STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345370	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinehurst Healthcare & Rehabilitation Center	**300 Blake Boulevard , Pinehurst, North Carolina, 28374**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 4/27/26 through 4/30/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22F554-H1.	E0000		05/19/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/27/26 through 4/30/26. Event ID #22F554-H1. The following intakes were investigated: 2741697, 2731746, 2733130, 2583582, 2976579, 2988089, and 2995867. 4 of the 9 complaint allegations resulted in deficiency. Intake 2578227 was withdrawn.	F0000		05/19/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812	F812 For dietary services, a corrective action was obtained on 4/27/2026. During initial walk through of the kitchen on 4/27/2026, it was noted dietary services had failed to properly label and date food in the walk-in cooler, walk-in freezer, and reach-in cooler. On 4/27/2026 the Dietary Manager and Dietitian discarded all improperly stored food items. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 4/29/2026, the Dietary Consultant completed a kitchen and nourishment walk through with the Dietary Manager to ensure all food items were stored properly. Systemic changes	05/20/2026

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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F0812 SS = E	Continued from page 1 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to label, date, and seal leftover food stored ready for use in 1 of 1 walk-in refrigerator, 1 of 1 walk-in freezer and 1 of 1 reach-in refrigerator. This practice had the potential to affect food served to residents. The findings included: a. Accompanied by Dietary Aide #1, an observation was made of the walk-in refrigerator on 4/27/26 at 6:30 AM. An undated piping bag, partially filled with whipped topping, was sitting on the shelf of the walk-in refrigerator. Dietary Aide #1 stated the whipped topping was likely used on desserts from the previous day. b. An observation was conducted of the walk-in freezer on 4/27/26 at 6:32 AM which contained one undated and open-to-air bag of twenty biscuits and one undated partially used bag of hash browns. Dietary Aide #1 was unable to state when the packages had been opened. c. An observation was conducted of the reach-in refrigerator on 4/27/26 at 6:34 AM. The reach-in refrigerator contained one bag of opened and undated turkey lunchmeat and seven undated zipper sealed bags of food containing a sandwich, marshmallow pie, oatmeal pie, and peanut butter crackers labeled “dialysis ready”. Dietary Aide #1 was unable to state when the lunchmeat had been opened or when the bags of food had been prepared. An interview was conducted with Dietary Aide #1 on 4/27/26 at 6:35 AM who stated all foods should have been wrapped and sealed, dated, and labeled with their contents. On 4/27/26 at 6:38 AM Cook #1 was interviewed and stated he was unaware when the zipper sealed storage bags labeled “dialysis ready” were prepared and explained they should have been dated.	F0812	Continued from page 1 In-service education was provided to all full time, part time, and as needed dietary staff on 4/29/2026. Topics included: Storage and dating policies and regulations. Use by dates. Inspections on shifts to observe all food are within their dates and tossed if out of date. Daily audits will be completed by dietary manager to ensure all food items are properly stored. These audits were initiated on 04/30/2026 and will continue through 05/19/2026. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance monitoring procedure. The Dietary Manager or assignee will monitor procedures for proper food storage weekly x2 and monthly x3 Beginning the week of 5/20/2026. The Dietary QA Tool which will observe that all food is correctly labeled, dated, and stored. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	05/20/2026

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F0812 SS = E	Continued from page 2 On 4/27/26 at 12:45 PM Corporate Dietitian #1 was interviewed and stated all foods should have been wrapped and dated when they were opened or prepared. On 4/28/26 at 11:37 AM the Dietary Manager (DM) was interviewed and stated she was responsible for monitoring the freezer and refrigerators to ensure food items were properly dated and labeled. The DM stated she was unsure why the items were not dated when they were opened. The Director of Nursing was interviewed on 4/30/26 at 10:57 AM and stated all foods should be covered and stored correctly and dated if they were opened.	F0812		05/20/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F0550	F550 Plan of Correction Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to maintain resident dignity during an interaction between a nurse and Resident #1. The incident resulted in emotional distress to the resident. On 02/03/2026, the resident involved was assessed for any mental anguish initiated by the Director of Nursing. There were no concerns at that time, the resident stated he was fine and there were no issues. On 02/04/2026, the Social Services Director assessed the resident for any psychosocial distress by completing a Trauma Informed Assessment, and no emotional distress, change in condition, or decline in psychosocial status. The resident continued to demonstrate baseline affect with no identified concerns related to the incident. Nurse #1 was removed from the facility pending investigation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 05/12/2026, the Social Services Director completed interviews with all residents with a BIMs of 13 or greater regarding concerns about staff interactions and dignity. These interviews were	05/22/2026

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F0550 SS = D	Continued from page 3 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident, Nurse Practitioner (NP), and staff interviews, the facility failed to speak to a resident in a dignified manner causing the resident to feel shocked, angry, hurt and embarrassed for 1 of 1 resident reviewed for dignity (Resident #1). The findings included: Resident #1 was admitted to the facility on11/6/24. A review of the nursing progress notes dated 2/3/26 at 1:52 PM revealed a note written by Nurse #9 that read: “When the resident was asked about taking his morning medications Nurse #9 bumped his bed several times to wake him up and offer his morning medication along with getting his blood sugar reading. The Resident had covers pulled over his head and refused to respond. He was asked several times before breakfast. When the reporting nurse came in again at lunch time, looked behind the privacy curtain and resident was in the same spot. He did allow his blood sugar reading to be done by another staff member. Resident requested his medication that was pulled and when approached resident in his room at bedside he stated, “oh so you brought me my medications huh?” Reporting nurse “I came in several times and called your name and bumped your bed to wake up and you haven’t/wouldn’t respond”. Resident stated, “You are a lying bit*h, you haven’t brought me sh*t” Again, reporting nurse was holding the cup of medications to offer them to him but stated to the resident, “If I try to wake you up and you decide not to respond then I can’t do anything but go on”. Resident stated, “naw bit*h that’s your job to wake me up.” Reporting nurse, “Considering you have to choose to be noncompliant and continue to refuse your medications all I can do is try and wait, but I will not leave medications in your room at bedside.” Resident then stated (something to this effect), “bit*h get out my room and take them da*n meds with you, you lying bit*h, you did try to wake me	F0550	Continued from page 3 completed on 05/12/2026. The results of the interviews didn’t identify any additional concerns. Residents with a BIMS score of 12 or less may not be able to reliably verbalize concerns related to dignity or staff interactions. To ensure these residents were protected, on 05/11/2026 the Director of Nursing initiated focused assessments to identify any signs of distress, fear, behavioral changes, or decline possibly related to staff interactions. These assessments were completed on 05/11/2026. The results included that 0 of 75 residents showed no distress, fear, behavioral changes, or decline possibly related to staff interaction. On 5/14/2026 the Director of Nursing, Assistant Director of Nursing and Director of Social services, initiated interviews for all residents with a BIMs score of 13 and above. These interviews consist of asking the residents, Has any staff harmed or threatened you?, Do you know your rights as a skilled facility resident?, Do you know where to find resident rights information?, Do you feel that your patient rights are upheld here at the facility? On 05/14/2026, the Director of Nursing initiated random observations of resident encounters on different dates and different shifts to identify evidence of additional dignity concerns. These observations consist of observing encounters between staff and residents and asks if staff speak to a resident in an undignified manner? If it was observed did the auditor protect the resident immediately and did the auditor report the negative interaction between the staff member and the resident to the Administrator or Director of Nursing? These observations were completed through 05/19/2026. There was no additional dignity concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 5/11/2026, the Director of Nursing in-serviced all staff in all departments (including agency) on Resident Rights, dignity, professional conduct, and de-escalation techniques. Training included expectations for respectful communication, boundaries, and reporting concerns. Staff who do not complete training by 5/19/2026 will not be allowed to work until this training has been	05/22/2026

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F0550 SS = D	Continued from page 4 up." Reporting nurse was already at door and walked out and showed unit manager cup of medications and explained to her what happened." Review of the quarterly Minimum Data Set (MDS) dated 2/14/26 assessed Resident #1 as cognitively intact. Resident #1 was coded as displaying verbal behavioral symptoms towards others between 1 to 3 days during the look back period. An interview was conducted with Resident #1 on 4/27/26 at 9:58 AM who stated back in February 2026 Nurse #9 argued with him about whether she had given him his morning medications before ultimately calling him a "crippled motherf****r" before walking out of his room and slamming the door. In a follow-up interview with Resident #1 on 4/29/26 at 10:42 AM, the resident stated he was shocked at first then became angry and hurt when Nurse #9 called him that. Resident #1 stated it hurt his feelings because he is completely dependent on others for his care, and it embarrassed the resident to be called crippled because other people were in the room and heard her say those words. Resident #1 stated Nurse #9 told him she was going to feed him the same energy he fed her "you crippled motherf****r." On 4/28/26 at 5:20 PM a phone interview was conducted with Nurse #9 who stated she recalled the exchange she had with Resident #1 although she was unsure of the date. According to Nurse #9 she had "never been cussed out so bad by a resident before," and it caused her to become "so enraged" that she could neither "confirm nor deny" that she called him a derogatory term. A phone interview was conducted with Nurse Aide (NA) #1 on 4/28/26 at 5:28 PM who stated she remembered the incident between Resident #1 and Nurse #9 well. NA #1 affirmed she was assisting Resident #1 to get ready for an appointment when Nurse #9 walked into the resident's room. According to NA #1, Resident #1 was upset because he had not received his morning medications and was calling Nurse #9 "every name in the book". NA #1 stated Nurse #9 was trying to be professional and asked the resident to stop cursing at her when Resident #1 called her a "really derogatory name". NA #1 stated Nurse #9 informed Resident #1 she was "about to give him the same energy he was giving her" and then called the resident a "crippled motherf****r" and walked out. NA #1 stated she was "in shock" about what had happened and went to the Director of Nursing to report the exchange as soon as she	F0550	Continued from page 4 completed. The Director of Nursing or Staff Development Nurse will ensure that this training is incorporated into the general orientation for new hires including any new agency staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning on 5/21/2026, the Director of Nursing, Assistant Director of Nursing and Social Services Director will conduct interviews with 100% of residents with a BIMS score of 13 and above and 5 observations of staff to resident encounters to identify any concerns with dignity weekly for 3 weeks and then monthly for 2 months. Any findings that are concerning for dignity issues will be addressed immediately. Findings will be reported at the monthly Quality Assurance meeting attended by the Administrator, DON, MDS Coordinator, Therapy, Dietary Manager and Director of Social services.	05/22/2026

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F0550 SS = D	Continued from page 5 helped Resident #1 get dressed. On 4/29/26 at 10:55 AM the Nurse Practitioner (NP) was interviewed and stated he spoke with Resident #1 the day of the incident with Nurse #9, and the resident told him the phrase she used (he could not recall the exact words) against him. The NP indicated he thought Resident #1 might have been saying things out of anger or frustration, but he reported what Resident #1 told him to the Director of Nursing after the conversation was complete. According to the NP, the Director of Nursing later told him she had investigated the incident and what Resident #1 reported was true. The Director of Nursing (DON) was interviewed on 4/30/26 at 10:34 AM and stated back in February 2026 NA #1 reported she felt Nurse #9 spoke badly to Resident #1. According to the DON, NA #1 informed her Nurse #9 was calm and polite to Resident #1 when she told him she had tried to give his morning medications earlier that day but Resident #1 accused Nurse #9 of lying to him. The DON stated NA #1 further stated Nurse #9 told Resident #1 that he would not like it if she was giving him the same energy he was giving her and proceeded to call him a “crippled motherf****r”. The DON explained she was unable to speak with Resident #1 immediately because he had already left for an appointment. However, when Resident #1 returned from his appointment the DON interviewed him. According to the DON, Resident #1 informed her Nurse #9 could call him a motherf****r, but she could not call him crippled, and that he was “mad”. The DON stated she then called Nurse #9 to the office and the nurse informed her she had her back to Resident #1 and did not think he could hear her, but Nurse #9 admitted to calling Resident #1 a “crippled motherf****r”. The DON indicated she then walked Nurse #9 out of the building. The facility submitted a plan of correction that was reviewed but did not meet the standard for past non-compliance due to not focusing on dignity or including monitoring of the residents in section 4 of the plan of correction.	F0550		05/22/2026
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.	F0641	F-641 Accuracy of Assessments Corrective actions Resident #2 Minimum data set Quarterly assessment with Assessment Reference date of 1/25/2026 reviewed and section (N0415E) anticoagulant use and (N0415K) anticonvulsant use incorrectly coded for high-risk drug class. Assessment correction	05/20/2026

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F0641 SS = D	Continued from page 6 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of hospice participation (Resident #4), medications (Resident #2) and Preferences for Customary Routine and Activities (Resident #101). This deficient practice affected 3 of 22 residents whose MDS assessments were reviewed. The findings included: 1. Resident #4 was admitted to the facility on 12/16/25 with diagnoses that included Alzheimer's disease. A review of Resident #4's active physician orders included an order dated 3/27/26 for hospice services related to Alzheimer's disease.	F0641	Continued from page 6 completed on 4/30/2026 for item (N0415E,) anticoagulant use and (N0415K) anticonvulsant use Resident #4 Minimum data set Significant change in status assessment with Assessment reference date of 4/2/2026 reviewed and section (O0110K1B) Hospice services incorrectly coded. Assessment correction completed on 4/29/2026 for item 9O0110K1B) Hospice services. Resident #101 Minimum data set admission assessment with Assessment Reference date of 8/17/2025 reviewed and section F: Preferences for Customary and Routine activities was marked with dashes (-) indicating it was not assessed. Review of resident record with findings the resident interview was not conducted within the look-back period of the Assessment reference date, and the standard "no information" code (a dash "-") was entered in the resident interview items. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of the current residents' most recent Minimum data set assessments that have been accepted in IQIES in the past 14 days will be completed in order to identify assessments coded correctly at (N0415E) anticoagulant use and (N0415K) anticonvulsant use which are High-Risk Drug Classes. This audit will be completed by Regional Resident Assessment Instrument (RAI) consultant no later than 5/15/2026. Any assessment identified as having inaccurate coding of (N0415E) anticoagulant use and/or (N0415K) anticonvulsant use will have a correction of that assessment completed. Any necessary Minimum data set corrections identified from the audit will be completed by the facility Minimum data set coordinator (MDS) no later than 5/15/2026. An audit to identify all current residents receiving hospice services will be completed for accuracy of coding at section (O0110KB) hospice services of the most recent submitted Minimum data set assessment. This audit will be completed by the regional RAI consultant no later than 5/15/2026. Any assessment identified as having inaccurate coding of (O0110KB) hospice services will have a correction of that assessment completed. Any necessary Minimum data set corrections identified from the audit will be completed by the facility Minimum data set	05/20/2026

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F0641 SS = D	Continued from page 7 A Significant Change in Status MDS assessment 4/2/26 revealed Resident #4 was marked with an active diagnosis of Alzheimer's disease and a prognosis of less than six months but not coded with receiving hospice care. During an interview with MDS Nurse #1 on 4/29/26 at 12:19 PM, she confirmed Resident #4 received hospice services and verified that hospice care was not marked on the MDS assessment dated 4/2/26. She indicated that MDS Nurse #2 completed that section and felt it was an oversight not to have marked hospice care. Attempts made to interview MDS Nurse #2 were not successful. An interview was conducted with the Director of Nursing (DON) on 4/30/26 at 10:07 AM, who stated it was her expectation for the MDS assessment to be coded accurately. 2. Resident #2 was admitted to the facility on 05/13/25 with a diagnosis that included history of cerebral infarction (stroke) without residual deficits. Review of Resident #2's January 2026 Physician orders and Medication Administration Record (MAR) did not include an order for anticoagulant medication or anticonvulsant medication. A quarterly Minimum Data Set (MDS) assessment dated 01/25/26 indicated Resident #2's cognition was intact. The medications section was coded that she was receiving an anticoagulant medication and anticonvulsant medication on a routine basis. On 04/30/26 at 11:40 AM, an interview occurred with the MDS Nurse #2. MDS Nurse #2 stated she completed Resident #2's quarterly MDS assessment dated 01/25/26. MDS Nurse #2 reviewed the quarterly MDS assessment along with January 2026 medication orders for Resident #2 and verified she incorrectly coded the area of medications for the use of anticoagulant and anticonvulsant medications. MDS Nurse #2 indicated she was unsure why she incorrectly coded the medications and felt it was an oversight. An interview was completed on 04/30/2026 at 12:01	F0641	Continued from page 7 coordinator no later than 5/15/2026. Systemic Changes By 5/15/2026, the Director of Resident Enrichment and social services will complete an in-service training with the Assistant activity director. Educational training will focus on completion of Section F: Preferences for customary routine and activities interviews for assessment interviews in the absence of the activity director. By 5/15/2026 the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurses that includes the importance that the assessment is coded accurately. Special emphasis will be placed on the following area of the Minimum Data Set assessment: (N0415E) anticoagulant use and (N0415K) anticonvulsant use and High-Risk Drug Classes: Indication (O0110K1) Hospice services The MDS needs to be thoroughly reviewed for accuracy prior to saving and signing section (N0415E) anticoagulant use, (N0415K) anticonvulsant use, and (O0110K1) hospice services of the assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments for completion of section F preferences and customary routine activities interview and accuracy in coding for items (N0415E) anticoagulant, (N0415K) anticonvulsant High-Risk Drug Classes and (O0110K) hospice care to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. These audits will be done weekly x 2 weeks and then monthly x 2 months using the audit tool titled "Accurate Coding of MDS	05/20/2026

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F0641 SS = D	Continued from page 8 PM with the Director of Nursing (DON). She stated she was unaware Resident #2's MDS assessment had been coded incorrectly and she expected the assessments to be coded accurately. 3. Resident #101 was admitted to the facility on 8/11/25 with medical diagnoses that included hypertension, major depressive disorder, and anxiety disorder. A review of the admission Minimum Data Set (MDS) dated 8/17/25 revealed Resident #101 was cognitively intact. The Preferences for Customary Routine and Daily Activities section was marked with dashes (-) indicating it was not assessed. The dashes had been entered into the assessment by MDS Nurse #1. During an interview with the Activities Director on 4/30/26 at 8:55 AM, she stated she typically completed the MDS section which addressed the Preferences for Customary Routine and Activities. She reported that she did not complete Resident #101's admission assessment because she was on vacation at that time and in her absence the MDS Nurse was to complete that section. An interview was conducted on 4/30/26 at 10:51 AM with MDS Nurse #1. MDS Nurse #1 stated the Preferences for Customary Routine and Activities section was typically completed by the Activities Director and the Activities Assistant could complete the assessment in the Director's absence. MDS Nurse #1 explained during the period when Resident #101's assessment was due; she was working alone and did not have time to complete it and filled it in with dashes. MDS Nurse #1 explained that the MDS assessment schedule was available and she sent emails to remind staff when the assessment reference date (ARD, the last day of the assessment period) was approaching. She stated these were things done to ensure each department had time to complete their sections prior to scheduled days off. MDS Nurse #1 indicated she had assumed the Activity Assistant would complete the assessment. During an interview with the Activity Assistant on 4/30/26 at 10:58 AM she stated she had been employed as the Activity Assistant for approximately six months. She reported she had not completed any MDS assessments and had not been trained or asked to complete them. The Activity Assistant explained that the Activity Director had always been the one to complete them. During an interview with the Director of Nursing	F0641	Continued from page 8 Audit Tool". Reports will be presented to the Quality Assurance committee, to include the Director of Nursing, Administrator, MDS Coordinator to ensure corrective action for trends or ongoing concerns is initiated as appropriate.	05/20/2026

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F0641 SS = D	Continued from page 9 (DON) on 4/30/26 at 11:55 AM she explained that the facility's assessment schedule was available to staff and allowed sufficient time for each department to complete their assigned portions of the MDS prior to any planned vacation days. She stated it was her expectation that all sections of the MDS assessments be completed.	F0641		05/20/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and interviews with the Nurse Practitioner and staff, the facility failed to administer medications at the scheduled time for 2 of 6 residents reviewed for medication administration (Residents #102 and #92). The findings included: 1. Resident #102 was admitted to the facility on 4/8/25 with diagnoses that included hypertension. A review of Resident #102's active physician orders for April 2026 included the following: An order dated 4/8/25 for Hydralazine 100 mg one tablet by mouth three times a day for hypertension. An order dated 4/10/25 for Metoprolol Tartrate 25 mg one tablet by mouth two times a day for hypertension. A review of the April 2026 Medication Administration Record (MAR) and Medication Administration Audit Report dated 4/28/26, for Resident #102 revealed the following: Hydralazine (used to treat hypertension or high blood pressure) was scheduled for 9:00 AM. Nurse #1 documented the medication was administered at 11:17 AM on 4/28/26. Metoprolol Tartrate (used to treat hypertension or	F0658	F658 Plan of Correction 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to administer medications at the scheduled time for 2 of 6 residents, resident #92 and resident #102. A corrective action was initiated for resident #92 and resident #102. On 04/30/2026, the Nurse Practitioner was made aware of the medications not being administered at the scheduled time, at which time he reviewed the resident and confirmed there were no ill effects and resident remained clinically unaffected. On 04/29/2026, the Nursing staff were re-educated on medication administration timing requirements (one hour before or after scheduled time). On 05/13/2026, a Medication error report was initiated by the Director of Nursing for the medications being administered late. On 05/12/2026, the Assistant Director of Nursing collaborated with the provider to adjust the medication administration times if required. On 05/11/2026, the Director of Nursing notified the Pharmacy Consultant who offered no recommendations for corrective action. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 04/30/2026, the Director of Nursing initiated random observations of medication administration on different halls, on different days, and different shifts to identify concerns with medication administration timing requirements. The random observations consisted of medication administration direct observations and observation of the medication administration report. Random observations continued through 05/19/2026. The Director of Nursing completed corrective action for any variances identified with medication administration timing requirements including provider notification of any variances and staff education.	05/20/2026

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F0658 SS = D	Continued from page 10 high blood pressure) was scheduled for 9:00 AM. Nurse #1 documented the medication was administered at 11:18 AM on 4/28/26. An interview with Nurse #1 on 4/28/26 at 11:15 AM revealed she was an agency nurse who worked at the facility intermittently. Nurse #1 stated that she fell behind on the morning medication administration on 4/28/26 and did not administer Resident #102's scheduled morning medications until 11:00 AM. She reported she did not request assistance to ensure medications were given on time. On 4/30/26 at 9:35 AM, the Nurse Practitioner (NP) was interviewed. He reviewed Resident #102's medical record and confirmed she experienced no ill effects related to the late administration of her medications (Hydralazine and Metoprolol) on 4/28/26. He stated Resident #102's vital signs remained within normal limits and she appeared clinically unaffected. The NP acknowledged the facility's requirement that medications be administered within one hour before or after the scheduled time and stated he expected staff to follow this requirement, especially with medications that were ordered to be given more than once a day. The Director of Nursing (DON) was interviewed on 4/30/26 at 10:07 AM and stated Resident #102's medications were expected to be administered on time since these medications were ordered more than once a day. The DON reported Nurse #1 was an agency nurse and that agency staff had been instructed to request assistance if they fell behind with medication administration. The DON stated she didn't know why Nurse #1 did not request assistance the morning of 4/28/26 as the medications should have been given one hour before or one hour after their scheduled time to remain in an acceptable timeframe. 2. Resident #92 was admitted to the facility on 9/10/25 with diagnoses that included neuropathic pain. A review of Resident #92's active physician orders for April 2026 included an order dated 9/16/25 for Neurontin 300 mg one capsule by mouth two times a day for neuropathic pain.	F0658	Continued from page 10 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/30/2026, The Director of Nursing, the Assistant Director of Nursing, and the Staff Development Coordinator began education with all nursing staff and agency nurses were educated on medication timing, medication administration expectations, and requesting assistance when falling behind. Staff who do not complete training by 5/19/2026 will not be allowed to work until this training has been completed. The Director of Nursing or Staff Development Coordinator will ensure that this training is incorporated into the general orientation for new hires including any new agency staff. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or designee will conduct monitoring of medication administration by completing 10 random observations of medication administration to identify concerns with medication administration timing requirements weekly x 3 weeks and monthly x 2 months beginning the week of 5/20/2026. Findings will be reported at the monthly Quality Assurance meeting attended by the Administrator, Director of Nursing, Minimum Data set Coordinator, Therapy, Health information manager, and Dietary Manager.	05/20/2026

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F0658 SS = D	Continued from page 11 A review of the April 2026 Medication Administration Record (MAR) and Medication Administration Audit Report dated 4/28/26, for Resident #92 revealed Neurontin was scheduled for 9:00 AM. Nurse #1 documented the medication was administered at 12:06 PM on 4/28/26. An interview with Nurse #1 on 4/28/26 at 1:00 PM revealed she was an agency nurse who worked at the facility intermittently. Nurse #1 stated that she fell behind on the morning medication administration on 4/28/26 and did not administer Resident #92's scheduled morning medications until 12:00 PM. She reported she did not request assistance to ensure medications were given on time. On 4/30/26 at 9:35 AM, the Nurse Practitioner (NP) was interviewed. He reviewed Resident #92's medical record and confirmed he experienced no ill effects related to the late administration of his medication (Neurontin) on 4/28/26. He stated Resident #92's vital signs remained within normal limits and he appeared clinically unaffected. The NP acknowledged the facility's requirement that medications be administered within one hour before or after the scheduled time and stated he expected staff to follow this requirement, especially with medications that were ordered to be given more than once a day. The Director of Nursing (DON) was interviewed on 4/30/26 at 10:07 AM and stated Resident #92's medications were expected to be administered on time since the medication was ordered more than once a day. The DON reported Nurse #1 was an agency nurse and that agency staff had been instructed to request assistance if they fell behind with medication administration. The DON stated she didn't know why Nurse #1 did not request assistance the morning of 4/28/26 as the medications should have been given one hour before or one hour after their scheduled time to remain in an acceptable timeframe.	F0658		05/20/2026
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	F0689	Plan of Correction F689 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure that the resident	05/20/2026

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F0689 SS = D	Continued from page 12 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 observation and staff interviews, the facility failed to maintain a safe environment as evidenced by a housekeeping staff member mopping the entire width of the lower 300 hallway (Rooms 304 through 312) which would have required residents, staff, and visitors to walk on a wet floor. This deficient practice occurred on 1 out of 5 resident hallways. Findings included: A continuous observation was conducted on 4/29/26 from 2:47 PM to 2:51 PM of Housekeeper #1 mopping the entire length and width of the floor at the lower end of the 300 hallway. The total area mopped was approximately 4-foot x 10-foot, and the floor was completely wet across the hall. There was a wet floor sign located at the end of the hallway near room 304. An interview was conducted with Housekeeper #1 on 4/29/26 at 2:51 PM who stated she usually mopped across the entire floor then followed up with a dry mop to go back over the area. She explained she understood about safety and had placed a wet floor sign at the end of the hallway to warn residents, staff, and guests to be careful when they walked across the floor. Housekeeper #1 remarked she should have left a dry area for others to walk on for safety. On 4/29/26 at 3:01 PM the Director of Housekeeping was interviewed and stated Housekeeper #1 should have only mopped one side of the floor on the 300 hallway to leave a dry area for residents, staff, and visitors to walk on. He stated a wet floor cautionary sign should have been placed at the end of the wet floor area to warn others to use the other side of the hallway. The Director of Housekeeping further stated mopping was not normally the responsibility of the housekeepers unless there was a spill that needed attention. According to the Director of Housekeeping, the facility has floor technicians who clean the floors every day, and if Housekeeper #1 saw the entire floor needed to be cleaned, she should have reached out to the floor technician.	F0689	Continued from page 12 environment remain as free of accidental hazards as possible as evidenced by a housekeeping staff member mopping the entire width of the lower 300 hallway (rooms 304 through 312). A corrective action was initiated when the housekeeper dry-mopped one-half the width of the lower 300 hallway (rooms 304 through 312). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 4/29/2026, the Environmental Services Director inspected the entire facility for any replication of the deficient practice, and found none. Starting 04/30/2026 the Environmental Services Director began daily audit of the halls to ensure there were no hazards identified. These daily audits will continue through 05/19/2026. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/30/2026, the Environmental Services Director began education with all housekeeping and laundry staff on Hallway Mopping and Resident Safety. This training included: To Always Leave a Dry Walking Path Proper Use of Wet Floor Signs Understanding of Various Housekeeping staff Roles What Not To Do What To Do When One Is Unsure Staff Accountability, Including Consequences of Violating Hallway Mopping and Resident Safety Policy and Education	05/20/2026

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F0689 SS = D	Continued from page 13 On 4/30/26 at 9:39 AM Floor Technician #1 was interviewed and stated he used a floor cleaning machine to clean all the hallways every morning. He explained the machine was equipped with scrubbers that clean the floor as well as a vacuum and squeegee to dry the floor immediately after. Floor Technician #1 indicated he cleaned one half of the floor at a time and left half of the floor dry for others to walk on. Then he repeated the process on the other half of the hall once the first half was dry. Floor Technician #1 stated the only time housekeeping would need to mop the hall was if there was a minor spill or stickiness on the floor. He stated the floor technician team would clean up any major spill. The Director of Nursing was interviewed on 4/30/26 at 10:50 AM and specified Housekeeper #1 should have left a dry clear path for residents, staff, and visitors to walk on, and she should have only mopped one half of the hallway floor at a time.	F0689	Continued from page 13 Priority & Requirement of Cleanliness and Safety Regarding Floors Staff who do not complete training by 5/19/2026 will not be allowed to work until this training has been completed. The Environmental Services Director and Staff Development Coordinator will ensure that this training is incorporated into the general orientation for new hires including any new agency staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Environmental Services Director or designee will conduct monitoring of hallway monitoring and resident safety to ensure compliance by completing 5 random observations to verify hallway mopping and resident safety. This monitor will be completed weekly x 3 weeks and monthly x 2 months beginning the week of 5/20/2026. Findings will be reported at the monthly QA meeting attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, Dietary Manager and Environmental Services Director.	05/20/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and resident, staff, and Nurse Practitioner interviews, the facility failed to ensure oxygen was delivered at the prescribed rate for 3 of 3 residents reviewed for respiratory care (Resident #44, Resident #84, and Resident #123).	F0695	F695 Plan of Correction Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure oxygen was delivered at the prescribed rate for 3 of 3 residents reviewed (Residents #44, #84, and #123). A corrective action was initiated for resident #44, resident #84, and resident #123 on 04/30/2026 when the Director of Nursing corrected the oxygen flow rates to match the physician orders. The Nurse Practitioner reviewed the oxygen saturation levels and clinical status of each resident and confirmed that all residents remained within expected oxygen saturation ranges and did not exhibit any signs of respiratory distress or negative clinical outcomes related to the incorrect oxygen flow rates.	05/20/2026

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F0695 SS = D	Continued from page 14 The findings included: 1. Resident #44 was admitted to the facility on 11/15/21 with diagnoses of unspecified asthma and dependence on supplemental oxygen. The care plan revised on 2/2/26 had a focus area for Resident #44 requiring supplemental oxygen secondary to asthma with a flow rate of 3 liters per minute (lpm). An intervention read to give medications as ordered. A review of the active orders for Resident #44 included an order for supplemental oxygen at 3 lpm continuous by nasal cannula dated 2/16/26. A review of the quarterly Minimum Data Set (MDS) dated 2/22/26 assessed Resident #44 as cognitively intact and she was coded for using supplemental oxygen. On 4/27/26 at 8:00 AM an observation was conducted of Resident #44's oxygen concentrator. It was noted the oxygen concentrator flow rate was set at 1.5 lpm when viewed at eye level. Resident #44 was resting in bed with oxygen via nasal cannula and denied any shortness of breath or respiratory distress. On 4/28/26 at 10:00 AM a follow-up observation was conducted of Resident #44's oxygen concentrator. It was again noted the flow rate was set at 1.5 lpm when viewed at eye level. Resident #44 was using oxygen via nasal cannula while resting in bed and denied any respiratory distress. A review of the April 2026 Medication Administration Record (MAR) revealed an entry for oxygen at 3 liters per minute continuously every shift for oxygen supplement. The MAR had a daily check mark and staff initials for all three shifts on 4/27/26. The MAR was initialed by Nurse #7 on 4/27/26 and the MAR was initialed by Nurse #1 on 4/28/26. An observation and interview were conducted with Nurse #1 on 4/28/26 at 3:47 PM who worked the 7:00 AM to 7:00 PM shift and was assigned to Resident #44 that day. She stated she had checked Resident #44's oxygen concentrator setting during her medication pass that morning. Nurse #1 was asked to observe Resident #44's oxygen concentrator. Nurse #1 stood over the concentrator to view the setting and stated she could not clearly see it. When Nurse #1 bent down to view the concentrator at eye level, she stated it was set at 1.5 lpm and must have been bumped sometime during	F0695	Continued from page 14 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 04/302026, the Director of Nursing initiated a 100% audit of all current residents receiving oxygen therapy to verify that the oxygen was delivered at the prescribed rate. This audit was completed on 4/30/2026 and included: Verification of oxygen flow rate against physician orders Review of MAR documentation for oxygen checks Direct observation of oxygen concentrator settings at eye level The results included: All oxygen flow rates were verified and no additional residents were found to have incorrect oxygen settings at the time of audit. The Assistant Director of Nursing initiated random observations on different halls, on different days, and different shifts to ensure that current residents receiving oxygen was delivered at the prescribed rate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/30/2026, The Director of Nursing, the Assistant Director of Nursing, and the Staff Development Coordinator began education with all licensed nursing staff including agency staff on Respiratory care and Oxygen Administration. This training included:	05/20/2026

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F0695 SS = D	Continued from page 15 the day. Nurse #1 then adjusted the flow rate to 3 lpm. Nurse #7, who was assigned to Resident #44 on 4/27/26 from 7:00 AM to 7:00 PM was unable to be reached by telephone for an interview. The Nurse Practitioner was interviewed on 4/29/26 at 10:55 AM and stated there was always the potential for a problem to arise if supplemental oxygen orders were not followed correctly. After reviewing Resident #44's medical record and oxygen saturation levels recorded in her record, he indicated Resident #44 did not appear to have suffered any ill effects from the oxygen concentrator being set at 1.5 lpm instead of the 3 lpm as ordered. The Director of Nursing (DON) was interviewed on 4/30/26 at 10:48 AM and stated she assumed Nurse #1 was standing over the oxygen concentrator when she checked the flow rate. She stated her expectation was that nurses should assess the oxygen concentrator at eye level to determine if the flow rate matched the physician's order. 2. Resident #84 was admitted to the facility on 11/14/23 with diagnoses of emphysema, chronic obstructive pulmonary disease (COPD), and acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues which causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate and bluish skin). A review of Resident #84's active medication orders revealed an order dated 1/23/26 for supplemental oxygen at 3 liters per minute (lpm) continuous by nasal cannula. A review of the significant change Minimum Data Set (MDS) dated 1/28/26 assessed Resident #84 as being significantly cognitively impaired and she was coded as using supplemental oxygen. The care plan revised on 4/28/26 had a focus area for Resident #84 to receive supplemental oxygen secondary to COPD. On 4/27/26 at 11:05 AM an observation was conducted of Resident #84's oxygen concentrator. It was noted that the oxygen concentrator flow rate was set at 3.5 lpm when viewed at eye level. Resident #84 was using oxygen via nasal cannula while resting in bed and did not appear to be in respiratory distress. A follow-up observation of Resident #84's oxygen	F0695	Continued from page 15 Proper verification of oxygen flow rates at eye level Importance of aligning oxygen delivery with physician orders Documentation expectations on the MAR Risks associated with incorrect oxygen delivery Required actions if discrepancies are identified Staff who do not complete training by 5/19/2026 will not be allowed to work until this training has been completed. The Director of Nursing or Staff Development Coordinator will ensure that this training is incorporated into the general orientation for new hires including any new agency staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or designee will conduct monitoring of oxygen administration by completing 5 random observations of medication administration to verify residents are receiving oxygen at the prescribed rate. This monitor will bed completed weekly x 3 weeks and monthly x 2 months beginning the week of 5/20/2026. Findings will be reported at the monthly QA meeting attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and Dietary Manager.	05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345370	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0695 SS = D	Continued from page 16 concentrator conducted on 4/28/26 at 3:46 PM revealed the flow rate was again set at 3.5 lpm. Resident #84 was using oxygen via nasal cannula while resting in bed and did not appear to be in respiratory distress. A review of the April 2026 Medication Administration Record (MAR) revealed an entry for oxygen at 3 liters per minute continuously every shift for oxygen supplement. The MAR had a daily check mark and staff initials for all three shifts on 4/27/26. The MAR was initialed by Nurse #7 on 4/27/26 and the MAR was initialed by Nurse #1 on 4/28/26. An observation and interview were conducted with Nurse #1 on 4/28/26 at 3:47 PM who worked the 7:00 AM to 7:00 PM shift and was assigned to Resident #84. Nurse #1 stated she had checked Resident #84's oxygen concentrator during the morning medication pass and verified it was set at 3 lpm. When Nurse #1 observed the concentrator with the surveyor she stood over the concentrator and stated it was set between 3 and 4 lpm. When Nurse #1 viewed the concentrator setting at eye level, she stated the flow rate was set at 3.5 lpm and adjusted the setting to 3 lpm as ordered. Nurse #1 stated she didn't know why the concentrator was not set correctly unless a resident or visitor had "messed with it". Nurse #7, who was assigned to Resident #44 on 4/27/26 from 7:00 AM to 7:00 PM was unable to be reached by telephone for an interview. On 4/29/26 at 10:55 AM the Nurse Practitioner (NP) was interviewed and stated it could have been problematic if the oxygen order for Resident #84 was not followed. However, he stated since her oxygen flow rate was set above the ordered flow rate, he did not feel the resident suffered any ill effects. The NP reviewed Resident #84's oxygen saturation levels documented in her record and noted they were within her expected range. The Director of Nursing (DON) was interviewed on 4/30/26 at 10:48 AM and stated she assumed Nurse #1 was standing over the oxygen concentrator when she checked the flow rate. According to the DON, she expected the nurse to assess the oxygen concentrator at eye level to determine if the flow rate matched the physician's order. 3. Resident #123 was readmitted to the facility on 3/6/26 with diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and dependence on	F0695		05/20/2026

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F0695 SS = D	Continued from page 17 supplemental oxygen. A review of Resident #123's active physician orders included an order dated 3/9/26 for oxygen at 3 liters continuous via nasal cannula. An admission Minimum Data Set (MDS) assessment dated 3/12/26 indicated Resident #123 was cognitively intact and was coded for oxygen use. Resident #123's active care plan, last reviewed 3/30/26, included the following focus areas: I have congestive heart failure. One of the interventions was to administer oxygen as ordered. I require oxygen continuously due to COPD and acute/chronic respiratory failure. One of the interventions was to give oxygen therapy as ordered. I have altered cardiovascular status related to congestive heart failure and hypertension. One of the interventions was to give oxygen as ordered. A review of the April 2026 Medication Administration Record (MAR) revealed an entry for oxygen at 3 liters per minute continuously every shift for oxygen supplement. The MAR had a daily check mark and staff initials for all three shifts. The MAR was initialed by Nurse #7 on 4/27/26. On 4/27/26 at 12:23 PM, Resident #123 was observed sitting up in her wheelchair reading with oxygen on via a nasal cannula. She stated that oxygen was used all the time. The oxygen flow regulator on the concentrator was set at 2 liters when viewed at eye level. The oxygen concentrator was noted to not be within Resident #123's reach. On 4/29/26 at 9:43 AM, Resident #123 was observed sitting up in bed reading with oxygen on via a nasal cannula. The oxygen regulator on the concentrator was set at 2 liters flow when viewed horizontally, eye level. An observation and interview occurred with Nurse #4	F0695		05/20/2026

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F0695 SS = D	Continued from page 18 of Resident #123's oxygen concentrator on 4/29/26 at 11:45 AM. Nurse #4 stated she was the assigned nurse and had glanced at the oxygen concentrator that morning when she delivered Resident #123's morning medications but had not signed off on the MAR yet. She stated the oxygen regulator on the concentrator was set at 3 liters when viewed standing over and 2 liters when viewed horizontally at eye level. Nurse #4 acknowledged she should have been looking at the concentrator at eye level rather than standing over the machine to verify the oxygen flow was set at the correct rate. Nurse #4 verified Resident #123 should be using oxygen at 3 liters and adjusted the flow. Attempts to contact Nurse #7, who had been assigned to Resident #123 on 4/27/26 were unsuccessful. The Director of Nursing was interviewed on 4/30/26 at 10:07 AM and indicated it was her expectation for oxygen to be delivered at the ordered rate. She acknowledged that nursing staff should be observing the oxygen concentrator at eye level for the correct setting of the flow rate.	F0695		05/20/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F0757	F757 Plan of Correction Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to hold blood pressure medications per physician-ordered parameters for Residents #44 and #123, resulting in medications being administered despite systolic blood pressure readings below the ordered hold parameters. A corrective action was initiated for resident #44 and resident #123. On 04/30/2026, the Nurse Practitioner was made aware of the medications being administered outside of ordered parameters at which time he reviewed the residents and confirmed there was no harm and indicated both residents remained stable and within expected ranges. On 05/13/2026, a Medication error report was initiated by the Director of Nursing (DON) for the medications administered outside of ordered parameters. On 05/12/2026, the Assistant Director of Nursing collaborated with the provider to review the physician orders with	05/20/2026

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F0757 SS = D	Continued from page 19 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Nurse Practitioner and staff interviews, the facility failed to hold blood pressure medications per the parameters in the physician order for 2 of 7 residents whose medications were reviewed (Residents #44 and #123). The findings included: 1. Resident #44 was admitted to the facility on 10/7/21 with diagnoses that included paroxysmal atrial fibrillation (an irregular heart beat). Review of Resident #44's active physician orders included an order dated 2/19/26 for metoprolol tartrate (a medication that controls the heart rhythm) 25 milligrams (mg). Give half a tablet by mouth two times a day for paroxysmal atrial fibrillation. Hold for heart rate less than 60 or systolic (top number of blood pressure reading) blood pressure (SBP)) less than 120. The March 2026 and April 2026 Medication Administration Records (MARs) were reviewed and revealed Resident #44 had received metoprolol tartrate despite the SBP being below 120 on the following dates: 3/4/26 the SBP was 102 at 9:00 AM and was administered by Nurse #2. 3/17/26 the SBP was 110 at 9:00 AM and 5:00 PM and was administered by Nurse #1. 3/18/26 the SBP was 98 at 5:00 PM and was administered by Nurse #1. 4/5/26 the SBP was 112 at 9:00 AM and was administered by Nurse #4. 4/6/26 the SBP was 118 at 9:00 AM and was administered by Nurse #6. 4/12/26 the SBP was 101 at 9:00 PM and was administered by Nurse #8. 4/21/26 the SBP was 106 at 9:00 AM and was	F0757	Continued from page 19 parameters. On 05/11/2026, the Director of Nursing notified the Pharmacy Consultant who offered no recommendations for corrective action. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 04/30/2026, the Director of Nursing/ Assistant Director of Nursing completed 100% audit of Medication administration record (MAR) verses orders for residents with parameter, to determine if there were any concerns with medication being administered outside of parameter. These observations consisted of medication administration direct observations and observation of the medication administration report. This audit was completed on 4/30/2026 and included: Review of physician orders with parameters Comparison to MAR documentation Verification that medications were held appropriately when parameters were not met The results included: Additional documentation variances were identified and corrected at the time of review No residents were identified with adverse outcomes related to failure to follow hold parameters On 5/1/2026 the Director of Nursing/ Assistant Director of nursing began random audits on different days, different shifts and different halls to determine if any medication was given outside of parameters. These observations consisted of medication administration direct observations and observation of the medication administration report. Random observations continued through 05/19/2026.	05/20/2026

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F0757 SS = D	Continued from page 20 administered by Nurse #5. 4/23/26 the SBP was 105 at 9:00 AM and was administered by Nurse #1. 4/24/26 the SBP was 119 at 9:00 AM and was administered by Nurse #3. A phone interview occurred with Nurse #2 on 4/29/26 at 9:38 AM, who stated she was aware Resident #44 had parameters to hold the metoprolol tartrate. She stated she would have taken the blood pressure, recorded it on the MAR, and held the medication as needed per the parameter. The administration on 3/4/26 at 9:00 AM, was reviewed with Nurse #2 when the metoprolol tartrate was administered despite the SBP being below 120. She stated it was an oversight. Nurse #3 was interviewed on 4/29/26 at 9:46 AM. The April 2026 MAR was reviewed with him where the metoprolol tartrate was administered on 4/24/26 despite the SBP being below 120. He felt that this was an oversight and the medication should have been held per the parameter ordered. Nurse #4 was interviewed on 4/29/26 at 11:42 AM. The April 2026 MAR was reviewed with her where the metoprolol tartrate was administered on 4/5/26 despite the SBP being below 120. She stated the documentation on the MAR indicated the medication was administered but should have been held per the order. She stated it was a mistake. A phone interview was conducted with Nurse #1 on 4/29/26 at 3:18 PM. The March 2026 and April 2026 MARs were reviewed with Nurse #1 where metoprolol tartrate was administered despite the SBP being below 120 on 3/17/26, 3/18/26 and 4/23/26. She indicated she would have taken the blood pressure, recorded it on the MAR and should have held the metoprolol tartrate per the ordered parameter. Nurse #1 stated it was an oversight. Nurse #8 was interviewed via phone on 4/29/26 at 3:50 PM. The April 2026 MAR was reviewed with her where the Metoprolol tartrate was administered on 4/12/26 despite the SBP being below 120. Nurse #8 indicated the medication should have been held per the ordered parameter and stated it was an oversight.	F0757	Continued from page 20 The Director of Nursing completed corrective action for any variances identified with medications administered outside ordered parameter including provider notification of any variances and staff education. Corrective action for any identified discrepancies included review of orders, staff re-education, and reinforcement of parameter compliance. Additionally, on 05/13/2026 the provider reviewed 100% of all orders containing a parameter for blood pressure. As of 05/18/2026, all orders for blood pressure parameters have been discontinued with the exception of 1 order that is for an as needed medication. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/30/2026, The Director of Nursing, the Assistant Director of Nursing, and the Staff Development Coordinator began education with all licensed nursing staff and medication aides, including agency staff on Medication Administration related to parameter-based medications. This training included: Requirement to review vital signs prior to administration if ordered Understanding and following hold parameters exactly as ordered Documentation on the MAR Actions to take when parameters are not met (hold medication and notify provider as indicated) Risks associated with administering medications outside of parameters Staff who do not complete training by 5/19/2026 will not be allowed to work until this training has been completed. The Director of Nursing or Staff	05/20/2026

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F0757 SS = D	Continued from page 21 An interview occurred with Nurse #5 on 4/30/26 at 10:19 AM. The April 2026 MAR was reviewed with her showing the metoprolol tartrate was administered on 4/21/26 despite the SBP being below 120. She stated that she took the blood pressure, documented it on the MAR and should have held it per the ordered parameter. She indicated it was an error. Attempts to contact Nurse #6 were made without success. The Nurse Practitioner was interviewed on 4/30/26 at 9:35 AM and stated he didn't feel Resident #44 would have suffered any serious harm by receiving the metoprolol tartrate outside the ordered parameter to hold, however he would expect the nursing staff to follow the orders for the metoprolol tartrate hold parameter as written. The Director of Nursing was interviewed on 4/30/26 at 10:07 AM and stated she expected the nurses to follow physician orders including blood pressure medications with parameters to hold. 2. Resident #123 was admitted to the facility on 1/6/25 with diagnoses that included localized edema, coronary heart disease, and hypertension. Resident #123 was hospitalized from 2/26/26 through 3/6/26. Review of Resident #123's active physician orders included the following: An order dated 3/6/26 for Cozaar (a medication used to treat high blood pressure) 25 mg one tablet by mouth one time a day for hypertension. Hold for systolic blood pressure (SBP) less than 120. An order dated 3/13/26 for acetazolamide (a medication used to treat fluid retention) 250 mg one tablet by mouth one time a day for edema. Hold for SBP less than 110. An order dated 3/13/26 for Cardizem CD (Controlled Delivery- a medication used to treat high blood pressure and symptoms related to heart disease) 360	F0757	Continued from page 21 Development Coordinator will ensure that this training is incorporated into the general orientation for new hires including any new agency staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or designee will conduct monitoring of medication administration to ensure compliance with parameters by completing 5 random observations to verify medications were administered following parameters. This monitor will be completed weekly x 3 weeks and monthly x 2 months beginning the week of 5/20/2026. Findings will be reported at the monthly Quality assurance meeting attended by the Administrator, Director of Nursing, Minimum Data set Coordinator, Therapy, Health information manager, and Dietary Manager.	05/20/2026

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F0757 SS = D	Continued from page 22 mg one capsule by mouth one time a day for coronary heart disease. Hold for SBP less than 110. The March 2026 and April 2026 Medication Administration Records (MARs) were reviewed and revealed Resident #123 had received acetazolamide and Cardizem CD despite the SBP being below 110 as well as Cozaar despite the SBP being below 120, on the following dates: 3/15/26 the SBP was 111. Nurse #7 administered Cozaar. 3/16/26 the SBP was 108. Nurse #7 administered Cozaar. 3/19/26 the SBP was 115. Nurse #7 administered Cozaar. 3/20/26 the SBP was 100. Nurse #7 administered Cozaar. 4/9/26 the SBP was 118. Nurse #3 administered Cozaar. 4/20/26 the SBP was 102. Nurse #7 administered acetazolamide, Cardizem CD and Cozaar. Nurse #3 was interviewed on 4/29/26 at 9:46 AM. The April 2026 MAR was reviewed with him where the Cozaar was administered on 4/9/26 despite the SBP being below 120. He stated that this was an oversight and the medication should have been held per the parameter ordered. Attempts to contact Nurse #7 were made without success. The Nurse Practitioner was interviewed on 4/30/26 at 9:35 AM and stated he didn't feel Resident #123 would have suffered any serious harm by receiving the acetazolamide, Cardizem CD and Cozaar outside the ordered parameters to hold, however he would expect the nursing staff to follow the orders for the acetazolamide, Cardizem CD and Cozaar hold parameters as written. The Director of Nursing was interviewed on 4/30/26 at 10:07 AM and stated she expected the nurses to follow physician orders including blood pressure medications with parameters to hold.	F0757		05/20/2026