) was completed on 2/13/2026 at 11:04 AM. The DON confirmed that the nursing staff had not received training and competencies regarding the care of a port-a-cath. An interview with the Administrator was conducted on 2/13/2026 at 9:40 AM. The Administrator confirmed the facility had one resident with a port-a-cath. The Administrator also stated he was not aware the nursing staff had not received education and had competencies checked regarding providing care for residents with a port-a-cath. He indicated that he was responsible for updating the facility assessment with input from the DON and other administrative staff. The Administrator confirmed he had just updated the facility assessment 1/1/2026 to reflect the change in therapy providers. The Administrator indicated he knew that all of the care needs regarding residents should be reflected in the facility assessment.	F0838		