STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345314	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Haven of Forest City, LLC	**830 Bethany Church Road , Forest City, North Carolina, 28043**

(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 unnannouced recertification and complaint investigation survey was conducted on 03/30/26 through 04/02/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22C4CA-H1.	E0000		04/24/2026
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 03/30/26 through 04/02/26. Event ID #22C4CA-H1. The following intake was investigated: #836633. 1 of 1 complaint allegations did not result in deficiency.	F0000		04/24/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff,	F0552	Disclaimer: This Plan of Correction is submitted in response to the Statement of Deficiencies and does not constitute an admission of wrongdoing or agreement with the cited findings. During the survey process, Resident #47, Resident #67, and Resident #11 were noted to not have all required psychotropic consents obtained. These missing consents were completed by licensed nursing staff on 4/23/26. No negative outcomes were identified related to the missing consents. A facility-wide audit was initiated on 4/20/26 by the Administrator and the Director of Nursing for all residents receiving any psychotropic medications. During this audit, it was identified that the facility had been consistently obtaining consents for antipsychotics but had not been obtaining consents for antidepressants, anxiolytics, hypnotics, and mood stabilizers. Based on these findings, the audit was halted and nursing staff were directed to obtain consents for all psychotropic medications currently ordered, regardless of whether a previous consent existed. All required consents were obtained by nursing staff, and a repeat audit was completed by the Administrator on 4/23/26 verifying that all psychotropic medications ordered now have a corresponding consent in place. A complete list of all psychotropic medications was	04/24/2026

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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F0552 SS = D	Continued from page 1 Consulting Pharmacist, Nurse Practitioner (NP) and Medical Director interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of psychotropic medications prior to the initiation or increase of the medications for 3 of 5 residents reviewed for unnecessary medications (Resident #47, Resident #67, and Resident #11). The findings included: a. Resident #47 was admitted 5/31/2024 with diagnoses of panic disorder, depression, and anxiety disorder. Resident #47's physician's orders revealed an order dated 8/31/2024 for sertraline (antidepressant medication) 50 milligrams (mg) by mouth daily for depression. Resident #47's physician's orders revealed an order dated 10/25/2024 for alprazolam (antianxiety medication) 1 mg by mouth twice daily for anxiety. Resident #47's quarterly Minimum Data Set (MDS) dated 10/2/2025 revealed Resident #47 had intact cognition and received antianxiety and antidepressant medication during the 7-day look back period. A Nurse Practitioner (NP) note dated 10/9/2025 indicated Resident #47 reported anxiety was not well managed and had uncontrolled moderate anxiety in the afternoon, the plan indicated to increase alprazolam to three times daily. Resident #47's physician's orders revealed an order dated 10/9/2025 for alprazolam 1 mg by mouth three times daily for anxiety. An annual visit NP note dated 11/20/2025 indicated a depression screening was conducted and Resident #47 scored as moderately depressed. This note included a section for education which was left blank. Resident #47's physician's order revealed an order dated 11/20/2025 to increase sertraline to 75 mg daily. An NP note dated 12/4/2025 indicated Resident #47 reported lack of interest in activities and feeling flat in emotions. The plan included an increase of sertraline to 100 mg daily. Resident #47's physician's orders revealed an order	F0552	Continued from page 1 obtained, and new consents were secured for any resident prescribed any psychotropic medication. Consents were obtained from residents with a BIMS score of 12 or greater and from the responsible party for residents with a BIMS score of 11 or less. No negative outcomes were identified as a result of the missing consents. Education was completed with all licensed nurses by 4/23/26 via Relias. This education, created and assigned by the Administrator, included: identification of medications classified as psychotropics, requirements for obtaining psychotropic consents for all psychotropic medications, the requirement to obtain consent prior to the first dose unless an emergency situation exists (in which case consent must be obtained as soon as reasonably possible), and documentation requirements related to psychotropic medication notifications and consents. Licensed nursing staff will be responsible for obtaining psychotropic medication consents moving forward. For new hires, Relias will automatically assign this psychotropic consent education as part of the new-hire assignment list. The Director of Nursing or designee will be responsible for monitoring Relias to ensure all new employees complete the required education. Effective 4/23/26, no licensed nurse is permitted to work without completing this education. This requirement has been incorporated into the facility's staffing and scheduling process. A structured audit process has been implemented beginning the week of 4/27/26. Audits will be completed weekly × 4, then every two weeks × 2, then monthly × 1. Audits will verify all new or changed psychotropic medication orders since the previous audit, confirm that required psychotropic consents were obtained, and ensure completion of required assessments and notifications. Audits will be completed by the Administrator, DON, or designee. Audit results will be reviewed in QAPI meetings monthly for three months beginning in May, or until substantial compliance is achieved. Completion Date: 4/24/26	04/24/2026

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F0552 SS = D	Continued from page 2 dated 12/4/2025 for sertraline 100 mg daily for depression. Resident #47's quarterly MDS dated 1/2/2026 revealed Resident # 47 had intact cognition and received antianxiety and antidepressant medication during the 7-day look back period. Resident #47's Medication Administration Record (MAR) from 10/9/2025 to 3/31/2026 indicated Resident #47 was administered alprazolam and sertraline as ordered by the physician. A review of Resident #47's medical record revealed no information indicating if Resident #47 was informed in advance of the risks and benefits of increasing sertraline or alprazolam. An interview with Resident #47 was conducted on 4/02/2026 at 9:06 AM. Resident #47 stated none of the providers at the facility had discussed side effects, or the risks or benefits of taking or increasing alprazolam or sertraline, but Resident #47 stated she just knew she needed the medications. b. Resident #67 was admitted on 4/11/2025 with diagnoses of anxiety disorder and major depressive disorder. Resident #67's physicians' orders revealed an order dated 4/11/2025 for buspirone HCl (antianxiety medication) 15 mg by mouth twice daily. Resident #67's admission MDS dated 4/22/2025 revealed Resident #67 was severely cognitively impaired. The MDS indicated Resident #67 received antianxiety medication during the 7-day look back period. Resident #67's MAR from 4/11/2025 to 3/31/2026 indicated Resident #67 was administered buspirone HCl as ordered by the physician. A review of Resident #67's medical record revealed no information indicating if Resident #67's Responsible Party was informed in advance of the risks and benefits of initiating buspirone HCl. A telephone interview on 4/2/2026 at 11:39 AM with Resident #67's Responsible Party revealed the Responsible Party did not recall a discussion with the provider or other facility staff regarding the risks and benefits of buspirone HCL when Resident # 67 was admitted to the facility.	F0552		04/24/2026

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F0552 SS = D	Continued from page 3 c. Resident #11 was admitted on 7/01/21 and readmitted on 4/28/25. Diagnosis included anxiety disorder and major depressive disorder. Resident #11's physicians' orders revealed an order dated 5/09/25 for Xanax (antianxiety medication) 0.5 mg two tablets by mouth three times daily and an order dated 10/13/25 for Zoloft (antidepressant) 150 mg one tablet by mouth at bedtime. Resident #11's quarterly MDS dated 1/29/26 revealed Resident #11 was cognitively intact. The MDS indicated Resident #11 received antianxiety and antidepressant medication during the 7-day look back period. Resident #11's MAR from 5/09/2025 to 4/01/2026 indicated Resident #11 was administered Xanax as ordered by the physician. Resident #11's MAR from 10/13/25 to 4/01/26 indicated Resident #11 was administered Zoloft as ordered by the physician. A review of Resident #11's medical record revealed no information indicating if Resident #11's was informed in advance of the risks and benefits of initiating Xanax or Zoloft. An interview on 4/01/2026 at 10:39 AM with Resident #11 revealed she did not recall a discussion with the provider or other facility staff regarding the side effects or risks and benefits of taking Xanax and Zoloft. An interview on 4/01/2026 at 12:26 PM with the NP revealed psychotropic medication consents were handled by nursing. A telephone interview on 4/02/2026 at 8:25 AM with the Consulting Pharmacist revealed the Consulting Pharmacist did not review psychotropic consents for the facility during her monthly medication reviews. The Consulting Pharmacist verified antidepressants, and antianxiety medications were psychotropic medications and required consents when they were initiated and increased. An interview on 4/02/2026 at 10:09 AM with the Medical Director revealed he did not recall having discussions of risks and benefits with residents that were admitted on psychotropic medications prior to the medication being ordered and administered. The Medical Director stated the floor nurses and Rounding Nurse notified residents and resident representatives of medication changes. The Medical Director thought the Rounding Nurse would take	F0552		04/24/2026

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F0552 SS = D	Continued from page 4 care of psychotropic medication consents since the Rounding Nurse entered orders after rounding with the providers. The Medical Director indicated he expected psychotropic medication consents to be completed when psychotropic medications were initiated and increased. A telephone interview with the Rounding Nurse on 4/2/2026 at 11:59 AM revealed she was responsible for obtaining consents for residents who had orders for psychotropic medications. The Rounding Nurse stated when residents received a new order for psychotropic medication, she obtained consent from the resident or resident representative. The Rounding Nurse stated the psychotropic medication consent was only obtained for residents who started psychotropic medications after they were admitted to the facility. The Rounding Nurse explained that consents were not obtained for residents that were admitted with orders for psychotropic medications because those residents were taking the psychotropic medication prior to being admitted to the facility. The Rounding Nurse stated she did not obtain consents for residents that started or had an increased dose of antidepressants or antianxiety medications because she did not know those medications were psychotropic medications. The Rounding Nurse verified she had only obtained consents for residents who received orders for antipsychotic medications after they were admitted. An interview with the Director of Nursing (DON) on 4/2/2025 at 1:45 PM revealed the Rounding Nurse was responsible for obtaining psychotropic medication consents. The DON explained that the Rounding Nurse was the providers' nurse and worked with the providers and entered any orders. The DON verified that any order entered by the facility was a new order, including medications a resident took prior to admission to the facility. The DON stated she did not know antianxiety and antidepressants required consent to be completed when initiated and increased. The DON believed communication issues and no reeducation when the psychotropic policy was reviewed in January 2026 contributed to staff not being aware of what medications were psychotropics. She explained the policy indicated psychotropic medication consents should be completed when psychotropic medications were initiated and increased. An interview on 4/02/2026 at 3:20 PM with the Informatics Nurse revealed he had reviewed the psychotropic policy in January 2026. The Informatics Nurse stated the definition of psychotropic medications were the same as prior to the policy	F0552		04/24/2026

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F0552 SS = D	Continued from page 5 review and included antidepressant and antianxiety medications. The Informatics Nurse stated nurses should know what medications were considered psychotropics. The Informatics Nurse stated he was currently in the process of reviewing all of the facilities policies, then a full reeducation would be conducted. An interview with the Administrator on 4/2/2026 at 4:01 PM revealed the Administrator expected consents for psychotropic medications.	F0552		04/24/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this	F0645	Disclaimer: This Plan of Correction is submitted in response to the Statement of Deficiencies and does not constitute an admission of wrongdoing or agreement with the cited findings. During the survey process, it was noted that Resident #14 had a diagnosis of Bipolar but did not have a level II PASRR. A new PASRR submission has been completed and sent to the state portal to determine whether a Level II PASRR is required at this time. This was submitted on 4/23/26 by the social worker. No negative outcome was identified A facility wide completed on all residents' diagnosis to ensure that no other residents needed to have a new PASRR submitted to verify if they had any diagnosis to support a referral for a Level II. One other resident was noted with a diagnosis of Major Depressive Disorder, Single Episode, Severe with Psychotic Features. A PASRR submission was completed for this resident. No negative outcomes were noted. This audit was completed on 4/22/26 by the administrator. Education was provided to Social Services Director, DON, Medical Records, and MDS staff on reviewing PASRR status with every Admission, Significant Change, and Annual MDS assessment submitted. A new assessment process has been implemented in PCC to ensure PASRR review is documented with each of these assessments. This includes verification of existing PASRR Level 1 or II, identification of any diagnosis, or changes that may require a new PASRR submission, and documentation of PASRR review within the assessment workflow. This process has been incorporated into routine admission and assessment procedures. This education was completed on 4/23/26 by the administrator. Any new hires for Social Services, DON, Medical Records or MDS will be educated on this process during the hands-on orientation process by the	04/24/2026

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F0645 SS = D	Continued from page 6 section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for a Level II PASRR (Preadmission Screening and Resident Review) evaluation for a resident admitted with an active diagnosis of bipolar disorder for 1 of 3 residents reviewed for PASRR evaluations (Resident #14). The findings included: Review of Resident #14's medical record revealed a PASRR level I completed prior to admission to the facility dated 03/20/18.	F0645	Continued from page 6 administrator or designee. A structured audit process has been implemented to begin the week of 4/27/26. Audits will be completed every 2 weeks times 2, then monthly times 2. Audits will verify all residents that have had an Admission, Significant Change, or Annual MDS assessment has a completed assessment in PCC showing that the PASRR was reviewed and if a new submission was required that this was completed. Audits will be completed by the Administrator, DON, or designee. Audit results will be reviewed in QAPI meetings monthly for three months beginning in the month of May, or until substantial compliance is met. Completion Date: 4/24/26	04/24/2026

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F0645 SS = D	Continued from page 7 Resident #14 was admitted on 06/06/25 with diagnoses which included bipolar disorder. No PASRR level II evaluation had been completed per review of Resident #14's medical record. Resident #14's admission Minimum Data Set (MDS) assessment dated 06/13/25 revealed Resident #14 had an active diagnosis of bipolar disorder and was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #14's quarterly MDS assessment dated 02/25/26 revealed he was severely cognitively impaired. He had no behaviors and no signs of depression. Resident #14 was coded for an active diagnosis of bipolar disorder and received anticonvulsant and antidepressant medications daily. Resident #14's physician orders revealed the following active medication orders: mirtazapine (antidepressant medication) 15 milligrams by mouth daily at bedtime for depression and appetite; Lamictal (anticonvulsant medication used as a mood stabilizer) 25 milligrams by mouth daily for bipolar disorder. Resident #14's active care plan dated 06/17/25 revealed a focus area for antidepressant medications with indication of depression and bipolar disorder. The stated goal was that Resident #14 would remain free from side effects of the medication. Interventions included administering medications as ordered, and monitoring for adverse effects of medication. An interview with the Social Worker on 04/02/26 at 9:16 AM revealed that Resident #14 had a level I PASRR when he was admitted to the facility. The Social Worker stated that since he already had a PASRR level I evaluation completed, she did not submit a referral for a Level II PASRR evaluation and was not aware she had to. The Social Worker stated that she was aware Resident #14 had a bipolar disorder diagnosis and acknowledged she did not submit a request for a level II PASRR evaluation for Resident #14. An interview with the Administrator on 04/02/26 at 4:02 PM revealed that it was important that level II PASRR evaluations were completed for residents who met criteria so they could receive the services they needed.	F0645		04/24/2026

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	Disclaimer: This Plan of Correction is submitted in response to the Statement of Deficiencies and does not constitute an admission of wrongdoing or agreement with the cited findings. During the survey process it was noted that Resident #1 had an active diagnosis of COPD that was not reflected on the resident's care plan. The care plan has been updated to include COPD along with individualized interventions based on the resident's needs. This was Completed by Informatics Nurse. These were added at the time of the survey when it was brought to our informatics nurses attention. This was corrected in front of the surveyor. It was also noted that Resident #22 was receiving an anticoagulation medication that was not reflected on the resident's care plan. The care plan has been updated to include the anticoagulant and appropriate monitoring, safety, and bleeding-risk interventions. This was completed by MDS. These were added at the time of the survey when it was brought to our informatics nurses attention. This was corrected in front of the surveyor. No negative outcomes were noted with either of the above residents. An audit was complete of all residents with a diagnosis of COPD and any resident who was currently taking an anticoagulant medication. 9 other residents were noted with a diagnosis of COPD that was not reflected on the care plan, and 3 other residents were noted to be on an anticoagulant medication. Identified care plans were updated to include the appropriate diagnosis, medications, and individualized interventions. These were added by the informatics nurse by 4/24/26. This audit was completed on 4/22/26 by administrator. No negative outcomes were noted. MDS nurse, Informatics Nurse, and DON education was completed on ensuring that all resident care plans are resident specific, up to date, including active diagnoses, including current medications. Along with ensuring that all residents care plans are reviewed and updated with each MDS assessment completed. This expectation has been incorporated into the routine MDS and care plan review process. This education was provided by the administrator and completed on 4/24/26	04/25/2026

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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
F0656 SS = D	Continued from page 9 Based on record review, observation, and resident, staff, and Medical Director interviews, the facility failed to develop an individualized person-centered comprehensive care plan in the area of respiratory care (Resident #1) and anticoagulant medication use (Resident #32) for 2 of 3 residents whose comprehensive care plans were reviewed. Findings included: 1. Resident #1 was initially admitted to the facility on 06/28/22 with a readmission date of 02/23/26. Resident #1's diagnoses included chronic obstructive pulmonary disease (COPD, a progressive, debilitating respiratory disease), chronic respiratory failure with hypoxia (low levels of oxygen in the bodies tissues), and pneumonia due to methicillin resistant staphylococcus aureus (MRSA, a bacterial pneumonia resistant to antibiotics). A quarterly Minimum Data Set (MDS) assessment dated 02/27/26 revealed Resident #1 was coded for diagnoses of respiratory failure, chronic obstructive pulmonary disease, and pneumonia. A review of Resident #1's active comprehensive care plan most recently updated on 09/30/25, did not include a care plan in place for COPD, respiratory failure, or pneumonia. A review of Resident #1's physician orders revealed that since September 2025 Resident #1 received medication daily and as needed to help with COPD and chronic respiratory symptoms and had received multiple rounds of antibiotics for pneumonia. A Physician Progress Note dated 10/23/25 revealed Resident #1 had complained of cough, congestion, and respiratory distress and that aggressive treatment for COPD would continue. A Physician Progress Note dated 11/03/25 revealed Resident #1 had been hospitalized for pneumonia on 10/29/25, had been readmitted with supplemental oxygen and to continue the current treatment for pneumonia. A Physician Progress Note dated 01/29/26 revealed Resident #1 was undergoing treatment for pneumonia, had dyspnea (shortness of breath) and to continue the current antibiotic. A review of Resident #1's Pulmonologist consult dated 03/05/26 revealed Resident #1 was seen due to a recent hospitalization for right lower lobe	F0656	Continued from page 9 The staff member training new MDS nurses at the time of new hire will be responsible for ensuring they are aware that COPD and anticoagulants should be careplanned. Care plan audits will be conducted every 2 weeks times 2, then monthly times 2. Audits will begin the week of 4/27/26. Each audit will verify any high-risk medications, and significant diagnoses are reflected in residents' care plans. Audits will include all residents who have had any MDS submission since the previous audit. Audits will be completed by the Administrator, DON, or designee. Audit results will be reviewed in QAPI for 3 consecutive months beginning in May or until substantial compliance is achieved and maintained. Completion Date: 4/25/26	04/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345314	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

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F0656 SS = D	Continued from page 10 pneumonia. The Pulmonologist note indicated Resident #1 reported ongoing chest congestion, cough, and wheezing, and may have bronchiectasis with mucus impaction (a condition in chronic lung disease when the airway is unable to expel secretions) and recommended continuing antibiotics for 2 more weeks. An interview and observation with Resident #1 on 03/30/26 at 1:02 PM revealed she currently had a cough and reported that her respiratory issues were ongoing. Resident #1 had slightly labored breathing during the conversation but denied the need for oxygen or feeling distressed. An interview with the Medical Director on 04/02/26 at 10:59 PM revealed that Resident #1 had COPD which is a chronic lung disease. The Medical Director stated he would consider Resident #1's respiratory condition to be severe, chronic, and she required frequent monitoring and treatment of respiratory symptom management by the medical staff. An interview with the Informatics Nurse was conducted on 04/02/26 at 10:07 AM. The Informatics Nurse revealed he was temporarily in the role of the MDS Nurse and had only been in this role for a few weeks. He stated Resident #1 had a diagnosis of COPD, respiratory failure and had recurrent pneumonia. He explained that COPD should be included in Resident #1's care plan since it was a long-term issue and was unsure why one was not in place. An interview with the Director of Nursing (DON) on 04/02/25 at 12:14 AM revealed that she expected the residents' care plans to be accurate and reflect care concerns. The DON stated that Resident #1 should have a respiratory care plan in place due to her ongoing impaired respiratory status. The DON indicated the MDS Nurse who was responsible for updating care plans and had recently quit and this may have contributed to the overlooking Resident #1's respiratory care plan. An interview with the Administrator was conducted on 08/28/25 at 4:02 PM. The Administrator stated the care plans should reflect the clinical condition of the residents, including respiratory symptoms or diagnoses. 2. Resident #32 was admitted to the facility on 10/11/2025 with diagnoses which included myocardial infarction (heart attack) and chronic atrial	F0656		04/25/2026

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F0656 SS = D	Continued from page 11 fibrillation. The quarterly Minimum Data Set (MDS) assessment for Resident #32 dated 01/16/2026 indicated Resident #32 was receiving an anticoagulant. The active medication orders for Resident #32 revealed an order for Apixaban (an anticoagulant medication) 2.5 milligrams (mg) by mouth twice a day for history of myocardial infarction and deep vein thrombosis (blood clot) prevention. The medication had a start date of 10/11/2025. Resident #32's active comprehensive care plan initiated on 10/17/2025 and last revised on 01/21/2026 did not reveal any care plan focus area or interventions related to Resident #32 receiving an anticoagulant medication. Review of Resident #32's Medication Administration Record (MAR) from 01/01/2026 through 03/31/2026, revealed Resident #32 received Apixaban 2.5 mgs by mouth twice a day as ordered by the physician. An interview was conducted on 04/01/2026 at 10:30 AM with the Informatics Nurse who stated the facility did not currently have an MDS Coordinator and he had been temporarily filling in for the past couple of weeks. The Informatics Nurse stated that Resident #32’s quarterly MDS assessment dated 01/16/2026 was accurately coded for anticoagulant use, but her care plan did not address the use of anticoagulant medications. He indicated anticoagulant medications were considered high-risk medications and should be care planned. An interview was conducted on 04/02/2026 at 1:45 PM with the Director of Nursing (DON). The DON stated she did not know why Resident #32’s anticoagulant medication was not care planned, but she expected that all high-risk medications be care planned including anticoagulant medications. An interview was conducted with the Administrator on 04/02/2026 at 2:45 PM who stated she did not know why Resident #32’s anticoagulant medication was not care planned, but she expected all resident care plans to be reflective of the resident’s clinical condition including the use of anticoagulant medications. The Administrator stated that an anticoagulant care plan should have been implemented for Resident #32.	F0656		04/25/2026