STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345490	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Court Nursing and Rehabilitation Center	**128 Snow Hill Road , Ayden, North Carolina, 28513**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments The survey team entered the facility on 5/4/26 to conduct a recertification and complaint investigation survey and exited on 5/6/26. Additional information was obtained on 5/11/26 and 5/12/26. Therefore, the exit date was changed to 5/12/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 230046-H1.	E0000		06/09/2026
F0000	INITIAL COMMENTS The survey team entered the facility on 5/4/26 to conduct a recertification and complaint investigation survey and exited on 5/6/26. Additional information was obtained on 5/11/26 and 5/12/26. Therefore, the exit date was changed to 5/12/26. Event ID# 230046-H1. The following intakes were investigated: 2978612, 2711722, 820099, and 820100. 16 of the16 allegations did not result in a deficiency.	F0000		06/09/2026
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F0882	F882 Infection Preventionist Qualifications/Role 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/29/26, the facility designated the new Director of Nursing (DON) as the Infection Preventionist responsible for the facility's Infection Prevention and Control Program. The designated Infection Preventionist will complete the CDC's Nursing Home Infection Preventionist Training in CDC-Train. Training was completed on 5/30/26. The administrator will immediately notify the Facility Consultant of any vacancy related to Infection Preventionist. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	06/09/2026

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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F0882 SS = F	Continued from page 1 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to designate a qualified Infection Preventionist (IP) who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. This had the potential to affect all residents in the facility. Findings included: In an interview on 5/5/2026 at 12:10 pm with Director of Nursing (DON), in the presence of the Regional Nurse Consultant, the DON stated the Infection Preventionist position was currently vacant, however she and the Assistant Director of Nursing (ADON) shared in the responsibilities of Infection Preventionist. She stated they both completed the programs out of state and she would work on retrieving the documentation. DON could not remember the name of the infection prevention and control program she completed in Ohio but stated it was similar to the Statewide Program for Infection Control and Epidemiology (SPICE) program offered in North Carolina. On 5/6/2026 at 10:00 am in an interview with the DON in the presence of ADON and the Regional Nurse Consultant, the DON stated that she had been unable to locate documentation for herself or the ADON but she believed the Staff Development Coordinator (SDC) completed the Statewide Program for Infection Control and Epidemiology (SPICE) and would get the documentation. In a subsequent interview with the DON on 5/6/2026 at 3:16 pm she stated that she was unable to obtain documentation to show that there was a qualified Infection Preventionist at the facility. The Administrator was not available for interview during the survey.	F0882	Continued from page 1 On 6/1/26, the Facility Consultant completed a review of the facility's Antibiotic Stewardship Program for the previous 14 days to ensure required antibiotic monitoring, tracking, documentation, and reporting processes are in place and being completed in accordance with regulatory requirements. Any concerns identified during the audit will be addressed by the DON to include review of antibiotic utilization, physician notification as indicated, correction of documentation, implementation of appropriate monitoring, and staff education and/or re-education as warranted. The audit will be completed by 6/9/26. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/1/26, the Facility Consultant initiated an in-service with the Director of Nursing (DON) regarding the regulatory requirements for designation of a qualified Infection Preventionist, including the requirement for completion of specialized infection prevention and control training and maintenance of supporting documentation. In-service will be completed by 6/9/26. All newly hired DON will receive the in-service by the Facility Consultant during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing (DON) will review the Infection Prevention and Control Program weekly x 4 weeks, then monthly x one month utilizing the Infection Control Audit Tool. This audit is to ensure the facility maintains a qualified Infection Preventionist with completed specialized infection prevention and control training and appropriate documentation. The audit will also include review of the facility's Antibiotic Stewardship Program to ensure required antibiotic monitoring, tracking, documentation, reporting, and follow-up activities are completed in accordance with regulatory requirements and facility policy. The DON will address any concerns identified during the audit to include review of antibiotic utilization, physician notification as indicated, correction of documentation, and implementation of appropriate monitoring. The Administrator will review the Infection Control Audit Tool weekly x 4 weeks, then monthly x one month to ensure all identified concerns have been addressed and corrective actions have been implemented.	06/09/2026

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F0882 SS = F		F0882	Continued from page 2 The Administrator will forward the results of the Infection Control audit tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two months for review and to determine if additional interventions or continued monitoring are necessary to ensure ongoing compliance.	06/09/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that	F0605	F 605 Right to be Free from Chemical Restraints 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #32 was discharged home on 5/8/2026 and no longer resides in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/15/26, the Director of Nursing (DON), initiated an audit of all admissions receiving psychotropic medications within the previous 30 days to ensure physician orders were accurately transcribed, the medication had a documented diagnosis and clinical indication for use, and administration instructions were consistent with physician orders and hospital discharge documentation. Any concerns identified during the audit will be addressed immediately, including physician notification, order clarification, medical record updates, and staff education as indicated. The audit will be completed by 6/9/26. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/29/26, the DON and/or Staff Development Coordinator initiated education for all licensed nurses regarding 1) Transcribing MD orders with emphasis on admission medication reconciliation, documentation of indications for psychotropic medications, and the requirement to administer medications according to physician orders and hospital discharge instructions. Education included the importance of verifying PRN versus routine medication orders and obtaining clarification from the physician when discrepancies are identified. 2) Following Physician Orders with emphasis on special attention must be given to PRN medications to ensure they are transcribed exactly as ordered by the physician, including the reason for use and administration frequency. PRN medications must not be transcribed as routine medications, nor should routine medications be transcribed as PRN	06/09/2026

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F0605 SS = D	Continued from page 3 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific	F0605	Continued from page 3 medications. The in-service will be completed by 6/9/26. Any licensed nurse who has not completed the education by 6/9/26 will receive the education prior to their next scheduled shift. All newly hired licensed nurses will receive this education during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON, ADON, and/or Designee will review all new admissions receiving psychotropic medications weekly x 4 weeks then monthly x 1 month utilizing the Psychoactive Medication Audit Tool to ensure physician orders are accurately transcribed, diagnoses and indications for use are documented, and medications are administered according to physician orders. The DON, ADON, and/or Designee will immediately address any concerns identified during the audit to include order clarification, record correction, and staff re-education as indicated. The DON will review Psychoactive Medication Audit Tool Weekly x 4 weeks and monthly for 1 month to ensure compliance. The DON will forward the results of the Psychoactive Medication Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	06/09/2026

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F0605 SS = D	Continued from page 4 condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with the Resident Representative, staff, Medical Director, and Nurse Practitioner (NP), the facility failed to ensure a resident had an indication and a diagnosis for the use of an antipsychotic medication and failed to administer the antipsychotic medication on an as needed basis as specified in the hospital discharge summary. This was for 1 of 6 residents reviewed for chemical restraints (Resident #32). The findings included: Resident #32's hospital discharge summary dated 4/9/26 revealed a physician's order for Olanzapine (antipsychotic) 2.5 mg take 1 tablet by mouth at bedtime as needed (if agitated at night causing increased fall risk). Resident #32 was admitted to the facility on 4/9/26 with diagnoses which included Alzheimer's disease unspecified, chronic pain, hyperlipidemia (condition characterized by high levels of lipids (condition of high cholesterol or fats in the blood), and radiculopathy of the cervical region (the cervical spine is compressed or inflamed which results in radiating pain, numbness, or muscle weakness from the neck down to the shoulder and arm). Review of Resident #32's electronic medical record (EMR) revealed a signed informed consent dated 4/10/26 by the Resident Representative for the use	F0605		06/09/2026

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F0605 SS = D	Continued from page 5 of antipsychotic medication. Review of Resident #32's physician order dated 4/9/26 revealed an order for Olanzapine (antipsychotic) 2.5 milligrams (mg) to be administered at "bedtime for if agitated at night causing increased fall risk". A review of Resident #32's April 2026 Medication Administration Record (MAR) documented Olanzapine 2.5 mg was administered from 4/9/26 through 4/30/26 at bedtime. A review of Resident #32's May 2026 MAR documented Olanzapine 2.5 mg was administered from 5/1/26 through 5/7/26 at bedtime. A review of Resident #32's admission Minimum Data Set Assessment (MDS) dated 4/15/26 revealed Resident #32 was cognitively intact. She was coded for antipsychotic medications. Resident #32's care plan dated 4/20/26 revealed a focus for psychotropic drugs with interventions which included administering medications as ordered by physician, evaluating effectiveness and side effects of medications for possible reduction/elimination of psychotropic drugs, and pharmacy review of medications monthly and/or as ordered. A phone interview was conducted on 5/12/26 at 12:05 pm with the Nurse Practitioner (NP). The NP stated Resident #32 was admitted to the facility from the hospital with an order for Olanzapine. The NP further stated she continued the Olanzapine order for agitation and reported increased falls and considered these conditions to be supporting indications for the medication. The NP stated the nursing staff had not reported any agitation, behaviors, or falls for Resident #32 following admission to the facility. When asked whether the Olanzapine was intended to be administered as a scheduled medication or on an as-needed (PRN) basis, the NP stated, "the medication should have been administered on a PRN basis for agitation." The NP further stated she did not have concerns regarding Resident #32 receiving the Olanzapine every night. When asked whether the Olanzapine should have been discontinued due to no	F0605		06/09/2026

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F0605 SS = D	Continued from page 6 documented signs or symptoms of agitation, behaviors, or falls, the NP replied, “no.” In a phone interview conducted on 5/12/26 at 1:58 pm, the Medical Director stated he did not typically use Olanzapine on a PRN basis; however, Resident #32 was admitted to the facility from the hospital with an order for Olanzapine. The Medical Director stated Resident #32 had received the medication during her hospital stay and the Nurse Practitioner (NP) continued the medication upon her admission to the facility. The Medical Director stated the medication order should have been entered correctly to reflect PRN administration of Olanzapine for Resident #32; however, he expressed no concern regarding the resident receiving the medication daily because Resident #32 experienced decreased agitation and no falls while residing in the facility. When asked whether the Olanzapine should have been discontinued due to no documented signs or symptoms of agitation, behaviors, or falls, the Medical Director replied, “the outcome was good” with the medication.	F0605		06/09/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F0641	F641 Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/5/26, the Minimum Data Set (MDS) Nurse completed a modification of assessment dated 4/15/26 MDS comprehensive assessment section “N” for Resident #32 to reflect accurate coding for use of antipsychotic medication. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/15/26, the MDS Coordinator under the oversight of the MDS Consultant initiated an audit of the most recent comprehensive, significant change assessments and/or quarterly MDS assessment section “N”, for all residents to ensure all MDS’s assessments completed are coded accurately for antipsychotic medication use. The DON will address all concerns identified during the audit to include updating assessment when indicated. The audit will be completed by 6/9/26.	06/09/2026

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F0641 SS = D	Continued from page 7 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 accurately code a Minimum Data Set Assessment for Antipsychotic Medication Review for 1 of 21 residents reviewed for unnecessary medications (Resident #32). The findings included: Resident #32 was admitted to the facility on 4/9/26 with a diagnosis of unspecified Alzheimer's disease. Review of Resident #32's physician order dated 4/9/26 revealed an order for Olanzapine (antipsychotic) 2.5 milligrams (mg) to be administered at bedtime. A review of Resident #32's April 2026 Medication Administration Record (MAR) documented Olanzapine 2.5 mg was administered from 4/9/26 through 4/15/26 at bedtime. A review of Resident #32's admission Minimum Data Set Assessment (MDS) dated 4/15/26 revealed she received antipsychotic medications. The Antipsychotic Medication Review Section was coded as not receiving antipsychotic medication since admission. During an interview with MDS Coordinator #1 on 5/5/26 at 1:10 pm, she stated she completed this section of the admission MDS and should have indicated Resident #32 had received antipsychotic medications since admission. She verified the Minimum Data Set Assessment was inaccurate and that antipsychotic use should have been coded.	F0641	Continued from page 7 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/18/2026, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of section "N" per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for antipsychotic medication use. All newly hired MDS Coordinator or MDS nurses will be in-serviced regarding MDS Assessments and Coding of section "N" for antipsychotic medication use during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 5 audits of newly completed MDS assessments section "N" will be completed utilizing the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x one month by the MDS Coordinator. This audit is to ensure accurate coding of the MDS assessment section "N". All identified areas of concern will be addressed immediately by the MDS Coordinator to include retraining the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concern have been addressed. The DON will forward the results of MDS Accuracy Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	06/09/2026

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F0641 SS = D	Continued from page 8 During an interview on 5/6/26 at 4:45 pm with the Facility Nurse Consultant and the Director of Nursing (DON), both stated Resident #32's MDS assessments should have been coded accurately to reflect the use of antipsychotic medication since admission.	F0641		06/09/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by:	F0756	F756 Drug Regimen Review, Report Irregular, Act On 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #32 was discharged home on 5/8/2026 and no longer resides in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/2/26, the Pharmacy Regional Clinical Manager initiated an audit of Drug Regimen Reviews within the previous 30 days for all new admissions. This audit was to ensure that antipsychotic medication irregularities were appropriately identified and reported. The audit included review of psychotropic medications to verify accurate transcription of physician orders, documentation of appropriate diagnoses and indications for use, and identification and reporting of any medication irregularities in accordance with regulatory requirements. Any concerns identified during the audit were addressed by the Director of Nursing (DON) through physician notification, correction of the medical record, and/or staff education as indicated. The audit will be completed by 6/9/26. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/2/26, education was provided to the Consultant Pharmacist by the Pharmacy Regional Clinical Manager regarding Drug Regimen Review requirements, with emphasis on the responsibility to identify, document, and report medication irregularities, including but not limited to medication transcription errors, discrepancies between physician orders and medication administration records, missing diagnoses or indications for psychotropic medications, and medications not administered in accordance with physician orders. Education included requirements for timely communication of identified irregularities to the attending physician and facility leadership for resolution. 4. Indicate how the facility plans to monitor its	06/09/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Court Nursing and Rehabilitation Center	**128 Snow Hill Road , Ayden, North Carolina, 28513**

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F0756 SS = D	Continued from page 9 Based on record review and interviews with facility staff, pharmacy staff, Nurse Practitioner, and Medical Director, the Pharmacy Consultants failed to identify and report medication irregularities related to antipsychotic medication (primarily used to manage symptoms of psychosis, such as hallucinations, delusions, and paranoia) that included a medication transcription error and no adequate indication and diagnosis for use. This deficient practice affected 1 of 6 residents reviewed for unnecessary medications (Resident #32). The findings included: Resident #32's hospital discharge summary dated 4/9/26 revealed a physician's order for olanzapine (antipsychotic medication) 2.5 milligrams (mg) take 1 tablet by mouth at bedtime as needed (if agitated at night causing increased fall risk). Resident #32 was admitted to the facility on 4/9/26 with diagnoses which included Alzheimer's disease. The resident had no mental health diagnoses. A physician's order dated 4/9/26 for Resident #32 indicated olanzapine 2.5 mg at "bedtime for if [sic] agitated at night causing increased fall risk". An admission Medication Regimen Review (MRR) was conducted by Pharmacy Consultant #2 for Resident #32 on 4/10/26 with no potential clinically significant medication issues noted. Pharmacy Consultant #2 identified the resident was on olanzapine and recommended a Dyskinesia (a movement disorder characterized by involuntary and uncontrollable muscle movements) Identification System Condensed User Scale (DISCUS) evaluation. There were no other recommendations made related to Resident #32's olanzapine. In a phone interview with the Pharmacy Regional Clinical Manager on 5/12/26 at 1:16 pm, she stated Pharmacy Consultant #2 was unavailable for interview. Resident #32's admission Minimum Data Set (MDS) Assessment dated 4/15/26 revealed Resident #32 was cognitively intact. She was coded for antipsychotic medications.	F0756	Continued from page 9 performance to make sure that solutions are sustained. The Director of Nursing will review all new admissions requiring an initial Drug Regimen Review weekly x 4 weeks and then monthly x one month utilizing the Drug Regimen Review Audit Tool. The audit will ensure medication orders have been accurately transcribed, psychotropic medications have an appropriate diagnosis and indication for use, and any medication irregularities have been identified and reported in accordance with regulatory requirements. The Director of Nursing will immediately address any concerns identified during the audit to include physician notification, correction of the medical record, and re-education as indicated. The Director of Nursing will review the Drug Regimen Review Audit Tool weekly x 4 weeks and monthly x one month to ensure any areas of concern have been addressed. The DON will forward the results of the Drug Regimen Review Audit to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	06/09/2026

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F0756 SS = D	Continued from page 10 A review of Resident #32's April and May 2026 Medication Administration Records (MARs) documented olanzapine 2.5 mg was administered once daily from 4/9/26 through 5/7/26 at bedtime. A DISCUS evaluation was completed on 4/13/26 with no concerns identified. An MRR dated 5/6/26 completed by Pharmacy Consultant #1 indicated no drug irregularities were identified and no recommendations were made related to Resident #32's olanzapine. During a phone interview conducted on 5/12/26 at 1:16 pm Pharmacy Consultant #1 he stated he completed an MRR on 5/6/26 for Resident #32 and made no recommendations regarding the resident's antipsychotic medication (olanzapine). Pharmacy Consultant #1 stated he was unable to locate a documented supporting diagnosis for the antipsychotic medication in Resident #32's electronic medical record on 5/6/26; however, he reviewed the hospital discharge summary (dated 4/9/26) on 5/6/26 and noted documentation of worsening mentation, agitation, decline in functioning over the past several months, and recurrent falls. Pharmacy Consultant #1 stated he used that information to support the continued use of the antipsychotic medication and therefore did not make a recommendation. Pharmacy Consultant #1 further stated that if he had not located this information in the hospital discharge summary, he would have recommended obtaining a supporting diagnosis and a psychiatric evaluation to justify continuation of the antipsychotic medication. When asked whether the olanzapine was intended to be administered as a scheduled medication or on an as-needed (PRN) basis, Pharmacy Consultant #1 stated he was not sure and indicated he should have clarified the medication order with the Nurse Practitioner (NP). The Director of Nursing (DON) was interviewed via phone on 5/12/16 at 2:57 pm. The DON indicated there were no pharmacy recommendations requesting additional diagnoses to support the use of the olanzapine. A phone interview was conducted on 5/12/26 at	F0756		06/09/2026

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F0756 SS = D	Continued from page 11 12:05 pm with the NP. The NP stated Resident #32 was admitted to the facility from the hospital with an order for olanzapine. The NP further stated she continued the olanzapine order for agitation. When asked whether the olanzapine was intended to be administered as a scheduled medication or on an as-needed (PRN) basis, the NP stated the medication should have been administered on a PRN basis for agitation as ordered from the hospital physician. The NP stated she had not received a recommendation from the Pharmacy Consultant indicating the need for an additional diagnosis or other documented clinical indication to support the continued use of olanzapine. In a phone interview conducted on 5/12/26 at 1:58 pm, the Medical Director stated Resident #32 was admitted to the facility from the hospital with an order for as needed (PRN) olanzapine. The Medical Director stated Resident #32 had received the medication during her hospital stay and the NP continued the medication upon the resident's admission to the facility. The Medical Director stated the Pharmacy Consultant should have identified and recommended whether an additional supporting diagnosis, beyond Alzheimer's disease, was necessary to support the continued use of the medication. The Medical Director stated the medication order should have been entered correctly to reflect PRN administration of olanzapine for Resident #32 and the Pharmacy Consultant should have questioned this irregularity.	F0756		06/09/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F0880	F 880 Infection Prevention & Control 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/4/2026, the Staff Development Coordinator (SDC) in-serviced nurse #1 regarding Enhanced Barrier Precautions (EBP) to include the use of personal protective equipment (PPE) while providing Trach care and trach suctioning in rooms identified as requiring Enhanced Barrier Precautions. On 6/1/26, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed a resident care observation with nurse #1. This audit was to ensure nurse #1 utilized appropriate use of PPE while providing direct patient care to include trach care.	06/09/2026

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F0880 SS = D	Continued from page 12 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F0880	Continued from page 12 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/19/2026, the ADON, Unit Manager and/or Treatment Nurse (TX nurse) initiated 15 random resident care observations with all nursing staff to include all shifts. This audit is to ensure staff utilize appropriate use of PPE while providing direct patient care to include trach care, trach suctioning and high contact activities, to any resident identified as requiring EBP. The nurse supervisors and/or the TX nurse will address all concerns identified during the audit to include education of staff. The observations will be completed by 6/9/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/4/2026, the SDC initiated an in-service with all nurses, medication aides, nursing assistants, and therapy regarding Enhanced Barrier Precautions with emphasis on donning/doffing PPE with return demonstration while providing direct patient care to include trach care, trach suctioning and high contact activities, to any resident identified as requiring EBP. In-service will be completed by 6/9/26. After 6/9/26, any staff who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses, medication aides, nursing assistants, and therapy will be in-service by SDC regarding Enhanced Barrier Precautions with emphasis on donning/doffing PPE while providing high contact direct patient care. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Assistant Director of Nursing (ADON), Unit Manager and/or Treatment Nurse will complete 10 Resident Care Audits to include nurse #1 weekly x 4 weeks then monthly x 1 month. This audit is to ensure nurses, medication aides, nursing assistants, and therapy utilize appropriate PPE while providing direct patient care to include trach care, trach suctioning and high contact activities, to any resident identified as requiring EBP. The Assistant Director of Nursing (ADON), Unit Manager and/or	06/09/2026

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F0880 SS = D	Continued from page 13 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to implement infection prevention and control practices when a nurse provided tracheostomy care and did not wear a gown. This deficient practice occurred for 1 of 3 staff observed for infection control practices (Nurse #1). Findings included: A review of the facilities Infection Control Manual version date 04/2023 and page revision date of 06/13/2024 revealed: Enhanced Barrier Precautions (EBP) are used in conjunction with Standard Precautions to reduce the risk of MDRO (multidrug resistant organism) transmissions during high-contact resident care activities. Includes the use of both gowns and gloves. EBP are meant to be in place for the duration of the resident's stay or until resolution of a wound or discontinuation of an indwelling medical device occurs. Enhanced Barrier Precautions apply to residents with any of the following: Infection with a CDC (The Centers for Disease Control and Prevention)-targeted MDRO when Contact Precautions do not otherwise apply. Colonization with a CDC-targeted MDRO Wounds with or without the presence of an MDRO infection. Presence of indwelling medical devices with or without the presence of an MDRO infection or colonization. MDROs for which EBP applies are based on local epidemiology. At a minimum they should include resistant organisms targeted by the CDC but may also include other epidemiologically important MDROs. Resident #36 was readmitted to the facility on 5/1/2026 with a tracheostomy. A tracheostomy is a surgically created opening (stoma) in the windpipe (trachea).	F0880	Continued from page 13 Treatment Nurse will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Resident Care Audits weekly x 4 weeks and then monthly for 1 month to ensure all identified areas of concern have been addressed. The Director of Nursing will forward the results of the Resident Care Audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	06/09/2026

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F0880 SS = D	Continued from page 14 On 5/4/2026 at 10:30 am a blue sign was observed to be on outside of the door for Resident #36 that stated Enhanced Barrier Precautions. The Enhanced Barrier Precautions signage instructed staff to wear a gown and gloves for high contact activities such as device care for tracheostomy. The PPE was available outside of the room on a cart. On 5/4/2026 at 2:00 pm Nurse #1 was observed to perform tracheostomy care for Resident #36. He performed hand hygiene and put on gloves; however, he did not put on any additional personal protective equipment (PPE) such as gown as required for Enhanced Barrier Precautions. An interview with Nurse #1 on 5/4/2026 at 2:16 pm immediately following procedure revealed that he was aware resident was on Enhanced Barrier Precautions. When asked why he did not wear gown Nurse #1 replied “oh yeah”. On 5/4/2026 at 3:42 pm an interview was conducted with the Director of Nursing (DON). She acknowledged that Nurse #1 needed additional education around infection control practices and PPE. She stated that Nurse #1 should have worn a gown and gloves while doing tracheostomy care for Resident #36. On 5/6/2026 at 10:52 am an interview with the Assistant Director of Nursing (ADON) was conducted. ADON stated it was necessary to wear PPE since Resident #36 was on Enhanced Barrier Precautions. She stated that Nurse #1 should have worn a mask and gown in addition to the gloves on 5/4/2026 while providing tracheostomy care. The ADON told you mask on the previous version. An interview with the Medical Director on 5/6/2026 at 12:44 pm revealed that although he was not that familiar with performing tracheostomy care, he expected that nursing staff should do the procedure according to whatever policies or protocols were in place.	F0880		06/09/2026
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is	F0628		06/09/2026

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F0628 SS = A	Continued from page 15 documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F0628		06/09/2026

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F0628 SS = A	Continued from page 16 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F0628		06/09/2026

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F0628 SS = A	Continued from page 17 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or	F0628		06/09/2026

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F0628 SS = A	Continued from page 18 therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to notify the Resident Representative in writing of the reason for the unplanned transfer to the hospital (Resident #1) and failed to provide a bed hold notice to the resident and their representative when transferred to the hospital (Resident #11 and Resident #21) for 3 of 4 residents reviewed for hospitalizations (Resident #1, Resident #11, and Resident #21). The findings included: 1. Resident #1 was admitted to the facility on 2/13/26. Resident #1’s admission Minimum Data Set (MDS) dated 4/9/26 indicated he was severely cognitively impaired. A review of Resident #1's nursing progress note dated 4/23/26 revealed Resident #1 was transferred to the hospital on 4/23/26 due to shortness of breath and difficulty breathing. Resident #1’s Resident Representative was notified by telephone of	F0628		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345490	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Court Nursing and Rehabilitation Center	**128 Snow Hill Road , Ayden, North Carolina, 28513**

(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
F0628 SS = A	Continued from page 19 Resident #1's condition and transfer to the hospital for evaluation. Review of Resident #1's electronic medical record (EMR) revealed no evidence of a written notification of transfer/discharge to Resident #1's Resident Representative for the 4/23/26 transfer/discharge. During an interview with the Social Worker on 5/5/26 at 3:15 pm, she indicated she started in the position on 3/19/26. The Social Worker stated she did not complete the transfer/discharge written notification for Resident #1's discharge on 4/23/26. She further stated she was not aware that she was responsible for completing the transfer/discharge written notifications. The Corporate Nurse Consultant was interviewed on 5/5/26 at 1:30 pm. She indicated she was not sure if the floor nurse or the Social Worker was responsible for completing the written transfer/discharge written notifications. She stated the transfer/discharge written notifications should have been completed. 2. Resident #11 was admitted to the facility on 3/20/20. A review of Resident #11's nursing progress note dated 3/28/26 revealed she was discharged to the hospital on 3/28/25. Resident #11's Resident Representative (RR) was notified by telephone of Resident #11's condition and transfer to the hospital for evaluation. Review of Resident #11's electronic medical record (EMR) did not reveal that any written notification of a bed hold notice had been given to Resident #11 or her RR for the 3/28/26 discharge. The notice of transfer/discharge notice was provided and located in the EMR. During an interview with the Social Worker (SW) on 5/6/26 at 9:55 AM, she stated she started in the SW position on 3/19/26. She explained she could not locate documentation that Resident #11 or her RR had been notified of the bed hold policy for the 3/28/26 hospitalization. The Social Worker stated she had not done the notification. She further stated she was not aware that she was responsible for completing the bed hold notifications.	F0628		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345490	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

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F0628 SS = A	Continued from page 20 The Director of Nursing (DON) was interviewed on 5/6/26 at 3:30 PM. The DON stated Resident #11 and her RR should have received written notification of the bed hold policy for the hospitalization on 3/28/26. She stated the facility Social Worker was responsible for providing the bed hold policy. 3. Resident #21 was admitted to the facility on 12/30/21. A review of Resident #21's nursing progress note dated 2/25/26 revealed he was discharged to the hospital on 2/25/26. Resident #21's Resident Representative (RR) was notified by telephone of Resident #21's transfer to the hospital. Review of Resident #21's electronic medical record (EMR) did not reveal that any written notification of a bed hold notice or the notice of transfer/discharge to the hospital on 2/25/26 had been given to Resident #21 or his RR. The Corporate Nurse Consultant was interviewed on 5/5/26 at 1:30 PM. She indicated she was not sure if the floor nurse or the Social Worker was responsible for completing the written transfer/discharge written notifications. She stated the transfer/discharge written notifications and bed hold notifications should have been completed. During an interview with the Social Worker (SW) on 5/6/26 at 9:55 AM, she stated she started in the SW position on 3/19/26. She explained she could not locate documentation that Resident #21 or his RR had been notified of the bed hold policy for the 2/25/26 hospitalization. The Social Worker stated she had not done the notification. She further stated she was not aware that she was responsible for completing the transfer/discharge notice or bed hold written notifications. The Director of Nursing (DON) was interviewed on 5/6/26 at 3:30 PM. The DON stated Resident #21 and his RR should have received written notification of the bed hold policy and the transfer/discharge notice should have been given to Resident #21's RR. She stated the facility Social Worker was responsible for providing the bed hold policy and written notification of transfer/discharge.	F0628		06/09/2026