STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forrest Oakes Healthcare	**620 Heathwood Drive , Albemarle, North Carolina, 28001**

(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 5/26/26 through 5/29/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #232BF0-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/26/26 through 05/29/26. Event ID #232BF0-H1. The following intakes were investigated: 2794178, 2983351, 2809065, 2994952, 823479, 2997922, 823507, and 2979234. 2 of the 18 complaint allegations resulted in deficiency.	F0000		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of personal funds when the Medical Records Manager accepted money from the resident for cleaning his personal apartment. The Medical Records Manager was alleged to have accepted $280.00 from Resident #60 on 4/17/26. This deficient practice occurred for 1 of 1 resident reviewed for misappropriation of resident property (Resident #60). The findings included:	F0602	Between 04/22/2026 and 04/25/2026, the facility conducted a thorough investigation regarding an allegation involving staff acceptance of money from a resident related to services discussed outside of the facility. The resident was immediately interviewed by Social Services and assessed for any financial, psychosocial, emotional, or physical impact. The resident confirmed all funds were returned and no concerns remained. The resident denied coercion, intimidation, manipulation, pressure, or fear related to the interaction. No financial loss, exploitation, misappropriation of property, or negative psychosocial outcome was identified. The staff members involved were immediately removed from resident contact pending completion of the investigation and appropriate corrective action was taken in accordance with facility policy. Following identification of the deficient practice during survey, resident #60 had already discharged home on 05/04/2026. No concerns have been identified since resident #60 discharged to home. All residents have the potential to be affected by deficient practices involving professional boundaries,	06/18/2026

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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F0602 SS = D	Continued from page 1 A review of the facility's policy entitled Abuse, Neglect and Exploitation revised on 10/14/25 read in part: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent, use of a resident's belongings or money without the resident's consent. A review of the facility's undated code of ethics read in part: Accepting any gift or gratuity from a patient or family member is strictly prohibited. Resident #60 was admitted to the facility on 9/22/25 with diagnoses that included cerebral infarction, unspecified and cognitive communication deficit (difficulty with speech, listening, reading, or writing caused by impaired underlying brain functions like attention, memory, and executive function). A quarterly Minimum Data Set (MDS) assessment date 3/11/26 indicated Resident #60 was cognitively intact. An initial allegation report was submitted to the State Agency by the Director of Nursing (DON) on 4/22/26 at 1:30 PM. The report read that the DON was made aware of an allegation involving the Medical Records Manager and the Activity Director who reportedly accepted monetary compensation from Resident #60 on 4/17/26 to perform cleaning services at his personal residence outside of the facility. Local police were notified on 4/23/26 at 12:09 PM, and the facility investigation was initiated. On 5/28/26 at 12:37 PM the Activities Director (AD) was interviewed and stated the Administrator had asked her and the former Medical Records Manager to clean Resident #60's apartment since he was scheduled to discharge home soon. The AD explained that the Administrator instructed her and the Medical Records Manager to clock in at the facility each day then leave to clean the apartment for Resident #60. The AD stated at the end of the second day of cleaning on 4/17/26, the Medical Records Manager told her that the Administrator had called to ask if Resident #60 had offered to give them any money to clean his apartment. According to the AD, the Medical Records Manager told the Administrator Resident #60 had not offered them any money. The AD stated later that day on 4/17/26, the Medical Records Manager talked to her and informed her Resident #60 had given her money to split between them for cleaning his apartment. The AD indicated she did not know the amount of money Resident #60 had given to the Medical Records Manager. According to the AD, the Medical Records	F0602	Continued from page 1 financial interactions, exploitation, and misappropriation. On 06/16/2026, the Social Worker interviewed alert and oriented residents able to participate in interviews regarding whether any staff member had requested, accepted, or discussed money, gifts, favors, services, meals, transportation, or items of value. No concerns were identified. On 06/16/2026, the Director of Nursing and Social Worker reviewed grievances, abuse allegations, exploitation allegations, complaint logs, and investigation reports for the previous six months to identify any similar incidents, patterns, or trends. No additional concerns were identified. On 06/16/2026, the Business Office Manager reviewed resident trust fund accounts, withdrawals, receipts, reconciliations, and supporting documentation to verify appropriate financial safeguards were maintained. No concerns were identified. On 06/16/2026, Human Resources reviewed employee records related to prior allegations involving professional boundaries, exploitation, misappropriation, or inappropriate financial interactions with residents. No similar concerns were identified. An Ad Hoc QAPI Committee meeting was conducted on 06/16/2026 to review the deficient practice, identify contributing factors, and approve corrective actions. Root Cause Analysis determined the deficient practice occurred due to insufficient oversight and reinforcement of professional boundaries expectations and the absence of a formalized process requiring staff to immediately report resident offers of money, gifts, favors, services, meals, transportation, or items of value to facility leadership. On 06/16/2026, all facility staff were re-educated regarding: • Resident rights related to freedom from abuse, neglect, exploitation, and misappropriation. • Professional boundaries between staff and residents. • Prohibition against accepting money, gifts, favors,	06/18/2026

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F0602 SS = D	Continued from page 2 Manager told her Resident #60 handed the money to the Transportation Assistant who handed the money to the Medical Records Manager. The AD explained that the Medical Records Manager told her she had planned to return the money to the Administrator when she returned to work the following Thursday 4/23/26. According to the AD, she had received training and knew she was not to accept money from residents. The AD stated she did not receive any money from Resident #60 for cleaning his apartment. The former Medical Records Manager was interviewed by phone on 5/28/26 at 2:25 PM. She stated on 4/14/26 the Administrator pulled her and the Activities Director (AD) aside and asked if they would clean Resident #60's apartment before he discharged home. The Medical Records Manager stated that as she and the AD were leaving the facility the Transportation Director and Transportation Assistant asked if they were getting paid by Resident #60 to clean his apartment. The Medical Records Manager explained she told the Transportation Assistant they were on the clock while they cleaned Resident #60's apartment, and that if the resident wanted to do more then he could purchase more cleaning supplies. According to the Medical Records Manager, the Transportation Assistant and Transportation Director brought Resident #60 to the Medical Records Manager's home on 4/17/26. The Medical Records Manager explained she did not know why Resident #60 was taken to her home, and when she walked to the van she was told by the Transportation Assistant that the resident wanted to give her something for cleaning his apartment. The Medical Records Manager stated she felt Resident #60 was giving her money out of the goodness of his heart, and she did not feel it was her place to say anything to him or refuse to take the money. According to the Medical Records Manager, she did not attempt to give Resident #60 his money back and instead just stuck the money in her work bag and finished "handling her day". The Medical Records Manager stated the AD called her, and she informed her what had happened. According to the Medical Records Manager, she told the AD she was not going to spend Resident #60's money and was going to give it back to the Administrator when she returned to work the following week. The Medical Records Manager stated the facility had provided in-services about not accepting gifts or money from residents. On 5/28/26 at 3:15 PM the Administrator was interviewed and stated he had gone to Resident #60's apartment with one of the physical therapists	F0602	Continued from page 2 services, meals, transportation, or items of value from residents regardless of intent. • Requirement to immediately report any resident offer of money, gifts, favors, services, meals, transportation, or items of value to facility management. • Prohibition against engaging in personal, private, or paid services for residents outside of the facility. • Staff responsibilities related to reporting suspected exploitation, misappropriation, and boundary concerns. The facility's Abuse, Neglect, Exploitation, Misappropriation, Resident Rights, and Professional Boundaries policies were reviewed and reinforced with all staff on 06/16/2026. Effective 06/16/2026, the facility implemented a Professional Boundaries Reporting Process requiring staff to immediately notify the Administrator and the Director of Nursing if a resident offers money, gifts, favors, services, meals, transportation, or items of value. Staff are prohibited from accepting such offers or engaging in personal or paid arrangements with residents outside of the facility. New employees will receive education regarding professional boundaries, resident rights, exploitation, and misappropriation during orientation prior to assuming resident care responsibilities. Beginning 06/17/2026, the Director of Nursing, Administrator, or designee will interview five staff members weekly for four weeks and monthly thereafter for three months to verify understanding of professional boundaries requirements, reporting expectations, and the prohibition against accepting money, gifts, favors, services, meals, transportation, or items of value from residents. Beginning 06/17/2026, the Social Worker will interview five residents weekly for four weeks and monthly thereafter for three months regarding awareness of reporting concerns involving staff requests for money, gifts, favors, services, transportation, or personal arrangements. Beginning 06/17/2026, the Business Office Manager will audit five resident trust fund accounts weekly for four weeks and monthly thereafter for three months to verify compliance with facility financial safeguards.	06/18/2026

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F0602 SS = D	Continued from page 3 to see his living arrangements before the resident's discharge from the facility because he had heard Resident #60 was living in poor conditions. The Administrator stated he wanted to make sure Resident #60 had a safe discharge. The Administrator explained he had asked the Activities Director and Medical Records Manager if they would assist him with getting Resident #60's apartment cleaned before his discharge. According to the Administrator, he had spoken with Resident #60, who had agreed to let the AD and Medical Records Manager clean his house before his discharge. The Administrator stated he explained to the resident that the facility would pay the AD and Medical Records Manager for cleaning his apartment, and Resident #60 would not have anything out of pocket. The Administrator further explained he had gotten approval from the corporate office to pay the AD and Medical Records Manager to clean the apartment. The Administrator stated the apartment complex management had planned to repaint Resident #60's apartment once the cleaning was completed. He stated the facility never asked Resident #60 for any monetary compensation for the cleaning. The Administrator stated he had received a phone call on an unknown date from an unnamed source that informed him Resident #60 was going to pay the AD and Medical Records Manager for working on his apartment. The Administrator stated he spoke with the AD, Medical Records Manager, and Resident #60 to remind them there would be no monetary exchange. The Administrator stated the AD and Medical Records Manager affirmed to him that they were aware they could not accept payment from the resident. According to the Administrator, he was informed on 4/22/26 by the Director of Nursing that the Medical Records Manager had accepted money from Resident #60 and investigation began on 4/22/26. He stated he was informed by the DON that the Transportation Director and Transportation Assistant took Resident #60 to the Medical Records Manager's home on 4/17/26 and saw he gave the Medical Records Manager money for cleaning his apartment. He stated the Transportation Director and Transportation Assistant had reportedly taken Resident #60 to withdraw money from his bank to pay the deposit on his apartment that day. The Administrator stated he did not recall having received a phone call from the Transportation Assistant about the money exchange on 4/17/26. According to the Administrator, he never got a clear explanation as to why the Transportation Director and Transportation Assistant took Resident #60 to the Medical Records Manager's home. The Administrator stated on 4/22/26 he called the Medical Records Manager to ask if she accepted	F0602	Continued from page 3 Beginning 06/17/2026, the Administrator, Director of Nursing, or Social Worker will review grievance logs, abuse allegations, exploitation allegations, complaint investigations, and reports of professional boundary concerns weekly for four weeks and monthly thereafter for three months. Results of all audits will be presented to the QAPI Committee monthly for three months beginning July 2026 by the Executive Director. Any identified noncompliance will result in immediate corrective action, staff re-education, and additional monitoring as deemed necessary by the QAPI Committee.	06/18/2026

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F0602 SS = D	Continued from page 4 money from Resident #60 and was told she had accepted the money. The Medical Records Manager informed the Administrator she had an emergency, but she was going to return the money to the facility when she returned to work on 4/23/26. According to the Administrator, he, the Activities Director, and the Medical Records Manager were suspended while the Director of Nursing completed the investigation into the incident. On 5/28/26 at 7:27 PM the Transportation Assistant was interviewed by phone and stated when she returned to work on 4/15/26 she asked the Transportation Director where the Activities Director and Medical Records Manager were and was informed that they were cleaning Resident #60's apartment before he discharged home. The Transportation Assistant stated on 4/17/26 she and the Transportation Director had driven Resident #60 to a local store to get a money order to pay his rent and deposit on his apartment. She explained while they were at the store the Medical Records Manager called and asked if they would pick up more cleaning supplies. According to the Transportation Assistant, when they took Resident #60 to the apartment complex to pay his rent, the Medical Records Manager was no longer at the apartment. The Transportation Assistant indicated she called the Medical Records Manager who asked if they would drop the cleaning supplies off at her home instead. The Transportation Assistant explained when they arrived at the Medical Records Manager's home, the Medical Records Manager got on the van and unloaded the cleaning supplies. The Transportation Assistant stated Resident #60 reached into his pocket and handed the Medical Records Manager some money. According to the Transportation Assistant, when the Medical Records Manager got out of the van, she asked Resident #60 why he gave her money and he replied because they were going to paint his apartment. The Transportation Assistant stated she called the Administrator immediately on 4/17/26 to report the exchange of money between Resident #60 and the Medical Records Manager. The Transportation Assistant stated she did not ask the Medical Records Manager why she accepted money from Resident #60, and she did not ask the Medical Records Manager to return the money to the resident. On 5/28/26 at 7:37 PM an interview was conducted with the Transportation Director who stated sometime in April 2026 he drove the Administrator and one of the physical therapists to Resident #60's apartment to view it before he discharged from the	F0602		06/18/2026

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F0602 SS = D	Continued from page 5 facility. The Transportation Director stated when they entered the apartment it was extremely dirty, and the landlord said they would have to charge Resident #60 an extra $100.00 each month if the landlord had to clean the apartment prior to him moving back. He stated on 4/17/26 he and the Transportation Assistant drove Resident #60 to a local store to get a money order to pay his rent and deposit. Once at the store, he said the Medical Records Manager called and requested they pick up more cleaning supplies. The Transportation Director stated they drove Resident #60 to the apartment complex to pay his rent and deposit and noted the Medical Records Manager was not there. He further explained after paying the deposit at the apartment complex he drove Resident #60 to the Medical Records Manager's home to drop off the cleaning supplies. The Transportation Director stated while they were at the Medical Records Manager's home Resident #60 handed her some money. He stated he asked Resident #60 why he gave the Medical Records Manager money, and the resident told him they were supposed to paint his apartment. The Transportation Director stated the Transportation Assistant was already on the phone with the Administrator to report on the money exchange, so he did not call himself. The Transportation Director stated he was not sure what was going on, and he did not ask the Medical Records Manager to return Resident #60's money. On 5/29/26 at 11:34 AM the Director of Nursing (DON) was interviewed and stated on 4/22/26 she was alerted by an unnamed source that the Activities Director and Medical Records Manager had accepted money from Resident #60 to clean his apartment. The DON stated she reported the information to the Administrator immediately and then suspended all parties involved and began an investigation of the incident. According to the DON, she sent an initial allegation report to the State, notified the local police, reported it to Adult Protective Services, and called the Ombudsman to notify them about the incident. The DON explained she met with Resident #60 who told her he was not asked to give money to anyone. Per the DON, Resident #60 stated on 4/17/26 transportation took him to get a money order to pay his rent then took him to the Medical Records Manager's home to drop off cleaning supplies. The DON stated while Resident #60 was at the Medical Records Manager's home Resident #60 gave her money. According to the DON, when the Medical Records Manager was asked why she did not refuse the money, she stated she was grieving the anniversary of her son's death, and she also did not want to hurt Resident #60's	F0602		06/18/2026

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F0602 SS = D	Continued from page 6 feelings by refusing his money. The DON indicated the Medical Records Manager should not have accepted the money at all. According to the DON, she called the Medical Records Manager on 4/22/26 when she became aware of the incident, and the Medical Records Manager informed her she had planned to return the money to Resident #60 when she returned to work later that week. The DON stated she asked the Medical Records Manager to return the money to the facility on 4/22/26 and met the Medical Records Manager in the parking lot on the afternoon of 4/23/26 where she received $280.00 from her. The DON stated she and the Business Office Manager met with Resident #60 immediately afterwards and counted his $280.00 back to him and obtained a signed receipt from him. The DON stated she educated the resident he should never pay any staff for services. A review was completed of a receipt for the return of $280.00 to Resident #60 dated 4/23/26 and was signed by Resident #60 and the DON. Multiple attempts were made to contact Resident #60 by phone calls and text messages but were unsuccessful. The facility submitted a plan of correction that was not accepted for past non-compliance as it did not address measures to prevent misappropriation from recurring.	F0602		06/18/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F0645	The identified resident's PASARR documentation/letter was immediately reviewed. Required PASARR Level I and/or Level II screening was obtained and updated review information was sent to NC PASARR on 5/28/26 with all requested documentation to see if residents PASARR needed to be updated. The interdisciplinary team reviewed PASARR recommendations and made updates as needed. A 100% audit of current residents who have been admitted within the previous 3 months was completed to verify PASARR Level I screenings, Level II determinations, when applicable and implementation of recommended services on 5/28/2026 by the Administrator/Social Worker. No other issues were identified. An Adhoc Quality Assurance and Performance Improvement (QAPI) Committee meeting was conducted on 06/05/2026 to review deficient practice and approve corrective actions.	06/16/2026

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F0645 SS = D	Continued from page 7 (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual	F0645	Continued from page 7 Facility Social Worker and Admissions Director were re-educated regarding PASARR screening requirements by the Nursing Home Administrator on 06/05/2026, including: Assuring PASARR screening process is completed correctly Ensuring if resident has a diagnosis that would trigger for a Level II, Social Worker would go ahead and begin the process for obtaining possible new PASARR The facility's PASARR screening process policy was reviewed with Social Worker and Admissions Director The Administrator or Designee will audit new admissions weekly x 4 weeks, then monthly x 2 months for PASARR verification and to ensure any residents who may have diagnosis that will trigger Level II is reported to appropriate personnel to conduct proper review screening process. Results of audits will be reported to Quality Assurance Performance Improvement (QAPI) committee for 3 months. Any identified issues will result in immediate corrective action and re-education will be completed.	06/16/2026

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F0645 SS = D	Continued from page 8 disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Level I Preadmission Screening and Resident Review (PASRR) was completed prior to admission for 1 of 2 residents reviewed for PASRR (Resident #7). The findings included: The North Carolina Department of Health and Human Services (NCDHHS) PASRR determination letter dated 5/11/2023 for Resident #7 indicated a Level I screen and provided a PASRR number that remained valid for the duration of the individual's stay (this Level I screen was not requested by or for the current facility). The letter stated that no additional PASRR screening was required unless a significant change in the individual's condition occurred, which could suggest a diagnosis related to mental illness. Resident #7 was admitted from home to the facility on 3/30/2026 with a diagnosis of post-traumatic stress disorder. The admission Minimum Data Set (MDS) dated 4/7/26 indicated that Resident #7 was cognitively intact and was not currently considered by the state Level II PASRR process to have serious a mental illness. The MDS further revealed that Resident #7 was identified as having a serious mental illness with a diagnosis of PTSD, had not exhibited any behaviors or rejection of care during the assessment period, and had received antipsychotic medications. In an interview on 5/28/26 at 2:58 PM, the Social Services Director stated she was responsible for ensuring that a PASRR was completed prior to admission when required. She reported she did not know that Resident #7 needed a new PASRR evaluation prior to his admission on 3/30/26 because he had a PASRR evaluation provided by hospice dated 5/11/23 that had no expiration date. The Social Services Director stated she did not realize the notice indicated it was valid for the length of his stay in a different facility. In an interview on 5/28/26 at 3:55 PM, the Administrator stated that Resident #7's Level I PASRR screen was provided by hospice on admission that indicated no further screening was required unless a significant change occurred with	F0645		06/16/2026

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F0645 SS = D	Continued from page 9 his status that suggested a diagnosis of mental illness or a change in treatment needs for the conditions. The Administrator reported that Resident #7 did not have a new mental health diagnosis and had no changes in treatment needs for his PTSD. The Administrator stated he was unaware that a new evaluation was required and confirmed that the Social Services Director was responsible for submitting requests for PASRR screenings and evaluations. The Administrator stated it was his expectation that PASRR screenings and evaluations be completed in accordance with regulations and that he would notify the Social Services Director that Resident #7 required a new PASRR.	F0645		06/16/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Nurse Practitioner and staff, the facility failed to accurately transcribe and carry out physician orders for protective skin care for 1 of 3 residents reviewed with pressure ulcers (Resident #48). The findings included: Resident #48 was originally admitted to the facility on 7/2/09. Her diagnoses included contractures of both knees and protein calorie malnutrition. A quarterly Minimum Data Set (MDS) assessment	F0686	Resident #48's medical record was reviewed by the Treatment Nurse on 05/28/2026. The physician order for protective skin care was dated 6/26/2025 and was subsequently discontinued on 8/30/2025. The Treatment Nurse reviewed the clinical record to ensure all current treatment orders accurately reflected physician directives. The Treatment Nurse and Nurse Supervisor reviewed the resident's skin condition and current treatment plan to ensure appropriate interventions were in place on 05/28/2026. No current discrepancies were identified. The Director of Nursing/ LPN Supervisor conducted an audit of residents with active pressure ulcers, wounds, and skin treatment orders on 6/11/2026 to verify physician orders were accurately transcribed to the Treatment Administration Record (TAR) and implemented as ordered. No identified discrepancies were noted. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) Committee meeting was conducted on 06/05/2026 to review the deficient practice and approve corrective actions. Licensed nurses were educated on 06/11/2026 on physician order transcription requirements, treatment order verification, and implementation of physician-prescribed skin care interventions. A secondary verification process was implemented for all new treatment and wound care orders to ensure accurate transcription to the TAR on 06/11/2026. The DON/ Supervisor will review newly initiated	06/16/2026

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F0686 SS = D	Continued from page 10 dated 6/18/25, indicated Resident #48 had severely impaired cognition and limited range of motion to both lower extremities. She was coded with one unstageable pressure ulcer. A review of Resident #48's care plan, last reviewed 6/23/25, included a focus area for impaired mobility, thin/fragile skin, poor oral intake. She is under hospice care due to terminal prognosis of vascular dementia. She has actual impairment to skin integrity related to deep tissue injury wound of the right hip and blisters to right inner ankle and left posterior thigh. The interventions included administer treatments as ordered and monitor for effectiveness. Review of Resident #48's physician orders included the following orders: - An order dated 6/26/25 for Skin Prep to the left great toe twice a day. This order was created by the Wound Nurse. - An order dated 6/26/25 for Skin Prep to the right lateral foot twice a day. This order was created by the Wound Nurse. Review of the June 2025 Treatment Administration Record (TAR) revealed: - Skin Prep to the left great toe daily starting on 6/26/25. The TAR was initialed by a nurse as being completed once a day. - Skin Prep to the right lateral foot daily starting on 6/26/25. The TAR was initialed by a nurse as being completed once a day. A review of Resident #48's medical record indicated that as of 5/26/26, she was without any skin breakdown. An interview occurred with the Wound Nurse on 5/28/26 at 10:52 AM. She reviewed the orders for skin prep to the left great toe and right lateral foot dated 6/26/25 to be applied twice a day. She verified she had transcribed the order incorrectly to the TAR as daily instead of twice a day. The Wound Nurse stated Resident #48 had discoloration to those areas and the Skin Prep was used to toughen up the skin to prevent breakdown. The Wound Nurse confirmed	F0686	Continued from page 10 wound care and skin treatment orders weekly to verify accurate transcription and implementation. The DON/ Supervisor will conduct monthly audits to verify active treatment orders match physician orders and are being completed as prescribed. Staff Education On 06/11/2026 all licensed nursing staff received education on accurate transcription of physician orders, verification of treatment orders, timely implementation of physician-prescribed treatments, documentation requirements for skin care and wound management, and reporting and correcting documentation discrepancies. The DON/ Supervisor will audit 5 residents with active treatment orders weekly x 4 weeks, then 5 residents with active treatment orders monthly for two months. Audits will verify physician orders are accurately transcribed, treatments are implemented as ordered, and documentation is complete. The Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI Committee monthly and quality monitoring audits will be updated as indicated.	06/16/2026

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F0686 SS = D	Continued from page 11 that Resident #48 was without any skin breakdown. The Nurse Practitioner (NP) was interviewed on 5/28/26 at 9:52 AM and stated she would have expected the order to be transcribed and carried out correctly. An interview was completed with the Director of Nursing (DON) on 5/29/26 at 9:50 AM and stated it was her expectation for the skin protective orders to be transcribed and carried out correctly to prevent any further breakdown.	F0686		06/16/2026
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, staff, and Nurse Practitioner interviews, the facility failed to ensure oxygen was delivered at the prescribed rate for 1 of 1 resident reviewed for respiratory care (Resident #46). The findings included: Resident #46 was admitted to the facility on 5/23/23 with diagnoses of acute and chronic respiratory failure with hypoxia (when tissues and cells do not receive enough oxygen to function properly), asthma, alveolar hypoventilation (breathing is too shallow or slow to meet the body's metabolic needs), and acute and chronic respiratory failure with hypercapnia (an abnormally elevated level of carbon dioxide). A review of Resident #46's care plan revealed a focus area revised on 11/29/23 that read Resident #46 had potential for altered respiratory status/difficulty breathing. An intervention initiated on 1/21/26 indicated the resident would receive oxygen at 3 liters per minute (lpm) continuously via	F0695	Upon identification of the deficient practice on 05/28/2026, resident #45's oxygen concentrator was immediately set to 3 liters per minute (LPM) per physician order by the nurse on duty. The resident was assessed for any adverse effects related to the deficient practice, including evaluation of oxygen saturation, respiratory status, and overall condition by the nurse on duty. No adverse outcome was identified. The physician was notified as indicated. Any resident receiving oxygen therapy has the potential to be affected by the deficient practice. On 05/28/2026, the Director of Nursing completed a 100% audit of all residents receiving oxygen therapy to verify physician orders matched oxygen concentrator settings and oxygen delivery requirements. No additional deficient practices were identified. On 06/02/2026, the Director of Nursing re-educated all licensed nurses regarding: Verification of physician orders prior to oxygen administration. Proper reading of oxygen concentrators and flowmeters at eye level. Verification of correct oxygen flow rates (LPM). Documentation requirements. Immediate reporting of unclear physician orders, equipment concerns, or malfunctioning oxygen	06/16/2026

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F0695 SS = D	Continued from page 12 nasal cannula. A review of Resident #46's active orders included an order dated 12/12/25 for continuous oxygen at 3 lpm via nasal cannula. Review of Resident #46's annual Minimum Data Set (MDS) assessment dated 3/18/26 indicated he was cognitively intact. Resident #46 was coded as receiving oxygen therapy. An observation of Resident #46's oxygen concentrator was conducted on 5/26/26 at 10:24 AM. The oxygen flow rate was noted to be set at 2.5 lpm when viewed at eye level. Resident #46 was lying in bed wearing his nasal cannula. He denied any shortness of breath or respiratory distress. On 5/27/26 at 9:56 AM an observation of Resident #46's oxygen concentrator revealed the flow rate was set at 2.5 lpm when viewed at eye level. Resident #46 was lying in bed wearing his nasal cannula. He denied any shortness of breath or respiratory distress. On 5/28/26 at 9:53 AM an observation and interview were conducted with Nurse #1 who was assigned to Resident #46 from 7:00 AM through 7:00 PM on 5/26/26 and 5/28/26. Nurse #1 accompanied the surveyor to Resident #46's room and viewed the oxygen concentrator setting at eye level. Nurse #1 verified the flow rate was set at 2.5 lpm upon viewing and stated the flow rate should have been set at 3 lpm. Nurse #1 explained she had completed rounds on Resident #46 at 7:30 AM the morning of 5/28/26 and checked his oxygen flow rate at that time. She stated the concentrator was set at 3lpm during her rounds and that someone must have bumped the concentrator afterwards and caused the flow rate to be lower than 3 lpm. Nurse #2 who was assigned to Resident #46 on 5/27/26 from 7:00 AM to 7:00 PM could not be reached for an interview. A review of the May 2026 Medication Administration Record (MAR) revealed an entry for oxygen at 3 liters per minute continuously every 12 hours for COPD. The MAR had a daily check mark and staff initials on all shifts on 5/26/26, 5/27/26, and the morning of 5/28/26. The MAR was initialed by Nurse #1 on 5/26/26 and 5/28/26, and the MAR was initialed by Nurse #2 on 5/27/26. The Nurse Practitioner (NP) was interviewed on 5/28/26 at 10:42 AM and stated she thought the	F0695	Continued from page 12 equipment. Following education, all licensed nurses successfully completed competency validation and return demonstration on verification and adjustment of oxygen concentrator settings by 06/15/2026 by the Director of Nursing, Infection Control RN, or LPN Supervisor. All prn nurses will successfully complete competency validation and return demonstration prior to next scheduled working shift. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) Committee meeting was conducted on 06/05/2026 to review the deficient practice and approve corrective actions. The Director of Nursing will educate all newly hired licensed nurses during orientation regarding: Verification of oxygen orders prior to administration. Proper reading of oxygen concentrators and flowmeters. Verification of prescribed oxygen flow rates. Appropriate documentation. Identification and reporting of equipment concerns. Competency validation and return demonstration will be completed prior to independent assignment. Verification of oxygen concentrator settings against physician orders will be incorporated into routine nursing rounds and change-of-shift clinical observations to ensure ongoing compliance. The Director of Nursing will be responsible for oversight of compliance with this corrective action plan. The Nurse Supervisor or Hall Nurse may conduct audits and report findings to the Director of Nursing. The Director of Nursing, Nurse Supervisor, or Hall Nurse will conduct audits of all oxygen-dependent residents daily x 4 weeks, then weekly x 8 weeks.	06/16/2026

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F0695 SS = D	Continued from page 13 staff did not know how to read the oxygen concentrator regulator correctly. She stated the staff should verify the bottom of the ball in the flow meter was sitting on the correct flow rate. The NP reviewed Resident #46's oxygen saturation levels and stated he did not show any adverse effects related to the lower flow rate and Resident #46 had maintained a good oxygen saturation level. The Director of Nursing (DON) was interviewed on 5/29/26 at 10:15 AM and stated staff should check an oxygen concentrator at eye level and verify the rate on the Medication Administration Record (MAR) matched the setting. The Administrator was interviewed on 5/29/26 at 11:47 AM and stated staff should verify the oxygen concentrator was set at the ordered flow rate.	F0695	Continued from page 13 Audits will verify that oxygen concentrator settings match physician orders and that oxygen is being administered as ordered. Audit findings will be reviewed monthly by the QAPI Committee for three months. Trends, patterns, and opportunities for improvement will be identified and addressed. Additional corrective actions and education will be implemented as indicated to ensure sustained compliance. The Executive Director will review audit findings through the QAPI process monthly for three months. Additional education and corrective action will be implemented as warranted by audit findings.	06/16/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on manufacturer recommendations, observations, record reviews, and staff interviews,	F0761	One bottle of Brimonidine Tartrate, one tube of Erythromycin ophthalmic ointment, and two bottles of Latanoprost were identified during observation as not being dated upon opening and were immediately removed from the cart on 05/28/2026 by the Medication Aide and replaced as appropriate on 05/28/2026. Rhopressa eye drops were identified as not being stored under manufacturer-recommended refrigeration conditions and were immediately removed from use and replaced as appropriate on 05/28/2026 by the Medication Aide. The prescribing physician and pharmacy were notified as indicated on 05/28/2026 by the nurse on duty. The residents were assessed by the nurse on duty for any adverse effects, and no negative outcome was identified. An audit of all medication carts, medication rooms, and medication refrigerators was completed to identify ophthalmic medications, insulin products, biologicals, and other medications requiring dating upon opening and/or temperature-controlled storage on 05/28/2026 by the LPN Supervisor. No other issues were identified. An Adhoc Quality Assurance and Performance Improvement (QAPI) Committee meeting was conducted on 06/05/2026 to review the deficient practice and approve corrective actions. Licensed nurses and medication aides were re-educated regarding medication management requirements by the Director of Nursing on 06/05/2026, including:	06/16/2026

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F0761 SS = D	Continued from page 14 the facility failed to date multi-use medications upon opening and failed to refrigerate unopened medication per manufacturer instructions on 1 of 3 medication carts reviewed (D Hall Cart). The findings included: Review of the manufacturer's guidelines for Rhopressa eye drops instructed to refrigerate unopened bottles. Review of the manufacturer's guidelines for Brimonidine Tartrate required discarding the medication 28 to 30 days after opening. Review of the manufacturer's guidelines for Erythromycin ophthalmic ointment read to discard the ointment within 28 days of opening. Review of the manufacturer's guidelines for Latanoprost eye drops read it must be discarded four to six weeks after opening. An observation was conducted on 5/28/26 at 10:00 AM of the D Hall medication cart in the presence of Medication Aide (MA) #1. The observation revealed the following medications stored in the medication cart: One (1) bottle of Rhopressa eye drops (a prescription eye drop used to lower high pressure inside the eye) that were unopened and not refrigerated. The manufacturer seal was intact and a sticker on the package read, "Refrigerate until opened". One (1) bottle of Brimonidine Tartrate (a prescription eye drop used to lower eye pressure associated with glaucoma) eye drops that were opened and undated. One (1) tube of Erythromycin ophthalmic ointment (an antibiotic used to treat and prevent bacterial infections of the eye) that was opened and undated. Two (2) bottles of Latanoprost (a prescription eye drop used lower eye pressure) eye drops that were opened and undated. An interview with MA #1 on 5/28/26 at 10:10 AM revealed she was unaware that the eye drops were not dated when opened. She stated that prescription eye drops should be dated upon opening and discarded 30 days after being opened. MA #1 also stated she was unaware that the Rhopressa eye drops on the medication cart had not been opened but confirmed that unopened eye drops should have	F0761	Continued from page 14 Dating all multidose medications upon opening. Reviewing manufacturer storage requirements prior to medication administration and storage. Proper storage of refrigerated medications immediately upon receipt and after use. Verification of medication labeling and storage during medication pass and medication cart checks. The facility's medication storage and labeling policy was reviewed with all licensed staff and medication aides. The Director of Nursing/ LPN Supervisor will conduct 5 audits weekly x 12 weeks of medication storage areas, medication carts, and medication refrigerators to verify medications are appropriately dated and stored according to manufacturer recommendations. The Executive Director will review in QAPI monthly for 3 months. Additional education and corrective action will be implemented as warranted by audit findings.	06/16/2026

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F0761 SS = D	Continued from page 15 been stored in the refrigerator per the manufacturer's directions written on the medication label, until opened. MA #1 explained that the nurses and medication aides who opened the eye drops were responsible for labeling the medication with the date opened and ensuring that medications requiring refrigeration were stored as directed. MA #1 removed the unopened and undated medications from the medication cart and requested replacement refills from the pharmacy. During an interview with the Director of Nursing (DON) on 5/28/26 at 3:10 PM, she stated that it was her expectation that nurses and MA's follow manufacturer directions for medication storage and expiration dates. She explained that the nurse or MA who opened a medication was responsible for labeling it with the date opened and ensuring the medication was discarded in accordance with manufacturer guidelines.	F0761		06/16/2026