STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345446	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Pines Health and Rehabilitation	**95 Locust Street , Connelly Springs, North Carolina, 28612**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification survey was conducted on 04/27/26 through 04/29/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22F55A-H1.	E0000		05/12/2026
F0000	INITIAL COMMENTS An unannounced recertification survey was conducted from 04/27/26 through 04/29/26. Event ID # 22F55A-H1.	F0000		05/21/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F0641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to accurately code the MDS assessment for Insulin injections received for Resident #6. On 4/29/26 MDS Nurse #1 amended and resubmitted Resident #6's MDS. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents and new admission residents have the potential to be affected by the deficient practice. An audit was completed on 4/29/26 by the Regional Reimbursement Manager to ensure all residents with Insulin injections were coded correctly on the MDS. No new concerns were found. An ad hoc QAPI was held on 4/30/26 to discuss the deficient practice and implement a plan of correction that included staff education and auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	04/30/2026

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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F0641 SS = D	Continued from page 1 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 1 of 5 sampled residents (Resident #6). The findings included: Resident #6 was admitted to the facility on 05/04/25 with diagnoses which included type 2 diabetes mellitus with hyperglycemia (high blood sugar). A review of Resident #6's physician admission orders dated 02/16/26 revealed an order for Lantus Solostar U-100 insulin (long-acting insulin and hypoglycemic medication used to manage blood glucose levels) 100 units per milliliter. Inject 10 units subcutaneously (under the skin) daily in the morning for diabetes. A review of Resident #6's February 2026 Medication Administration Record (MAR) revealed Resident #6 received insulin injections daily as ordered. Resident #6's quarterly Minimum Data Set (MDS) dated 02/20/26 was reviewed and did not indicate insulin injections or hypoglycemic medications had been received. An interview with the MDS Coordinator was conducted on 04/28/26 at 11:56 AM. The MDS Coordinator confirmed she completed the 02/20/26 MDS for Resident #6. The MDS Coordinator stated Resident #6 received insulin daily and the MDS assessment should have included both insulin injections and the use of hypoglycemic medication. She stated the insulin injections and hypoglycemic medication had been overlooked and the MDS had been coded incorrectly. An interview with the Corporate MDS Coordinator was conducted on 04/28/26 at 11:44 AM. The Corporate MDS Coordinator stated that all MDS assessments should be coded correctly for relevant medications.	F0641	Continued from page 1 MDS Coordinator #1 and #2 were educated on 4/29/26 by the Regional Reimbursement Manager to ensure residents with Insulin injections are accurately coded. The RAI manual was reviewed with the coordinators. The Regional Reimbursement Manager will educate all new hires before they can begin work, the Administrator will ensure this is completed. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Regional Reimbursement Manager will complete audits of the facility MDS assessments to ensure MDS assessments continue to be coded accurately, weekly for 4 weeks and monthly for 2 months to ensure continued compliance. The Administrator or designee will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance. The date of compliance is 4/30/26.	04/30/2026

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F0641 SS = D	Continued from page 2 An interview conducted with the Director of Nursing on 04/29/26 at 2:35 PM revealed Resident #6 had received daily insulin injections and the MDS should be coded correctly for relevant medications.	F0641		04/30/2026
F0584 SS = B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F0584	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to maintain window screens in good condition. The deficient practice affected 18 resident rooms. The window screen replacements were ordered immediately on 4/29/26. All repairs were completed by the Maintenance Director on 5/7/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected by this deficient practice. The maintenance director completed rounds to identify other areas needing repair. The surveillance rounds were completed on 4/29/26 and no other issues were found. A schedule was initiated by the administrator, for ongoing inspection and repairs every month, to ensure a safe, clean, comfortable homelike environment for residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The measures that have been put into place to ensure the deficient practice does not recur are as follows: The administrator educated the maintenance director, on expectations of monthly surveillance rounding and repairs for window screens. Education was completed on 4/29/26. The Administrator will be responsible for providing the education to all new facility maintenance staff prior to beginning to work. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Administrator will monitor 5 resident rooms and all common areas twice weekly for 4 weeks and then weekly for 8 weeks to ensure facility is maintaining a homelike environment and all window screens are maintained in good condition. The facility will monitor the corrective actions to ensure that the	05/08/2026

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F0584 SS = B	Continued from page 3 sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to maintain window screens in resident's room in good condition (Resident #44, #31, #49, #54, #4, #19, #3, #15, #108, #32, #48, #92, #58, #73, #83, #7, #64, #106, #14,#94, #29, #38, #72, #53). The deficient practice affected 18 of 65 rooms on 6 of 6 halls observed for environmental concerns. Findings included: Observations of the window screen in room #502 on 04/27/2026 at 1:45 PM and 04/28/2026 at 11:32 AM revealed the window screen's metal frame was out of the track at the bottom of the window frame. The unsecured screen would make it possible for flying insects to enter if the window was open. On 4/29/26 a walking tour of the outside of the facility was conducted with the Maintenance Director from 2:00 to 2:50 PM and revealed the following 18 window screens that needed repair: Room #109 showed the window screen's metal frame was bent and out of the track. Room #104 did not have a window screen in place. Room #112 showed the window screen to have a tear approximately 2 inches by 3 inches. Room #204 had a tear approximately 4 inches by 2inches in the bottom of the window screen. Rooms #206, #210, #302, and #416 revealed the window screen's metal frame was out of the metal track. Room #406 revealed a tear approximately 4 inches by 3 inches in the window screen. Room #408 showed the window screen's metal frame was out of the metal track and revealed a tear approximately 2 inches by 2 inches in the bottom of the screen. Room #410 showed the window screen to have a tear approximately 3 inches by 3 inches. Room #502 showed the window screen's metal frame was out of the track at the bottom of the window frame.	F0584	Continued from page 3 deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Date of compliance is 5/8/26.	05/08/2026

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F0584 SS = B	Continued from page 4 Room #509 showed the screen missing from the window. Room #511 showed a tear approximately 1 inch by 7 inches in the window screen. Room #512 revealed a tear approximately 1 inch by 3 inches in the window screen. Room #607 had a tear approximately 3 inches by 6 inches in the window screen. Room #608 revealed no window screen on the window. Room #609 revealed a tear approximately 4 inches by 2 inches in the window screen. An interview with Resident #14 in room #509 on 4/29/26 at 1:25 PM indicated he had no concerns with the window screen and had not opened his window since his admission. An interview with the Maintenance Director on 4/29/26 at 2:30 PM revealed he had only been employed with the facility for about two and a half months and had not yet established a good monitoring program of the windows. He reported he was aware of only two window screens that needed replacement and they were both in his office awaiting the new screen for the frames. He indicated all staff members could put in a work order if they noticed something in the building that required his attention, but he had not received any work orders for screen repairs. An interview with the Administrator on 4/29/26 at 3:18 PM revealed she expected all staff to alert maintenance staff to any issue and to fill out work orders for the concern. She reported that she was unaware there were that many screens that needed repairing. She stated the previous Maintenance Director had done an assessment of the window screens in early fall of 2025 and had repaired any that were damaged at the time.	F0584		05/08/2026