STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
E 000	Initial Comments An unannounced recertification and complaint survey was conducted from 12/16/24 through 12/19/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6RN411.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 12/16/24 through 12/19/24. Event ID# 6RN411. The following intake was investigated: NC00209293. One (1) of 1 complaint allegation did not result in a deficiency.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		1/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to utilize an official form for code status (official portable Do Not Resuscitate [DNR] or Medical Order for Scope of Treatment [MOST] form) recognized by emergency medical services and pursuant to North Carolina (NC) general statute for residents who chose a code status of DNR (did not want chest compressions if their heart stopped beating) for 5 of 24 residents (Resident #52, #51, #73, #20, and #43) reviewed for advance directives. The findings included: The North Carolina Office of Emergency Medical Services (EMS) website indicated the following: Pursuant to N.C. General Statute 90-21.17, the department, through the Office of Emergency Medical Services, has adopted an official portable	F 578	" How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 1/8/2025 facility obtained a signed Goldenrod form for Resident # 52 On 1/8/2025 facility obtained a signed Goldenrod form for Resident # 51 On 1/8/2025 facility obtained a signed Goldenrod form for Resident # 73 On 1/8/2025 facility obtained a signed Goldenrod form for Resident # 20 On 1/3/2025 facility obtained a signed Goldenrod form for Resident # 43 " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 1/3/25 the Medical Records Director verified that 100% resident code status	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 578	Continued From page 2 Do Not Resuscitate (DNR) form and Medical Order for Scope of Treatment (MOST) form for use by physicians and other licensed healthcare facilities to assist in providing information relating to a patient ' s desire for resuscitation or life-prolonging measures. The website further clarified that DNR Forms must be printed on "Goldenrod" colored paper. a) Resident #52 was admitted to the facility on 11/18/2024. Review of a code status book at the nurse's station revealed Resident #52 had a facility generated form that had Do Not Resuscitate printed on it. There was also a "Code Status Resuscitation Request/Order" form for the facility that indicated Resident #52 had chosen "no, do not resuscitate." The form was signed by Resident #52 on 11/18/2024 along with a facility staff member. There was no official DNR form recognized by Emergency Medical Services (EMS). There was no Medical Orders for Scope of Treatment (MOST) form for this resident. A physician's order dated 11/19/2024 revealed Resident #52's code status was DNR. b) Resident #51 was admitted to the facility on 9/1/2022. Review of a code status book at the nurse's station revealed Resident #51 had a facility generated form that had Do Not Resuscitate printed on it. There was also a "Code Status Resuscitation Request/Order" form for the facility	F 578	was on file in facility, based on resident/RR preferences and wishes On 1/3/25 the Medical Records Director verified that 100% of residents and or RR were offered MOST form upon initial admission/discharge planning meeting On 1/9/2025 the Medical Records Director implemented new process to include all residents completing a portable Goldenrod DNR code form when resident selects code status as Do Not Resuscitate. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 12/27/2024 the SDC completed Advance Directive education with DON, ADON, Social Workers, Medical Records, SDC, IP, Business Office, HR-AP, Maintenance Director, Activities, and Admissions Coordinators, Receptionists, on the process enhancement relative to adding Goldenrod portable DNR form to all Admission Packets. Beginning on 1/6/25, DON or Designee initiated Daily review of new physician orders during morning clinical meeting, to include Code Status change orders. On 1/10/2025, the SDC completed education with 100% of Nurses-Registered Nurses, Licensed Practical Nurses, on the process enhancement relative to adding Goldenrod portable DNR form to all Admission Packets. All other nurses will be educated prior to next scheduled shift or upon hire during orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 578	Continued From page 3 that indicated Resident #51 had chosen "no, do not resuscitate." The form was signed by Resident #51's Responsible Party (RP) on 9/1/2022 along with a facility staff member. There was no official DNR form recognized by Emergency Medical Services (EMS). There was no Medical Orders for Scope of Treatment (MOST) form for this resident. A physician's order dated 9/30/2024 revealed Resident #51's code status was Do Not Resuscitate. c) Resident #73 was admitted to the facility on 10/18/2022. Review of a code status book at the nurse's station revealed Resident #73 had a facility generated form that had Do Not Resuscitate printed on it. There was also a "Code Status Resuscitation Request/Order" form for the facility that indicated Resident #73 had chosen "no, do not resuscitate." The form was signed by Resident #73's Responsible Party (RP) on 11/10/2022 along with a facility staff member. There was no official DNR form recognized by Emergency Medical Services (EMS). There was no Medical Orders for Scope of Treatment (MOST) form for this resident. Review of a physician's order dated 10/1/2024 revealed Resident #73's code status was Do Not Resuscitate. d) Resident #20 was admitted to the facility on	F 578	" How does the facility plan to monitor its performance to make sure that solutions are sustained? On 1/9/2025 the Medical Records Director completed 100% audit of Code Form books to monitor new process implementation Goldenrod portable DNR form for residents that choose do not resuscitate code status. On 1/9/2025 the Medical Records Director will perform weekly audits on 100% of residents weekly for code status and/or portable DNR Goldenrod x 4 weeks, then monthly x 11 months. On 1/16/25 Executive director scheduled results to be reviewed at quarterly QA meetings x one year or until substantial compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 578	Continued From page 4 11/8/2024. Review of a code status book at the nurse's station revealed Resident #20 had a facility generated form that had Do Not Resuscitate printed on it. There was also a "Code Status Resuscitation Request/Order" form for the facility that indicated Resident #20 had chosen "no, do not resuscitate." The form was signed by Resident #20's Responsible Party (RP) on 11/8/2024 along with a facility staff member. There was no official DNR form recognized by Emergency Medical Services (EMS). There was no Medical Orders for Scope of Treatment (MOST) form for this resident. A physician's order dated 11/12/2024 revealed Resident #20's code status was Do Not Resuscitate. e) Resident #43 was admitted to the facility on 4/19/2022. Review of a code status book at the nurse's station revealed Resident #43 had a facility generated form that had Do Not Resuscitate printed on it. There was also a "Code Status Resuscitation Request/Order" form for the facility that indicated Resident #43 had chosen "no, do not resuscitate." The form was signed by Resident #43's Responsible Party (RP) on 4/19/2022 along with a facility staff member. There was no official DNR form recognized by Emergency Medical Services (EMS). There was no Medical Orders for Scope of Treatment (MOST) form for this resident.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 578	Continued From page 5	F 578		

A physician's order dated 9/26/2024 revealed Resident #43's code status was Do Not Resuscitate.

An interview was conducted on 12/17/2024 at 10:40 am with Unit Secretary #1. Unit Secretary #1 stated when a resident was admitted, the Admission Nurse would discuss code status with the resident and would mark their selection on the "Code Status Resuscitation Request/Order" form. Unit Secretary #1 stated the facility also used a MOST form that was completed by the Medical Director (MD). Unit Secretary #1 stated after the forms were completed, the forms would be scanned into their medical record and their code status would be entered into the computer.

The Admission's Nurse was not available for an interview.

An interview was conducted on 12/17/2024 at 1:12 pm with Nurse #5. Nurse #5 stated she filled in for the Admission's Nurse. Nurse #5 stated when a resident was admitted to the facility, the resident filled out a "Code Status Resuscitation Request/Order" form. Nurse #5 stated she thought the facility used both a MOST and DNR form. Nurse #5 verified there was not a MOST or official DNR form in the code status book for Resident #52, Resident #51, Resident #73, Resident #20, and Resident #43.

An interview was conducted on 12/18/2024 at 11:21 am with the Medical Director (MD). The MD stated the facility utilized a MOST form when a resident wished to be a DNR. The MD stated he was not sure why there was not a MOST form for residents when they wished to be a DNR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 578	Continued From page 6 An interview was conducted on 12/19/2024 at 9:37 am with the Assistant Director of Nursing (ADON). The ADON stated when a resident was admitted to the facility, part of the admissions process was to elect code status on the "Code Status Resuscitation Request/Order" form. The ADON stated the facility utilized a MOST form, and stated this form was optional. The ADON stated if a resident was a DNR the only required document for the facility was the "Code Status Resuscitation Request/Order" form. An interview was conducted on 12/19/2024 at 10:00 am with the Director of Nursing (DON). The DON stated when a resident was admitted to the facility a "Code Status Resuscitation Request/Order" form was completed which indicated whether a resident wanted to be a full code or a DNR. The DON stated the MOST form was encouraged by the facility, but not required. The DON stated the only required form in the facility was the "Code Status Resuscitation Request/Order" form.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		1/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 580	Continued From page 7 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and family and staff interviews, the facility failed to immediately notify	F 580	" " How will corrective action be accomplished for those residents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 580	Continued From page 8 a resident's Responsible Party of a new order for antibiotic medication to treat a bacterial infection for 1 of 1 sampled resident reviewed for notification of change (Resident #4). Findings included: Resident #4 was admitted to the facility on 08/21/18. The annual Minimum Data Set (MDS) dated 10/09/24 assessed Resident #4 with severe impairment in cognition. Review of Resident #4's profile revealed her family member was listed as her Responsible Party (RP). Review of Resident #4's urine culture results dated 12/12/24 revealed an abnormal value positive for Escherichia coli (type of bacteria that can cause urinary tract infections). A physician order for Resident #4 dated 12/12/24 read, amoxicillin potassium clavulanate (antibiotic medication used to treat bacterial infections) 875-125 milligrams (mg) - give one tablet by mouth every 12 hours for cystitis (type of urinary tract infection that affects the bladder) for 7 days. Review of Resident #4's December 2024 Medication Administration Record (MAR) revealed she received her first scheduled dose of amoxicillin potassium clavulanate on 12/12/24 at 8:00 PM. Review of the staff progress notes for Resident #4 revealed no entries dated 12/12/24 or 12/13/24 indicating Resident #4's RP was notified	F 580	have been affected by the deficient practice? On 12/14/2024 Nurses note reflects that Residents daughter was updated on new orders. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 12/31/24 date, Director of Nursing or Designee 100% audit of orders for antibiotics or significant changes FOR THE P and corresponding nursing notes for the last 7 days for resident, and RR notification (for non-alert and oriented residents). " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 12/27/24 date, SDC completed education of nursing staff (RNs, LPNs) regarding notification of resident, and/or RR upon initiation of new antibiotic orders, and Policy for Notification. All other nurses will be educated prior to next scheduled shift or upon hire during orientation. Beginning on 1/6/25, DON or Designee initiated Daily review of new physician orders during morning clinical meeting, to include review of nursing notes for notification of resident and/or RR for new antibiotic orders, and implemented documentation on the morning clinical meeting form for verification of notification of resident and/or RR. " How does the facility plan to monitor its performance to make sure that solutions are sustained? On 1/6/25, Director of Nursing or Designee to complete review of all new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 580	Continued From page 9 of the positive lab results or new order for antibiotic medication. Further review of progress notes revealed a progress note written by Nurse #1 on 12/14/24 at 3:00 PM that read in part, Resident #4's RP was updated today on new orders while at the facility visiting Resident #4. During an interview on 12/16/24 at 1:24 PM, Resident #4's RP stated that within the past week Resident #4 was diagnosed with a Urinary Tract Infection (UTI) and started on an antibiotic. Resident #4's RP stated she was supposed to be notified when there were any changes to Resident #4's medications and/or treatment. The RP stated she was not notified when Resident #4 was started on an antibiotic medication to treat a UTI until she arrived at the facility on 12/14/24 and spoke with Nurse #1. During an interview on 12/19/24 at 8:39 AM, Nurse #1 stated she spoke with Resident #4's RP on 12/14/24 when she was at the facility visiting Resident #4 and informed her that Resident #4's urine culture was positive and an antibiotic was ordered. Nurse #1 recalled Resident #4's RP stating that no one had called her to let her know about antibiotic medication being started. Nurse #1 stated the Charge Nurse was the one who typically notified the family when new medication orders were received from the provider. During an interview on 12/19/24 at 9:15 AM, the Charge Nurse revealed when she received lab results back from the provider with new medication orders, she activated the medication order in the resident's medical record and then notified the family of the new medication order	F 580	orders for antibiotics daily and verification of notification of resident and/or RR. On 1/6/25, Director of Nursing or Designee will complete weekly audit x 12 weeks, quarterly x 3 for verification of notification of resident and/or RR for new antibiotic medication orders. On 1/6/25, Executive Director scheduled results to be reviewed at quarterly QA for one year or until substantial compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 580	Continued From page 10 and positive lab results. The Charge Nurse reviewed Resident #4's medical record and stated that she had received Resident #4's lab results from the provider on 12/12/24 with an order to start antibiotic medication and activated the order in Resident #4's medical record. The Charge Nurse confirmed she did not notify Resident #4's RP regarding the lab results and new order for antibiotic medication and should have. The Charge Nurse recalled it was during a time when there was a lot of medical issues going on with other residents and she just forgot to call. During an interview on 12/19/24 at 12:34 PM, the Director of Nursing (DON) reviewed Resident #4's medical record and confirmed there was nothing documented by nursing staff indicating Resident #4's RP was notified of the new antibiotic medication order. The DON stated nursing staff should have notified Resident #4's RP of the new medication order when received from the provider. During an interview on 12/19/24 at 1:26 PM with the Corporate Nurse Consultant present, the Administrator stated nursing staff should have notified Resident #4's RP when the lab results were received from the provider and antibiotic medication started.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 641	"" How will corrective action be	1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 641	Continued From page 11 facility failed to accurately code Minimum Data Set (MDS) assessments in the area of nutritional status for 2 of 8 sampled residents reviewed for nutrition and tube feeding (Residents #80 and #23). Findings included: 1. Resident #80 was admitted to the facility on 06/03/24 with diagnoses that included diabetes and dysphagia (difficulty swallowing). Resident #80's weights for the past six months were documented as follows: -06/03/24 203.3 pounds -07/01/24 206.2 pounds -08/06/24 214.0 pounds -09/02/24 211.4 pounds -10/21/24 217.0 pounds -11/06/24 200.8 pounds Review of Resident #80's weights for October 2024 and November 2024 reflected a 7.47% weight loss in the last month. The annual Minimum Data Set (MDS) dated 11/07/24 for Resident #80 revealed she had severe cognitive impairment and did not reflect she had a weight loss of 5% or more in the last month. During a joint interview on 12/19/24 at 9:29 AM, MDS Coordinator #1 and MDS Coordinator #2 revealed the Assistant Dietary Manager was responsible for coding the nutrition section of MDS assessments. During an interview on 12/19/24 at 12:47 PM, the	F 641	accomplished for those residents found to have been affected by the deficient practice? On 12/18/2024 a Corrected MDS was submitted for resident # 23 On 1/17/2025 a corrected MDS was submitted for resident # 80 " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 1/9/2025, Registered Nurse/MDS completed 100% review of resident MDS assessments recorded in Oct., Nov. and December 2024 for accuracy in the area of nutritional status (weight loss) and tube feeding. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 12/31 SDC Completed MDS Accuracy training with the Treatment Nurse, Social services, Medical Records, MDS, Activities, Therapy Manager, CDM, BOM, DON, Administrator, Admission Assistant and HR/AP regarding accuracy of nutrition section coding and assessments. All employees as listed above will be educated prior to next scheduled shift or upon hire during orientation. On 1/13/2025 Registered Nurse/MDS completed Step by step education with CDM On 1/13/2025, MDS updated facility process relative to nutritional status documentation. MDS implemented utilization of Point Click Care Report,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 641	Continued From page 12 Assistant Dietary Manager confirmed she completed the nutrition section of Resident #80's annual MDS assessment dated 11/07/24. She explained upon reviewing Resident #80's weights for October 2024 and November 2024, the MDS assessment should have reflected she had a non-physician prescribed weight loss of 5% or more in the last month. She stated it was an oversight. During an interview on 12/19/24 at 1:26 PM, the Administrator stated she expected MDS assessments to be completed accurately. 2. Resident #23 was admitted to the facility on 2/10/23 with diagnoses which included diabetes mellitus and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 11/25/24 was coded for a nutritional approach which included a feeding tube while a resident. Review of physician's orders revealed no order for a feeding tube. Resident had an order dated 9/26/24 for controlled carbohydrate diet with regular texture and regular, thin consistency liquids. An interview with the MDS Coordinator on 12/18/24 at 8:19 AM revealed the Assistant Dietary Manager was responsible for coding the nutrition section of the MDS. An interview with the Assistant Dietary Manager on 12/18/24 at 8:45 AM revealed she had coded the nutrition section of Resident #23's quarterly MDS. She stated the resident did not have a feeding tube and she had mistakenly coded the resident as having a feeding tube.	F 641	Weight and Vitals Exemptions as tracking source for weights that should be utilized when determining gains and losses for 3 month evaluation. Would also need to use VS/Weights report from PCC dashboard when determining gains and losses for 6 months. On 1/13/25, MDS completed Education and Step by step instructions of the Weights and Vitals Exemptions report to CDM. " How does the facility plan to monitor its performance to make sure that solutions are sustained? On 1/16/2024 MDS RN completed a review for the previous week□s ARDs during the weekly weight meeting for feeding tube and significant weight changes based on implemented report for coding accuracy and will continue to perform weekly x 12 weeks then quarterly x 3 quarters. On 1/16/2024 Executive Director scheduled results of audits to be brought to be reviewed at quarterly QA meetings for one year or until substantial compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 641	Continued From page 13 An interview with the Administrator on 12/19/24 at 9:49 AM indicated the resident's MDS assessments should be coded accurately.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to apply offer application of tubing grip stockings (compression stockings used to treat swelling) to a resident as ordered by the physician 1 of 1 resident (Resident # 73) with a physician order for tube grip stockings. The findings included: Resident #73 was admitted to the facility on 10/18/2022. Review of a physician's order dated 11/5/2024 revealed Resident #73 was ordered to have tubing grip stockings (compression stockings used to treat swelling) applied every day shift for edema (swelling). Review of a quarterly Minimum Data Set (MDS)	F 684	"" How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 12/18/2025 Treatment nurse updated documentation on resident # 73 to reflect accurate care and services rendered. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 1/14/2025, Director of Nursing or Designee to complete 100% audit of TARS for completion of treatments and application of compression hose. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 1/9/2025, SDC completed 100% education of Nurses- RNs, LPNs,	1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 684	Continued From page 14 dated 11/22/2024 revealed Resident #73 was cognitively intact with no behaviors or rejections of care. Resident #73 had impairment on both sides of her lower extremities and was dependent for lower body dressing. Review of a care plan dated 11/7/2024 revealed Resident #73 was to be free from skin alterations with interventions which included to elevate her legs while in bed and staff should apply tube grip stockings daily. Review of the Treatment Administration Record (TAR) for December 2024, for the period of 12/1/2024 through 12/17/2024 revealed the Treatment Nurse had documented he had applied Resident #73's tubing grip stockings on 12/16/2024 and 12/17/2024. An interview and observation were conducted on 12/16/2024 at 11:06 am with Resident #73. Resident #73 was observed in bed with no tubing grip stockings on the right or left leg. Resident #73 stated no one had come to put them on that day, 12/16/2024. Resident #73 had edema (swelling caused by excess fluid) of both the left and right lower leg. Resident #73 stated the stockings made her uncomfortable, but she had not refused the application because no one had come to put them on. An interview and observation were conducted on 12/17/2024 at 12:10 pm with Resident #73. Resident #73 was observed in bed with no tubing grip stockings on the right or left leg. Resident #73 stated no one had come to put them on that day, 12/17/2024. Resident #73 had edema of both the left and right lower leg. Resident #73 stated the stockings made her uncomfortable, but	F 684	Treatment nurse and Ward Clerks on Quality of Care fundamentals to include professional standards of practice, comprehensive person-centered care plan and resident choices. All other nurses and ward clerks will be educated prior to next scheduled shift or upon hire during orientation. On 12/31 2024, SDC educated RNs, LPNs and Ward clerks on Accurate documentation and application of compression Stockings. All other nurses and ward clerks will be educated prior to next scheduled shift or upon hire during orientation. On 1/14/2025 Director of nursing or designee will complete ten resident observations of eTAR treatment or compression hose, application and documentation based on orders and resident preferences, observations weekly x 12 weeks, then 5 observations/month x 9 months or until substantial compliance is achieved " How does the facility plan to monitor its performance to make sure that solutions are sustained? On 1/16/25, Executive Director scheduled DON to review results at quarterly QA for one year or until substantial compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 684	Continued From page 15 she had not refused the application because no one had come to put them on. An interview was conducted on 12/18/2024 at 1:33 pm with the Treatment Nurse. The Treatment Nurse stated Resident #73 only got Nystatin Powder as a treatment. The Treatment Nurse stated he had not attempted to put Resident #73's tubing grip stockings on her on 12/16/2024 or 12/17/2024. The Treatment Nurse stated she had previously told him that they made her uncomfortable and had meant to have the order discontinued by the Medical Director (MD). An interview was conducted on 12/19/2024 at 10:08 am with the Director of Nursing (DON). The DON stated any floor staff could apply tubing grip stockings. The DON stated the Treatment Nurse had informed her that the tubing grip stockings had made Resident #73 uncomfortable, and he had meant to contact the MD to get the order discontinued.	F 684		
F 695 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 review, and staff interviews the facility failed to obtain an order for	F 695	"" How will corrective action be accomplished for those residents found to	1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 695	Continued From page 16 a resident who required oxygen oxygen (Resident #51) and failed to place post cautionary safety signs that indicated the use of oxygen (Resident #52) for 2 of 4 residents reviewed for oxygen use. The findings included: 1) Resident #51 was admitted to the facility on 9/1/2022 with diagnoses which included chronic obstructive pulmonary disease (COPD, lung disease that makes it difficult to breathe). Review of a quarterly Minimum Data Set (MDS) dated 10/25/2024 revealed Resident #51 was severely cognitively impaired and was not on oxygen. Review of Resident #51's physician's orders revealed there were no orders for supplemental oxygen. An observation was conducted on 12/16/2024 at 11:10 am of Resident #51. Resident #51 was observed lying in bed with oxygen on at 3 liters per minute via nasal canula. Resident #51 had cautionary oxygen signage posted on the door frame. An observation was conducted on 12/17/2024 at 8:58 am of Resident #51. Resident #51 was observed lying in bed with oxygen on at 2.5 liters per minute via nasal canula. Resident #51 had cautionary oxygen signage posted on the door frame. An interview was conducted on 12/17/2024 at 1:20 pm with Nurse #2. Nurse #2 stated if a resident was on oxygen, there should be an order in the resident's chart. Nurse #2 stated Resident	F 695	have been affected by the deficient practice? ON 12/17/2024 order was written for Oxygen for resident # 51. ON 12/17/2024 Oxygen signage was placed on door frame outside of resident□s room for resident # 52. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 12/27/2024, 100% Audit of residents on O2 completed by Director of Nursing Services or Designee for physician order. On 12/27/2024, 100% audit of residents on O2 with signage at resident room door by Director of Nursing Services or Designee to identify utilization of O2 On 12/27/2024,100% audit of residents with O2 orders for presence of O2 tubing and concentrator in use or accessible. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 1/1/25, Executive Director implemented weekly Rooms Rounds by Medical Records, Social worker, Admissions, Activities, Infection Control, Business Office, HR-AP, and MDS to include observation for O2 on residents and placement of O2 signage on resident room door. On 1/1/25, SDC to complete 100% education with Medical Records, Social worker, Admissions, Activities, Infection Control, Business Office, HR-AP, and MDS on the Room Rounds form and completion. Hiring of any new team member as listed above, will be educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 695	Continued From page 17 #51 had been on oxygen and stated she was unsure why she did not have an order. Nurse #2 stated Resident #51 should have had an order for oxygen. An interview was conducted on 12/17/2024 at 1:53 pm with Nurse #3. Nurse #3 stated if a resident was on oxygen there would be an order in the resident's chart and would sign off that oxygen was in use on the Medication Administration Record (MAR). Nurse #3 stated she was not aware Resident #51 did not have an order for oxygen and stated she should have. An interview was conducted on 12/19/2024 at 9:43 am with the Assistant Director of Nursing (ADON). The ADON stated if a resident was on oxygen there should be a physician's order. The ADON stated the facility also had standing orders for oxygen that could be implemented by the nursing staff. The ADON stated she was not sure why Resident #51 did not have an order. An interview was conducted on 12/19/2024 at 10:04 am with the Director of Nursing (DON). The DON stated if a resident required oxygen there should be an order in the resident's chart. The DON stated she was not sure why Resident #51 did not have an order for oxygen and stated she should have. 2) Resident #52 was admitted to the facility on 11/18/2024 with diagnoses which included respiratory failure (a condition where the lungs are unable to exchange oxygen and carbon dioxide making it difficult to breathe). Review of a physician's order dated 11/19/2024 revealed Resident #52 was ordered oxygen at 3	F 695	prior to next scheduled shift or upon hire during orientation. On 1/7/25, Director of Nursing or Designee will complete 100% audit of room rounds form for observation of residents on O2, and O2 signage on resident room door and will verify an active order is present. On 1/9/25 date, SDC to complete 100% education of RNs, LPNs regarding writing medication orders for O2 and placement of O2 signs at resident□s door. All other RNs, LPNs will be educated prior to next scheduled shift or upon hire during orientation. " How does the facility plan to monitor its performance to make sure that solutions are sustained? On 1/7/25, Audit of room rounds form showing residents observed with O2 and O2 signage present will be completed. Will review resident orders to ensure Oxygen order is present. Monitoring will be weekly x 4 weeks followed by 10 random observations per month x 11 months. On 1/16/25, Executive Director scheduled DON to review results at quarterly QA for one year or until substantial compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 695	Continued From page 18	F 695		

liters per minute continuously every shift related to respiratory failure.

Review of a care plan dated 11/24/2024 revealed Resident #52 was at risk for alteration in respiratory status due to a diagnosis of respiratory failure and supplemental oxygen use.

Review of an admission Minimum Data Set (MDS) dated 11/25/2024 revealed Resident #52 was cognitively intact and used oxygen.

An observation was conducted on 12/16/2024 11:14 am of Resident #52. Resident #52 was observed laying in bed with oxygen on at 3 liters per minute via nasal canula. There was no cautionary signage outside of Resident #52's room that indicated oxygen was in use.

An observation was conducted on 12/17/2024 at 9:04 am of Resident #52. Resident #52 was observed laying in bed with oxygen on at 3 liters per minute via nasal canula. There was no cautionary signage outside of Resident #52's room that indicated oxygen was in use.

An interview was conducted on 12/17/2024 at 1:20 pm with Nurse #2. Nurse #2 stated when a resident was on oxygen, facility staff placed a cautionary signage outside of the resident's room on the door frame.

An interview was conducted on 12/17/2024 at 1:53 pm with Nurse #3. Nurse #3 stated whenever a resident was started on oxygen, the nurse that applied the oxygen would place the cautionary signage outside of the resident's room. Nurse #3 did not know why Resident #52 did not have precautionary signage outside of her room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 695	Continued From page 19 and stated there should have been. An interview was conducted on 12/19/2024 at 9:43 am with the Assistant Director of Nursing (ADON). The ADON stated the facility had implemented placing cautionary oxygen signage outside of resident's room within the past 3 months. The ADON stated she was unsure why there was no precautionary signage outside of Resident #52's room. An interview was conducted on 12/19/2024 at 10:04 am with the Director of Nursing (DON). The DON stated the facility had implemented the use of cautionary signage recently. The DON stated whenever a resident was placed on oxygen any staff member could place signage outside of the resident's door. The DON was not aware there was no cautionary oxygen signage outside of Resident #52's door.	F 695		
F 761 SS=E	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.	F 761		1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 761	Continued From page 20 §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 observation, staff interviews, and record reviews, the facility failed to discard expired eye drops from the medication carts as specified by the manufacturer's guidelines and failed to remove expired over the counter (OTC) medications from the medication cart in accordance with the manufacturer's expiration date for 2 of 7 medication carts (600 halls and 700 halls). The findings included: a. The manufacturer's package inserts for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between the temperature of 36° to 46° Fahrenheit (F) and protected from light. Once it was opened, Latanoprost could be stored at room temperature up to 77° F for up to six weeks. A medication storage audit was conducted on 12/18/24 at 2:34 PM for 700 halls medication cart in the presence of Nurse #1. One opened bottle of Latanoprost 0.005% eye drops was found in the medication cart under room temperature and ready to be used. The handwriting on the label indicated it was opened on 11/03/24. The eye	F 761	"" How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 12/18/24, Director of Nursing Services removed expired medication and over the counter medication from medication cart. MD notified. No concerns or issues related to resident. No resident negative effects. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 12/18/24, 100% of medication carts audit by Pharmacist of eye drops with no identified concerns. On 12/18/24 date, 100% of all OTC audited on medication cart by Director of Nursing with no identified concerns. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 12/20/24, Assistant Director of Nursing added Pharmacy checklist with eye drop expiration listing to the front of narcotic book on each resident hallway. On 1/13/25, Director of Nursing updated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 761	Continued From page 21 drops expired on 12/15/24 after they were opened and stored in the room temperature for 42 days. Further review of the eye drop revealed a blue sticker of "Keep Refrigerated" was placed on top of the label that stated, "Store opened bottle at room temperature for up to 6 weeks". An interview was conducted with Nurse #1 on 12/18/24 at 2:40 PM. She stated she checked the medication cart last Sunday without finding any medications that were expired or stored in an improper condition. She added she checked the medication cart thoroughly at least once per week. She did not recall the facility had set a specified routine to check the medication cart on a regular basis. Typically, she would check the expiration date of medication before administration. Nurse #1 explained the eye drop was scheduled to be given at bedtime and did not recall she had ever administered it to the resident so far. b. During a medication storage audit conducted on 12/18/24 at 3:03 PM for 600 halls medication cart in the presence of Medication Aide #1 (MA), an opened box of sore throat relief that contained 3 lozenges with active ingredients of menthol and benzocaine that expired on 10/31/24 were found in the medication cart and ready to be used. An interview was conducted with MA #1 on 12/18/24 at 3:06 PM. She did not recall the facility had ever instructed her to check the expiration of medication in the medication cart on a regular basis so far. She was told to check the medication cart whenever she had time, especially during the down time. She did not recall administering any sore throat relief lozenges in the past 3 months. She explained	F 761	nurse assignments to include weekly medication cart checks for each unit. On 1/13/25, SDC completed 100% Education of RNs, LPNs and Medication aides relative to dating, labeling and expiration of all medications (including eye gtts and over the Counter), policy for dating and labeling, location of the Pharmacy checklist, and assignments associated with medication cart checks. All other RNs, LPNs and medication aides will be educated prior to next scheduled shift or upon hire during orientation. " How does the facility plan to monitor its performance to make sure that solutions are sustained? Beginning on 12/18/24, Director of Nursing and Designees will complete 100% audit of medication carts x 4 weeks; 50% of medication carts audited x 4 weeks and 25% medication carts monthly. On 1/16/2025, Executive Director scheduled results to be reviewed at quarterly QA for one year or until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 761	Continued From page 22 when she worked with this medication cart last Friday, it was a very busy day that she did not have time to check the medication cart on that day. During an interview conducted with the Director of Nursing (DON) on 12/18/24 at 3:14 PM, she stated the original label that contained the instruction to store the opened bottle of Latanoprost at room temperature for up to 6 weeks was covered by a blue sticker placed by the pharmacy and it had caused the nursing staff to miss this important instruction. She did not know why the expired sore throat lozenges were not removed from the medication cart. It was her expectation for the facility to remain free of expired medications. An interview was conducted with the Administrator on 12/19/24 at 1:46 PM. She stated it was her expectation to keep the facility free of expired medication.	F 761		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident;	F 790		1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 790	Continued From page 23 §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with the Dental Representative, family, resident and staff, the facility failed to obtain dental services for a resident with a broken partial denture for 1 of 1 resident reviewed for dental services (Resident #4). Findings included: Resident #4 was admitted to the facility on 08/21/18.	F 790	"" How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 12/19/2025 Resident # 4□s dental appliance was located in the facility. Facility contacted Access Dental and was provided instruction. Appliance was placed in resident□s mouth and did not require denture adhesive to stay in place. Resident denied any discomfort. Follow up with resident□s daughter on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 790	Continued From page 24 A care plan initiated on 10/27/22 revealed Resident #4 had her own natural teeth with some missing and had an upper partial denture. Interventions included to assist in arranging dental exams as needed, requested or ordered. The annual Minimum Data Set (MDS) assessment dated 10/09/24 revealed Resident #4 had severe cognitive impairment. Resident #4 was independent with eating, was not receiving a mechanically altered or therapeutic diet and there were no oral/dental concerns. A staff progress note dated 11/21/24 written by Social Worker (SW) #2 revealed in part, Resident #4's Responsible Party (RP) called the SW to discuss Resident #4's broken partial denture and requested the SW to examine the partial denture to see what exactly was broken. The SW noted the metal bracket was missing on one side that helped hold the partial denture in place, there were no sharp edges where the metal bracket had been and Resident #4 was able to continue wearing the partial denture. The SW reported the findings to Resident #4's RP and informed the RP that Resident #4 was added to list to be seen the next time the dentist was at the facility. During an observation and interview on 12/16/24 at 1:24 PM, Resident #4 was sitting up in bed visiting with her RP. Resident #4 had most of her natural teeth but was missing her two front teeth. There was no redness or inflammation noted to her gums and Resident #4 stated she was not having any oral pain. Resident #4 stated she had partial denture but she didn't wear it because it was broken. She stated it was uncomfortable to wear when eating because the partial denture would move up and down on one side.	F 790	1/14/2025. Daughter commented resident is doing fine with her partial and has not voiced any complaints and denies need for outside treatment at this time. On 12/19/24, Scheduler followed up with dental provider (Access Dental Services) for dental service request. On 12/17/24, MD Assessment completed. ST assessment for dietary. RD/CDM review of resident preferences based on diet. Resident with no adverse effects. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 12/27/24, Director of Nursing and Designee completed Oral assessments on 100% of residents to identify dental needs. On 1/02/2025, 100% audit of resident□s routine dental services for timeliness of visit was completed by Social Service Director. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 12/20/24, Social Service Director implemented new tracking form to support dental services follow-up. Any new dental service requests will be taken to morning meeting to discuss with administrative team and notify Transporter. On 12/31/24, Director of Nursing or Designee will implement Stop and Watch resident notification communication form to include any dental needs. On 12/31/24, SDC completed100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 790	Continued From page 25 During a follow-up interview on 12/19/24 at 1:46 PM, Resident #4 stated she wanted her partial denture repaired. Resident #4 stated it made her feel self-conscious when she wasn't wearing the partial denture because people noticed and would ask about her missing two front teeth. During an interview on 12/16/24 at 1:24 PM, Resident #4's RP revealed Resident #4 received dental services through the facility and her partial denture had been broken for approximately 6 weeks. The RP stated she spoke with SW #2 to inquire about getting it repaired and was told by SW #2 that it would be around 3 months before the dentist was back at the facility. The RP stated the facility dentist had done an impression for Resident #4's partial denture in the past and to her knowledge no one from the facility had reached out to the facility dentist to inquire about getting Resident #4's partial denture repaired or a new partial made. During an interview on 12/19/24 at 10:02 AM, SW #2 revealed she received a call from Resident #4's RP on 11/21/24 regarding Resident #4's partial denture. SW #2 stated when she examined Resident #4's partial denture, the part that fits on the gum was not broken but the wire bracket on one side that fits over her tooth to hold the partial denture in place was gone and there were no rough edges where the bracket had been. SW #2 stated Resident #4 did not complain of any pain and could still wear the partial denture but reported to SW #2 that it was uncomfortable because one side would be tight and the side with the missing bracket was loose. SW #2 stated she sent an email to the Transportation Coordinator 11/21/24 about	F 790	education of Social Service Director, Nurse□s, Medication aides, Nursing Assistants, PCAs, and Therapy regarding routine dental service needs, actions and coordination for dental services by a Social Service Director, as well as utilization of the Stop and Watch form. All other Social Service, Nurse□s, Medication aides, Nursing Assistants, PCAs, and Therapy will be educated prior to next scheduled shift or upon hire during orientation. " How does the facility plan to monitor its performance to make sure that solutions are sustained? Beginning on 1/14/2025 DON or designee will write orders for ST, Dietary and notify MD for residents experiencing damaged or lost dentures and will notify RR. By 1/16/2025 DON or Designee will complete lost or damaged appliance tracking form monthly x 12 months. On 1/16/2025 Executive Director scheduled results to be reviewed at quarterly QA for one year or until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 790	Continued From page 26	F 790		

Resident #4's partial denture being broken and for her to contact the dental company about getting it repaired. SW #2 stated she also spoke with Resident #4's RP to explain what she had observed when she examined Resident #4's partial denture and informed her they had sent Resident #4's partial denture to the dental company to be repaired. SW #2 stated Resident #4's RP told her that the dental company stated it would be 3 to 4 months before it was fixed. SW #2 stated she spoke with the Transportation Coordinator and an emergency request for repair was sent to the dental company on 12/18/24 to see if that would help expedite the repair. SW #2 stated to her knowledge, the dental company was currently working on repairing Resident #4's partial denture but they have not gotten back with a timeframe of when it would be completed.

During a telephone interview on 12/19/24 at 11:43 AM, the Dental Representative stated they did not have anything in their system indicating they had received Resident #4's partial denture from the facility to be repaired. She stated the last dental note they had was when Resident #4 had a dental exam and cleaning in August 2024.

During an interview on 12/19/24 at 1:26 PM, the Administrator stated she spoke with the Transportation Coordinator regarding Resident #4's partial denture and the Transportation Coordinator informed her she had reached out to the Dental Representative but it had slipped her mind to follow-up when she never heard back from the Dental Representative.

Review of email correspondence provided by the Administrator on 12/19/24 revealed on 11/25/24 at 5:15 AM, an email was sent to the Dental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 790	Continued From page 27 Representative by the Transportation Coordinator informing them Resident #4's partial denture was missing the metal bracket on one side but did not seem to be causing any pain. The email further noted the Transportation Coordinator questioned if a dental concern was needed or just to add Resident #4 to the next list of dental appointments to be seen. During an interview on 12/19/24 at 2:03 PM with the Administrator present, the Transportation Coordinator revealed she was responsible for coordinating dental appointments. She stated her typical procedure was to send an email to the Dental Representative, wait for a response and then follow-up in a couple of weeks if she had not heard back. The Transportation Coordinator stated when she was notified of Resident #4's broken partial denture by SW #2, she sent an email to the Dental Representative on 11/25/24 but never received a response back and it slipped her mind to follow up with the Dental Representative. She stated she sent the Dental Representative a Dental Emergency Report form yesterday (12/18/24) and they requested a photo of the partial denture but she did not have the partial denture to take one.	F 790		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 812	Continued From page 28 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to prevent the potential for cross contamination by storing a plastic scoop inside the dry flour ingredient bin allowing the handle to touch the dry flour for 1 of 1 observation. The facility also failed to ensure staff had their hair restrained in the kitchen while bagging utensils for 1 of 1 staff observed bagging utensils and failed to ensure staff changed gloves before touching resident foods for 2 of 3 staff observed preparing food. These practices had the potential to affect food served to all the residents. Findings included: a. During an observation of the kitchen on 12/16/24 at 9:50 AM, the flour scoop was observed in the flour bin and the handle was visibly touching the flour. During an interview on 12/16/24 at 9:50 AM, the Dietary Manager stated the staff had just forgotten to take the scoop out of the flour. b. During an observation of the kitchen on 12/17/24 at 11:45 AM, Dietary Aide #1 was	F 812	"" How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 12/16/24, Dietary Manager removed flour scoop from bin of flour. On 12/17/24, Dietary Manager removed employee from kitchen service to ensure that hair was properly restrained. On 12/18/24, Dietary Manager removed employee from service to ensure proper utilization of gloves. On 12/18/24, Nurse Clinical Liaison reviewed Nursing notes for all residents that received meal trays for s/s of GI upset. No residents negatively affected. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 12/18/24, Regional Dietary Manager completed audits on the kitchen procurement, storage, preparation and service to ensure sanitation of practice standards. On 12/18/24, Regional Dietary Manager implemented a new audit checklist tool	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 812	Continued From page 29 observed to be bagging eating utensils. He was not wearing a hair restraint or hat. He was observed to have short dark hair on his head with no facial hair. During an interview on 12/17/24 at 11:45 AM, Dietary Aide #1 stated he had been at work since between 10:00 AM and 10:30 AM and had forgotten to put his hair restraint on. c. During a continuous observation of the kitchen on 12/17/24 from 11:30 AM until 1:50 PM, Cook #2 was observed to touch food items being placed on resident plates for the meal service. He was observed to touch kitchen objects which included the plate warmer, plate cover, serving spoons, serving tongs, and plates. While wearing the same gloves he was observed to put Brussels sprouts on a plate and then scoot the Brussels sprouts around on multiple resident plates with his gloved hand. He was also observed to use the same gloved hand to form a wall to prevent the chopped pork loin from falling off the plate when scooping it onto multiple resident plates. During an interview on 12/18/24 at 9:25 AM with Cook #2, he stated he wasn't aware he was touching the food while plating it. He stated he was taught not to touch the food to prevent cross contamination. During an interview on 12/17/24 at 2:10 PM, the Corporate Dietary Manager stated that she had observed Cook #2 touching food without changing gloves while putting food on multiple plates. She also stated he should not have touched the food without changing gloves but did not say why she had not intervened during the meal plating.	F 812	called Manager opening checklist which includes observations for dietary staff wearing hair nets, no scoops left in dry good bins and gloves worn and hands washed after each task to be completed daily by Dietary Manager or designee. Any areas of concern identified on the checklist would be resolved upon identification. On 12/18/2024 Executive Director implemented an F812 checklist for Dietary manager/designee to complete for AM and PM audit of observations of dietary staff wearing hair nets, no scoops left in dry good bins and gloves worn and hands washed after each task. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 1/6/2025 Dietary Manager or designee will complete F-812 Audit of kitchen as part of routine duties and provide completion daily to Dietary Regional Manager and Executive Director. If any areas of concern are identified, they will be immediately addressed to support compliance. Beginning on 1/10/2025, all new dietary employees will participate in facility orientation process to include education on not leaving scoop in flour, proper utilization of hair restraints and safe glove utilization. All dietary employees will complete an orientation check off prior to working scheduled shift. From 1/10/25-1/16/2025, Dietary Regional Manager completed 100% education of current dietary personnel and implemented process of all new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 812	Continued From page 30 d. During a continuous observation of the kitchen on 12/17/24 from 11:30 AM until 1:50 PM, Cook #1 was observed to make 4 salads. Wearing gloves, he used a knife to cut open a bag of lettuce and pour into a large bowl. He then cut open a bag of purple cabbage and poured it into the bowl with the lettuce. Cook #1 then cut open a bag of shredded carrots and poured it into the bowl of lettuce and cabbage. He then used his same gloved hands to mix the lettuce, cabbage, and carrots. During the continuous observation of the kitchen, Cook #1 was observed to make a ham and cheese sandwich. He was not observed to change gloves at any time during the process while touching all packaging to open the bread, ham, and cheese and handled all food items. During an interview on 12/18/24 at 1:58 PM with Cook #1, he stated he did not change gloves as he had been taught due to the kitchen being 'behind'. He stated he was taught to use tongs for the salad and to change gloves before handling food items to prevent cross contamination. During an interview on 12/17/24 at 2:10 PM with the Dietary Manger, she did not have anything to say. An interview on 12/19/24 at 9:32 AM with the Administrator stated that the kitchen staff wear a hair restraint, change gloves when required, and the flour scoop should not be left in the bin.	F 812	employees being educated prior to first scheduled shift regarding requirements of F 812 to include no scoop in flour bin, utilization of proper hair restraint and safe glove utilization. " How does the facility plan to monitor its performance to make sure that solutions are sustained? As of 1/13/25, Regional Dietary Manager and Infection Control Designee will complete random audits on kitchen three times a week x one month, weekly x four months, monthly x 7 months. As of 1/13/25, Regional Dietary Manager will complete analysis of the kitchen audits monthly. Any identified issues will be remedied and brought to QA for discussion, with plan modification if needed. On 1/16/2025 Executive Director scheduled results to be reviewed at quarterly QA for one year or until substantial compliance is achieved.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)	F 842		1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 842	Continued From page 31 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 842	Continued From page 32 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to ensure accurate medical records when a resident's edema (swelling) stockings were incorrectly documented as applied for 1 of 1 resident (Resident # 73) reviewed for medical record accuracy. The findings included: Resident #73 was admitted to the facility on 10/18/2022.	F 842	"• How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 12/18/2025 Treatment nurse updated documentation on resident # 73 to reflect accurate care and services rendered. • How will the facility identify other residents having the potential to be affected by the same deficient practice? On 1/14/25, Director of Nursing or Designee 100% Audit of TARS and MARs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 842	Continued From page 33 Review of a physician's order dated 11/5/2024 revealed Resident #73 was ordered to have tubing grip stockings (compression stockings used to treat swelling) applied every day shift for edema (swelling). Review of a quarterly Minimum Data Set (MDS) dated 11/22/2024 revealed Resident #73 was cognitively intact with no behaviors or rejections of care. Resident #73 had impairment on both sides of her lower extremities and was dependent for lower body dressing. Review of the Treatment Administration Record (TAR) for December 2024, for the period of 12/1/2024 through 12/17/2024 revealed the Treatment Nurse had documented he had applied Resident #73's tubing grip stockings on 12/16/2024 and 12/17/2024. An interview and observation were conducted on 12/16/2024 at 11:06 am with Resident #73. Resident #73 was observed in bed with no tubing grip stockings on the right or left leg. Resident #73 stated no one had come to put them on that day, 12/16/2024. Resident #73 had edema of both the left and right lower leg. Resident #73 stated the stockings made her uncomfortable, but she had not refused the application because no one had come to put them on. An interview and observation were conducted on 12/17/2024 at 12:10 pm with Resident #73. Resident #73 was observed in bed with no tubing grip stockings on the right or left leg. Resident #73 stated no one had come to put them on that day, 12/17/2024. Resident #73 had edema of both the left and right lower leg. Resident #73	F 842	for residents with order for compression hose. Make any changes as needed to ensure accurate record. • What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 12/31/24, SDC completed 100% education of Nursing (Registered Nurses, Licensed Practical Nurses, including the Treatment Nurse) on Accurate documentation and application of compression hose. On 12/31/24, SDC completed 100% education with Registered Nurses, Licensed Practical Nurses, including the Treatment Nurse for accurate medication administration documentation, to include documentation of errors to ensure chart accuracy. On 12/27/24, Director of Nursing or Designee updated the process for compression hose orders to be placed on the MARS. On 12/31/24, SDC completed education of Nurses-Registered Nurses, Licensed Practical Nurses, including the Treatment Nurse and ward clerks regarding placement of compression hose orders on e-MARs (instead of e-TARS). Any other Nurses, treatment nurses or ward clerks will be educated prior to next scheduled shift or upon hire during orientation. • How does the facility plan to monitor its performance to make sure that solutions are sustained? On 1-10-2025 Director of nursing or designee will complete an audit of ten resident observations of e-MAR compression hose application and e-Mar	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 842	Continued From page 34 stated the stockings made her uncomfortable but she had not refused the application because no one had come to put them on. An interview was conducted on 12/18/2024 at 9:16 am with Nurse #3. Nurse #3 stated she was not sure if Resident #73 was supposed to wear tubing grip stockings as she worked only as needed at the facility but confirmed she was responsible for Resident #73 on 12/18/2024. An interview was conducted on 12/18/2024 at 1:33 pm with the Treatment Nurse. The Treatment Nurse stated Resident #73 only got Nystatin Powder as a treatment. The Treatment Nurse stated he had not attempted to put Resident #73's tubing grip stockings on her on 12/16/2024 or 12/17/2024 because she had stated they made her uncomfortable. The Treatment Nurse was unable to explain why he had charted they were applied. The Treatment Nurse stated he was going to speak with the Medical Director about getting the order discontinued, because Resident #73 did not want to wear them. An interview was conducted on 12/19/2024 at 9:51 am with the Assistant Director of Nursing (ADON). The ADON stated the facility had a Treatment Nurse who worked Monday through Friday at the facility. The ADON stated she could not speak as to why the Treatment Nurse documented that tubing grip stockings were applied to Resident #73 and stated there was an option for refusal or incomplete that could have been chosen instead in the electronic medical record. An interview was conducted on 12/19/2024 at	F 842	documentation weekly x 12 weeks, then 5 observations/month x 9 months or until substantial compliance is achieved. On 1-16-2025, Executive Director scheduled results to be reviewed at quarterly QA for one year or until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

(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
F 842	Continued From page 35 10:08 am with the Director of Nursing (DON). The DON stated any floor staff could apply tubing grip stockings. The DON stated the Treatment Nurse had come to her and told her that he had charted the tubing grip stockings were applied when they were not. The DON stated the Treatment Nurse should not have documented the tubing grip stockings were applied if they were not.	F 842		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345190	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	**230 NC HWY 141 MURPHY, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 554	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Resident and staff interviews, the facility failed to ensure a resident was assessed for self-administration of a medication at the bedside for 1 of 9 residents (Resident #73) reviewed for medication administration. The findings included: Resident #73 was admitted to the facility on 10/18/2022 and had a diagnosis of a retinal detachment (a situation where the thin layer of tissue in the back of the eye moves from its usual position, causing visual disturbances). Review of a quarterly Minimum Data Set (MDS) dated 11/22/2024 revealed Resident #73 was cognitively intact. Review of the December 2024 physician's orders revealed Resident #73 did not have an order for Visine (tetrahydrozoline ophthalmic drops). An observation was conducted on 12/17/2024 at 9:03 am revealed Resident #73 had an open, what appeared to be full, container of Visine brand eyedrops on her bedside table that were not labeled by the pharmacy, in a clear cup, within reach of the resident. An observation was conducted on 12/17/2024 at 12:09 pm revealed Resident #73 had an open container of Visine eyedrops on her bedside table, in a clear cup, within reach of the resident. An interview was conducted on 12/17/2024 at 1:57 pm with Nurse #2. Nurse #2 stated if a resident wanted to have medications at the bedside, they were required to have an assessment for self-administration and an order from a physician to self-administer the medication. Nurse #2 stated Resident #73 did not have an assessment or an order for self-administration of medications. A follow-up interview was conducted on 12/17/2024 at 3:20 pm with Nurse #2. Nurse #2 stated she had gone into Resident #73's room and saw the Visine eye drops in a cup. Nurse #2 stated she notified the Director of Nursing (DON). An interview was conducted on 12/19/2024 at 10:37 am with the MDS Nurse. The MDS Nurse stated if a resident wanted to self-administer medications, there was an assessment that had to be conducted. The MDS Nurse stated she was asked to complete a self-administration assessment for Resident #73 on 12/17/2024.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345190	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	**230 NC HWY 141 MURPHY, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 554	Continued From Page 1

An interview was conducted on 12/19/2024 at 9:51 am with the Assistant Director of Nursing (ADON). The ADON stated residents were allowed to keep medications at their bedside if they had an order for self-administration of medications. The ADON stated she was not sure why Resident #73 had Visine eyedrops without an order for self-administration. The ADON stated sometimes families do not acknowledge over the counter medications to the facility.

An interview was conducted on 12/19/2024 at 10:08 am with the Director of Nursing (DON). The DON stated it had been brought to her attention that Resident #73 had medications at her bedside. The DON stated if a resident wanted to have medications at their bedside there should be an order and an assessment for self-administration of medications.