STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 investigation survey was conducted on 02/17/25 through 02/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XHCO11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/17/25 through 02/21/25. Additional information was obtained on 2/24/25. Therefore, the exit date was changed to 2/24/25. Event ID# XHCO11. The following intakes were investigated NC00212474, NC00222241, NC00220634, NC00210949, NC00211317, NC00217067, NC00216235, NC00216753, NC00224116, NC00218555, NC00214790, NC00215284, and NC00227576. 7 of the 35 complaint allegations resulted in deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		3/12/25

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

Electronically Signed | 03/12/2025

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F 561	Continued From page 1 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to honor a resident's choice to receive coffee as requested for 1 of 3 residents reviewed for choices (Resident #10). The reasonable person concept was applied for Resident #10 due to his inability to express his feelings and a reasonable person would feel angry and frustrated if their choices were not met. The findings included: Resident #10 was admitted to the facility on 3/20/19 with diagnoses that included dementia, anxiety disorder and aphasia (difficulty expressing self). An annual Minimum Data Set (MDS) assessment dated 11/20/24 indicated that Resident #10 had moderately impaired cognition and required setup assistance for eating.	F 561	Corrective action for the resident(s) found to be affected by the deficient practice. Resident #10 continues to reside at the facility. His request for coffee is on his meal ticket and resident□s care plan and resident profile reflects offering coffee is an intervention for his anxiety/anxiousness. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the right to determine and request choices with reasonable accommodation. The Interdisciplinary Team reviewed and updated all resident care plans and care guides to reflect individual choices that are requested and/or may be an intervention for his anxiety/anxiousness.	

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F 561	Continued From page 2 On 2/18/25 at 10:59 AM, an interview occurred with the Floor Technician. He explained that on 11/12/24 he witnessed Resident #10 yelling out for coffee in the dining room and Nurse Aide (NA) #1 removed Resident #10 from the dining room instead of providing him with a cup of coffee as requested. A phone interview was conducted with NA #1 on 2/19/25 at 5:51 PM. She explained that on 11/12/24 Resident #10 was in the dining room, had completed his lunch meal and was requested more coffee. She was in the middle of assisting another resident at his table with their lunch and told him, "give me a few minutes". She stated Resident #10 became agitated and she removed him from the dining room instead of providing him with coffee. On 2/17/25 at 10:33 AM, Resident #10 was observed sitting up in his bed with a cup of coffee in front of him. He was unable to recall the events of 11/12/24. A phone interview occurred with the Administrator and Director of Nursing (DON) on 2/20/25 at 1:01 PM. They explained that Resident #10 received meals in the dining room per his choice and loved drinking black coffee. The DON indicated that coffee was often used to help ease his anxiety and agitation when present. They both indicated that Resident #10 should have been provided with coffee as requested on 11/12/24.	F 561	Systemic changes made to ensure that the deficient practice will not recur. The Director of Health Services will complete training for all staff 100% on Resident Rights/Self-Determination, including updating resident care plans and resident profiles to reflect individual choices that are requested and/or may be an intervention for anxiety/anxiousness with completion date 03-12-25. Resident Rights/Self-Determination training will be completed 100% and any staff will be trained prior to their next scheduled shift if not in the facility. Resident Rights/Self-Determination training will continue for new employees during orientation. Plans to monitor its performance to make sure that the solutions are sustained. The Social Services Director will ensure substantial compliance with residents to ensure Resident Rights/Self-Determination are accommodated. The Social Services Director will monitor residents□ requests via F561 Self-Determination Audit: 5 residents daily x 5 days week for 2 weeks. 5 residents 3 x weekly for 2 weeks. 5 residents weekly for 1 month. The Social Services Director will ensure substantial compliance of residents□ requests. Any concerns will be immediately reported to the Administrator or Director of Health Services for immediate corrective action.	

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F 561	Continued From page 3	F 561	Beginning March 2025, Social Services will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Date of compliance: 03-12-2025	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		3/13/25

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F 585	Continued From page 4	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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F 585	Continued From page 5 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain documentation of resolved grievances and evidence of the results of all grievances for 9 of 13 months reviewed (December 2023 to August 2024). Findings included: During an interview with Administrator #1, the current administrator, on 2/17/25 at 4:20 PM she	F 585	Corrective action for the residents found to be affected by the deficient practice. 08-25-2024: Upon arrival at PruittHealth-Rockingham as the new administrator, I discovered that there was no grievance process being managed. I met with the Social Services Director who stated she was informed by the previous administrator that the administrator managed grievances.	

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F 585	Continued From page 6 stated the grievances from December 2023 through August 2024 were not available and could not be reviewed because she did not have the grievances. On 2/17/25 at 4:30 PM the Social Worker was interviewed. She stated the former administrator, Administrator #2, would not allow her to assist in the grievance process. She indicated Administrator #2 told her the administrator's role was the grievance official, and that the Social Worker was not to touch the grievances. The Social Worker stated she did not know where the grievance log (which was a record of the grievances) or the copies of grievances were kept. Administrator #2, the former administrator, was interviewed by phone on 2/18/25 at 10:07 AM and stated when she left the facility in August 2024, she gave the grievance log binder to the Director of Nursing in a "box of stuff." She further stated the Social Worker also had copies of the grievances during the time she was the Administrator from December 2023 to August 2024. The Director of Nursing (DON) was interviewed on 2/18/25 at 3:51 PM. She stated Administrator #2 had called her in August 2024 after Administrator #2 was no longer employed at the facility and asked the DON to meet at a grocery store parking lot in a nearby town so Administrator #2 could return some papers belonging to the facility. She stated Administrator #2 handed her a box from her car, and the DON indicated she put the box in her car's trunk. The DON stated that she did not open the box to check the contents, but that she placed the box in	F 585	The Social Services Director and I searched for grievances. The Social Services Director found two and both were addressed, and the grievances were written and resolved. Effective 08-27-25, to ensure all grievances are being addressed daily is Morning Meeting. The Social Services Director will log all grievances, all identified grievances will be resolved, the Administrator and Social Services Director will respond to the resident and/or family member on the resolution and all grievances will be maintained in the Social Services Director□s office. Corrective action for other residents having the potential to be affected by the same deficient practice. 08-27-2024: 100% of staff educated on grievance policy and procedure, reviewed how to complete grievance. Staff were informed that the Administrator□s expectation was to have numerous grievances every month for the residents to be comfortable, listen to, develop trust, and always know the staff are here to care for them and make them feel safe. All grievances are to be brought to the attention of the Administrator and the Social Services Director will manage the grievance process. Systemic changes made to ensure that the deficient practice will not recur. On 08-27-2024, In Morning Meeting the grievances are addressed. The Administrator to log every grievance and ensure follow through complete. The	

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F 585	Continued From page 7 the Administrator #1's office when she went back to work. The current administrator, Administrator #1, was interviewed on 2/17/25 at 4:20 PM. She stated she began working for the facility on 8/18/24. She stated she had searched her office and throughout the facility, but she had not been able to find the grievances or grievance logs from December 2023 to August 2024. She indicated she was unsure if grievances were recorded before she became the Administrator because she was informed by the Social Worker, the former administrator would not allow the Social Worker to participate in the grievance process. However, she stated she would continue to search for the grievances and the grievance log. During a follow up interview with Administrator #1 on 2/20/25 at 2:22 PM, she stated she began working with the Social Worker to assist with the grievance process when she became the Administrator in August 2024. She indicated grievances were discussed during the morning meeting each day, and each month the Social Worker would report to her regarding any further action required for grievances which were of concern. The facility provided a copy of the Quality Assurance and Performance Improvement (QAPI) meeting minutes dated 8/27/24 and a copy of its Performance Improvement Plan (PIP) dated 8/27/24 to review for a potential determination of past noncompliance. The measures and systemic changes put into place and monitoring in the corrective action plan did not address the deficient practice. As a result, the survey team was unable to make a determination of past noncompliance for	F 585	Administrator and Social Service Director will ensure that each resident grievance/concern is resolved with an appropriate resolution. The Administrator will ensure the grievance/concern is completed with a mailed/hand delivered resolution letter. A copy of the resolution letter will be maintained in a file by the Social Service Department. On 03-12-25, 100% of the Interdisciplinary Team were educated by the Administrator on the importance of ensuring the facility grievance policy and procedure by completion of grievance form, follow with resolution, maintaining documentation and evidence of results and follow up with resident and/or responsible party. Grievance forms will be recorded on the Grievance Log and the Social Services Director will maintain the log. This education will be provided to all new Interdisciplinary Team members during orientation. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will conduct weekly random audits to ensure the written Grievance documentation continues to be completed per policy and procedure. This audit will be completed: "Weekly x 4 weeks for 3 months The Administrator will review the results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. The next	

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F 585	Continued From page 8 grievances.	F 585	Quality Assurance Performance Improvement (QAPI) Committee Meeting will be held on March 20, 2025, with the Medical Director in attendance. Date of compliance: 03-13-2025	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to protect a resident's right to be free from staff to resident abuse when Nurse Aide #1 tilted Resident #10's wheelchair back, let it back down then pushed the wheelchair forcefully down the hall. This was for 1 of 8 residents reviewed for accidents. The findings included: Resident #10 was admitted to the facility on	F 600	Corrective action for the residents found to be affected by the deficient practice. Resident #10 continues to reside at the facility and has the right to be free from abuse and neglect. Resident #10 was assessed immediately on 11-12-24, by the Director of Health Services. Resident #10 had no signs and symptoms of injuries as evidenced by no reddened areas, complaints of pain and no display of emotional distress. The	3/13/25

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F 600	Continued From page 9 3/20/19 with diagnoses that included dementia, anxiety disorder, aphasia (difficulty expressing self) and lack of coordination. Resident #10 resided on the D Hall. A review of the facility Initial Allegation Report, investigation, and statements revealed on 11/12/24 Resident #10 was in the dining room when Nurse Aide (NA) #1 was observed tilting Resident #10's wheelchair back, letting it go back to the ground, pushing Resident #10's wheelchair forcefully down the hall and returning to the dining room without ensuring Resident #10 was safe. NA #1 was suspended pending the outcome of the investigation and then terminated. All staff received education on abuse. An annual Minimum Data Set (MDS) assessment dated 11/20/24 indicated that Resident #10 had moderately impaired cognition and verbal behavioral symptoms one to three days during the look back period. He had limited range of motion to bilateral lower extremities and utilized a wheelchair for mobility. He was coded with setup assistance for wheelchair mobility of 50 feet with two turns. Resident #10 was coded as weighing 152 pounds and was 72 inches tall. Resident #10's care plan, last reviewed 11/21/24 included the following problem areas: - Resident required assist with Activities of Daily Living (ADL) related to impaired mobility and cognitive status and was at risk for further decline in ADL function. - Resident had physical behavioral symptoms towards others (hitting, kicking, scratching). The interventions included to avoid power struggles, maintain a calm environment and approach to resident and divert resident's behavior as much	F 600	Nurse Aide #1 was removed from the facility. An investigation was initiated, law enforcement and Department of Social Services were notified at that time and a reportable to the State was submitted. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the right to be free from abuse and neglect. The Abuse Survey was completed by the Social Services Director for all residents with a Brief Interview for Mental Status (BIMS) of 12 or greater regarding their safety, care and comfort at the facility. All other residents with Brief Interview for Mental Status of 11 or less had a complete skin assessment completed and no bruising, skin impairment that required further investigation of abuse. Completion on 11-12-24. Systemic changes made to ensure that the deficient practice will not recur. The Director of Health Services completed Abuse Prevention Training including all types of abuse for 100% of staff on 11-12-2024. Education included resident choice, allowing the residents to communicate needs, especially with residents with dementia who may have different ways of communicating needs. Forcefully removing a resident from an area because of the assumption that the resident is being disruptive is never acceptable. Staff are required to provide resident□s needs. Abuse training completed 100% on new	

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F 600	Continued From page 10 as possible. On 2/19/25 at 5:51 PM, a phone interview was conducted with NA #1. She was able to recall the events of 11/12/24 and stated she was in the dining room assisting residents with their lunch meal and Resident #10 was asking for coffee. She stated he had finished his meal, and she told him to "give me a few minutes". She stated Resident #10 began yelling out, so she attempted to pull him away from the table. She stated he was holding on to the table and his feet were on the floor. NA #1 confirmed she tilted the wheelchair back "a little" to get Resident #10's feet off the floor so she could wheel the chair and then let it back down. NA #1 stated it was not normal to tilt the wheelchair back but wanted to get his feet off the floor so she could move the wheelchair. She stated, "I pushed him through the double doors of D hall and remember the floor technician standing there". NA #1 stated that Resident #10 resided on the D hall. NA #1 confirmed she was suspended pending the investigation and never returned to the facility. On 2/18/25 at 10:59 AM, an interview occurred with the Floor Technician who witnessed the events of 11/12/24. He explained that he was walking up D Hall and could see clearly in the dining room. He heard Resident #10 yelling out for coffee and had his meal tray in front of him. NA #1 was observed pulling Resident #10 away from the table, tilting the wheelchair back where Resident #10's legs were in the air and letting it drop back down to the ground. During this time Resident #10 was heard yelling "leave me alone". The Floor Technician stated he began to walk in the dining room to intervene and was told by NA #1 "don't touch him". NA #1 was then observed	F 600	employees during orientation. On 03-12-25, Abuse Prevention education included resident choice, allowing the residents to communicate needs, especially with residents with dementia who may have different ways of communicating needs. Forcefully removing a resident from an area because of the assumption that the resident is being disruptive is never acceptable. Staff are required to provide resident□s needs. This training was completed by the Administrator and Director of Health Services. Any employee that has not completed this training will be trained prior to their next scheduled shift. This education will be provided during orientation for all new employees. Plans to monitor its performance to make sure that the solutions are sustained. "The Administrator will ensure substantial compliance to ensure residents are free from abuse and neglect. A F600 Abuse Audit will be completed by the Administrator to prevent abuse and neglect: 5 employees randomly 2 x weekly for 4 weeks. 5 employees 1 x weekly for 4 weeks. "The Social Services Director will interview residents with a BIMS score 12 or greater regarding their safety, care and comfort at the facility: 3 residents randomly 2 x weekly for 4 weeks. 3 residents 1 x weekly for 4 weeks. "The Director of Health Services will	

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F 600	Continued From page 11 pushing Resident #10 to the double doors of the dining room and D hall, pushing the wheelchair forcefully and returning to the dining room. The Floor Technician stated the wheelchair rolled approximately 20 feet before coming to a stop on its own. He stated he reported the incident immediately to NA #2/staffing scheduler. On 2/18/25 at 2:32 PM, an interview was completed with NA #2/staff scheduler. She explained that she was approached by the floor technician and housekeeper who reported the incident they observed between Resident #10 and NA #1. She recalled they stated Resident #10 was in the dining room at the table and saw NA #1 remove him from the table as he was yelling out "leave me alone". NA #1 tilted the wheelchair back, letting it go back down the ground then forcefully pushed Resident #10's wheelchair out on the hallway. It was reported that NA #1 turned around and walked back into the dining room. NA #2 stated she observed Resident #10 sitting in the hallway in a calm demeanor, after the allegation occurred. She reported the allegation directly to the Director of Nursing (DON). A phone interview occurred with the Housekeeper on 2/19/25 at 5:43 PM who observed the interaction between Resident #10 and NA #1 on 11/12/24. She explained she was standing at the nurse's station on the D Hall and observed NA #1 trying to pull Resident #10 away from the dining room table. After she pulled him away from the table, she tilted the wheelchair back where Resident #10's feet were off the ground and then let it go back towards the ground. NA #1 was observed pushing Resident #10's wheelchair roughly through the double doors of the dining	F 600	complete a skin assessment with residents with BIMS of 11 or less, 3 residents randomly 2 x weekly for 4 weeks. 3 residents 1 x weekly for 4 weeks. Beginning March 20, 2025, the Administrator, Social Services Director and Director of Health Services will review results of F600 Abuse Audit, Abuse Survey & Skin Observations during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for two months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Date of compliance: 03-13-2025	

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room and D hall, turning around and returning to the dining room. She stated the Floor Technician began to walk in the dining room and was told by NA #1 "don't touch him". The housekeeper stated that she didn't feel any resident should be treated this way. She reported it immediately to NA #2/staffing scheduler.

On 2/17/25 at 10:33 AM, Resident #10 was observed sitting up in his bed with a cup of black coffee in front of him. He was unable to recall the event of 11/12/24.

A phone interview was completed with the DON and Administrator on 2/20/25 at 1:01 PM. The DON explained on 11/12/24 she was notified by NA #2/staffing scheduler regarding the allegation of abuse witnessed by the housekeeping staff towards Resident #10. This was reported immediately to the Administrator and NA #1 was removed from the facility. The police department was notified, and the investigation began. The DON stated she assessed Resident #10, no injuries were noted and he had a calm demeanor. The Administrator and DON stated they were able to view video footage at the time that revealed Resident #10 was in the dining room at a table and NA #1 was assisting another resident at his table with the lunch meal. NA #1 was observed going to Resident #10, pulling him away from the table, tilting the wheelchair then putting it back down. She was then seen forcefully pushing the wheelchair at the double doors of the hallway and returning to the dining room. The Administrator stated that they substantiated the allegation of abuse and terminated NA #1. She said there was zero tolerance for abuse at the facility.

A phone interview was completed with the Floor

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Technician on 2/24/25 at 2:56 PM. He explained that NA #1 had no change in her demeanor during the incident on 11/12/24 and was heard telling Resident #10 "you need to quit your hollering" while she was pushing him towards the doorway. He stated that the wheelchair came to a stop on its own after rolling approximately 20 feet. He recalled Resident #10's feet were on the floor sliding with the wheelchair. He did not witness any verbalizations from the resident during the incident but stated "he had a look of surprise on his face".

A second phone interview occurred with the DON and Administrator on 2/24/25 at 3:06 PM. They explained that Resident #10 was able to self-propel with his feet when up in the wheelchair. At the time of the incident on 11/12/24 Resident #10 had his feet on the floor sliding along with the wheelchair. They stated the wheelchair came to a stop on its own. On assessment Resident #10 had a calm demeanor. They both indicated that NA #1 was slightly hostile when she was asked to leave the facility on 11/12/24. The DON stated NA #1 stated she was assisting another resident with their meal, Resident #10 kept hollering and she felt like it was bothering the other residents to the reason why she removed him from the dining room. The Administrator stated that NA #1 was approximately 5 feet 7 inches in height.

The facility was unable to provide evidence of a thorough, and complete, plan of correction regarding the facility's failure to protect a resident's right to be free from staff to resident abuse which would have allowed the survey team to evaluate if the facility would be eligible for past non-compliance.

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F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record reviews, and pharmacist and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medications (oxycodone and hydrocodone) prescribed to treat pain. This affected 6 of 6 residents reviewed for misappropriation (Residents #6, #54, #223, #55, #27, and #224. The findings included: A review of the facility policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property effective 12/1/01, revised 10/27/20 and reviewed 1/11/24, revealed it is the policy of PruittHealth and its affiliated entities to actively preserve each patient's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment and misappropriation of patient property. The Organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse, neglect, and exploitation. Further review of the policy revealed	F 602	Corrective action for the residents found to be affected by the deficient practice. On 08-11-24, a thorough investigation was conducted by the Director of Health Services into the misappropriation of narcotics for resident #6, who is now deceased, #54 still resides in facility, #223 who is deceased, #55 still resides in facility, #27 still resides in facility, #224 no longer in facility/discharged. The Director of Health Services reconciled the discrepancy for each resident affected. The nurse responsible was suspended pending investigation. The Director of Health Services reported the incident to the Drug Enforcement Administration, the local police, completed a report that was made to the state, and the nurse was reported to the North Carolina Board of Nursing. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. On 03-12-25, 100% of all residents with	3/13/25

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F 602	Continued From page 15 misappropriation of patient property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent. a. Resident #6 was admitted to the facility on 2/21/14. A review of the active physician orders for Resident #6 for August 2024 included an order dated 4/9/24 for Oxycodone-acetaminophen 5-325 milligrams (mg) tablet, one tablet by mouth twice a day; hold for sedation. A review of the controlled drug form revealed Resident #6 was signed out as receiving oxycodone-acetaminophen by Nurse #6 on 8/10/24 at 9:00 PM. Nurse #6 documented the number of pills left was 28. The corrected count completed by the Director of Nursing on 8/11/24 indicated there were 26 pills left. A review of Resident #6's Medication Administration Record (MAR) for August 2024 revealed Nurse #6 administered one oxycodone-acetaminophen tablet at 9:00 PM on 8/10/24. b. Resident #54 was admitted to the facility on 10/11/23. A review of the active physician orders for Resident #54 for August 2024 included an order dated 5/29/24 for hydrocodone-acetaminophen tablet, 5-325 mg; one tablet by mouth three times a day as needed for pain. A review of the controlled drug form revealed	F 602	narcotic medication was reviewed by Director of Health Services with no identified discrepancies. Systemic changes made to ensure that the deficient practice will not recur. The Director of Health Services trained 100% licensed nurse on proper policy and procedure on handling of medications. The Director of Health Services monitors narcotic flow records to ensure there are no discrepancies completed 03-12-25. On 03-12-25, the Director of Health Services completed 100% training to all licensed nurse on proper policy and procedures on handling of medications & medication administration. Any licensed nurse who has not received this training by 03-12-25, will receive training prior to their next scheduled shift. This education will be provided to all new licensed nurses during orientation. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services will audit for misappropriation/exploitation of medications via Misappropriation/Exploitation of medications audit: 3 random residents for 2 weeks 03-10-25 and 03-17-25. 2 random residents for 2 weeks 03-31-25 and 04-07-25. 1 random resident weekly 3 weeks for 04-14-25, 04-21-25, and 04-28-25. Beginning March 2025, the RN Treatment Nurse will review results of this monitoring during the Quality Assurance	

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F 602	Continued From page 16 Resident #54 was signed out as receiving hydrocodone-acetaminophen by Nurse #6 on 8/10/24 at 9:00 PM and at 4:00 AM on 8/11/24. Nurse #6 documented the number of pills left after the first dose was 12 and she documented the number of pills left after the second dose was 11. The corrected count on the Controlled Drug Form completed by the Director of Nursing on 8/11/24 indicated there were 9 pills left. A review of Resident #54's August 2024 MAR revealed Resident #54 did not receive hydrocodone-acetaminophen on 8/10/24 or 8/11/24. c. Resident #223 was admitted to the facility on 8/14/23. A review of the active physician orders for Resident #223 for August 2024 included an order dated 8/6/24 for oxycodone 5 mg tablet, one tablet every 8 hours as needed for pain. A review of the Controlled Drug Form revealed Resident #223 was signed out for one oxycodone tablet on 8/10/24 at 9:00 PM by Nurse #6 leaving a remaining number of pills as 26. Resident #223 was also signed out one oxycodone tablet on 8/11/24 at 4:30 AM by Nurse #6 leaving the remaining number of pills at 25. The corrected count on the controlled drug form completed by the Director of Nursing on 8/11/24 indicated there were 23 pills left. A review of Resident #223's August 2024 MAR revealed Resident #223 did not receive oxycodone on 8/10/24 or on 8/11/24. d. Resident #55 was admitted to the facility on	F 602	Performance Improvement (QAPI) Committee meetings monthly for two months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. The Director of Health Services to report any medication errors or discrepancies to the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for any additional monitoring/updates needed to maintain regulatory compliance. Date of compliance: 03-13-2025	

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1/17/24.

A review of the active physician's order for Resident #55 for August included an order dated 6/25/24 for oxycodone 5 mg tablet, one tablet four times a day as needed for pain.

A review of the Controlled Drug Form revealed Resident #55 had one oxycodone tablet signed out by Nurse #6 on 8/11/24 at 5:30 AM leaving a total of 25 pills. The corrected count completed by the Director of Nursing on 8/11/24 indicated there were 22 pills left.

A review of Resident #55's August 2024 MAR revealed Resident #55 did not receive oxycodone on 8/11/24 at 5:30 AM.

e. Resident #27 was admitted to the facility on 12/1/22.

A review of the active physician's orders for Resident #27 for August 2024 included an order dated 5/11/24 for oxycodone 5 mg tablet, one tablet every six hours as needed for pain.

A review of the Controlled Drug Form revealed that Resident #27 had one tablet signed out on 8/10/24 at 11:30 PM by Nurse #6 leaving a total of 17 pills and one signed out on 8/11/24 at 6:00 AM by Nurse #6 leaving a total of 16 pills. The corrected count completed by the Director of Nursing on 8/11/24 indicated there were 14 pills left.

A review of Resident #27's August 2024 MAR revealed Resident #27 did not receive oxycodone on 8/10/24 or 8/11/24.

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f. Resident #224 was admitted to the facility on 4/30/24.

A review of the active physician's orders for Resident #224 for August 2024 included an order dated 8/8/24 for oxycodone 5 mg tablet, one tablet three times a day as needed for pain.

A review of the Controlled Drug Form revealed that Nurse #6 signed out one oxycodone for Resident #224 on 8/10/24 at 9:00 PM leaving a total number of 18 pills left.

A review of Resident #224's August 2024 MAR revealed Resident #224 did not receive oxycodone on 8/10/24.

An initial report was submitted to the North Carolina Department of Health and Human Services Division of Health Service Regulation by Interim Administrator #3 on 8/11/2024 at 11:20 PM. The allegation of misappropriation of property was made on 8/11/2024 when narcotic discrepancies were found on six resident's narcotic records involving Nurse #6.

A review of the facility investigation completed by Administrator #3 on 8/11/2024 revealed on 8/11/2024 at 11:20 PM the Director of Health Services (DHS) was notified by Nurse #3 that Nurse #6 stated she had a migraine and was going to the emergency room. When Nurse #3 went to the unit where Nurse #6 was assigned, Nurse #3 observed medication cups filled with pills with initials written on the cups on top of the medication cart. Nurse #3 called Nurse #7 to assist her with counting the narcotic medication and reviewing pill cups; Nurse #3 and Nurse #7 were unable to account for 10 narcotic pills. No

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medications had been signed as they were given. Residents who could be interviewed denied receiving medication that evening. Following review by Nurse #3, Nurse #7, and DHS, Nurse #3 and Nurse #7 gave medications to residents in Nurse #6's assignment. The DHS reviewed the facility cameras in Nurse #6's assignment area and medication cart. Other employees were observed walking past the medication cart; nobody had touched the medication cart until reviewed by Nurse #3 and Nurse #7. DHS contacted Nurse #6 and told her she needed to return to the facility to account for the missing narcotic pills; Nurse #6 did not return to the facility at that time. A report was made with the local police department. While the police department was in the facility, Nurse #6 returned to the facility approximately an hour after speaking with the DHS and attempted to retrieve her "bag" but left the facility again as the DHS was attempting to interview her regarding the occurrence. Nurse #6 stated to the DHS, "I don't know what happened to it". Nurse #6 was suspended pending investigation. Nurse #6 went to the facility to retrieve her bag on 8/13/24. She provided a urine sample per request which showed a trace of opiate; urine sample sent per facility protocol for further review. Nurse #6 gave her verbal resignation to the Human Resources Coordinator on 8/13/24.

A review of Nurse #6's timecard for 8/10/24 revealed she was scheduled to work from 7:00 PM to 7:00 AM. According to the time captured, she clocked in at 6:50 PM and clocked out at 7:16 AM. Nurse #6's timecard for 8/11/24 revealed she was scheduled to work from 7:00 PM to 7:00 AM. According to the time captured, she clocked in at 7:05 PM and clocked out at 9:03 PM.

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A witness statement dated 8/11/24 by Nurse #3 read she was made aware Nurse #6 left the facility. The statement read around 10:00 PM she walked to the D hall and noted the medication cart was sitting at the top of the C hall with cups of pills sitting on top of the cart. The statement continued that Nurse #3 and Nurse #4 counted the cart and noted the narcotic count was off. Because of the pills on top of the cart in cups Nurse #3 called Nurse #7 to help go through the pills to see if they matched the narcotics in the cart drawer. It was noted there were 10 pills missing. The Director of Nursing (DON) was then called and made aware. The cart was not touched or any pills given off the cart until the DON arrived and counted the cart with Nurse #3. The DON took the keys and called the Administrator afterwards.

An interview with Nurse #3 occurred on 2/19/25 at 5:50 AM, and she stated she worked on the A hall the night of 8/11/24 and was training Nurse #4 regarding the medication pass. She stated Nurse #6 worked the D hall. She indicated Nurse #6 was the lead nurse that night. Nurse #3 stated Nurse #6 complained to her about having a headache and that she was tempted to take a resident's narcotic. Nurse #3 indicated she informed Nurse #6 "that would be the dumbest thing she ever did". She did not report the statement to the DON because she did not believe Nurse #6 was serious. Nurse #3 stated that Nurse #6 had called her at some point during the night and wanted Nurse #4 to pass the pills for her before she left the facility. Nurse #3 stated she informed Nurse #6 that Nurse #4 could not pass pills for her. Nurse #3 further stated she had received a text message from Nurse #7 notifying

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her that Nurse #6 left her cart and went to the hospital. Nurse #3 indicated she did not make it to the D hall until 9:00 or 10:00 PM after she finished the medication pass on the A hall. She stated Nurse #7 had pushed the cart to the top of the hall where she could watch it since the cart had cups of pills on top of it and had noted the keys to the cart were sitting on top of it. Nurse #3 stated that she and Nurse #7 counted the narcotics and noted several were not signed out and missing from multiple residents' medication cards. She indicated she called the DON to report the missing narcotics.

A witness statement dated 8/11/24 by Nurse #7 read around 8:30 PM she was approached by Nurse #6 who told her she was going to the emergency room across the street for a migraine cocktail and she would return shortly after. Nurse #7 wrote she informed Nurse #6 that her cart needed to be counted, and Nurse #7 was unable to accept the keys to the cart until this was done. Nurse #7 wrote she continued to pass the medications to the residents on the C hall. Nurse #7 further wrote between 8:45 PM and 9:00 PM she received a call from Nurse #6 stating she had left and was at the emergency room and would not be returning to the facility because she was loopy from the medications she received for her migraine. Nurse #7's statement indicated Nurse #6 had slurred speech. According to the statement, Nursing Assistant (NA) #4 notified Nurse #7 he had seen the D hall medication cart with 25-30 medication cups on top without supervision. Nurse #7 wrote she and NA #4 pulled the medication cart to the top of C hall within her sight while she continued to pass medications to the residents on the C hall. The statement continued at around 10:00 PM Nurse

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#7 was summoned to go to the D hall cart because Nurse #3 wanted to speak with her and informed her some narcotics were missing from a resident's cup. She stated Nurse #3 called the DON to make her aware of the missing narcotics around 10:15 PM.

An interview was conducted with Nurse #7 on 2/20/25 at 11:48 AM, she stated Nurse #6 had reported her head was hurting on the night of 8/11/24. She indicated one of the NAs informed her the medication cart on the D hall had a bunch of medications on top of it. Nurse #7 stated she thought Nurse #6 might be outside smoking so she pulled the medication cart to the hall where she was working so she could keep an eye on it. Nurse #7 indicated she later found out that Nurse #6 had left the facility without asking anyone to count the cart with her. She stated at some point she had received a text from Nurse #6 saying she was not going to return to the facility. Nurse #7 stated until she walked to the D hall cart, she was unaware there were cups of pills or anything laying on that cart. She indicated she also found the keys to the cart lying underneath the straws. Nurse #7 stated Nurse #3 called the DON who came into the facility. She stated the DON counted the narcotics with Nurse #3 and Nurse #7 and found a bunch of medications had been pulled but not given. After counting the narcotics, the cart was left in the DON's hands.

A witness statement dated 8/15/24 by NA #4 read on the evening of 8/11/24 he spoke with Nurse #6 who complained to him about having a headache. He wrote he was walking the halls performing his duties of "Firewatch" when he became concerned when he saw the D hall medication cart in the middle of the hall with at least 25-30 cups full of

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F 602	Continued From page 23	F 602		

pills. His statement reflected he notified Nurse #7, and she walked with him to the cart and took control of the situation where she pushed the D hall cart over to the C hall where Nurse #7 was working where the cart remained as far as he knew.

NA #4 could not be reached for an interview after multiple attempts were made.

Nurse #6 was called for an interview on 2/20/25 at 10:42 AM. After initial phone greetings and introductions she refused to be interviewed and hung up the phone.

The Director of Nursing was interviewed on 2/18/25 at 1:30 PM, and she stated she was notified by Nurse #3 on the night of 8/11/24 of the missing narcotics. The DON indicated when she arrived at the facility that night, she began an investigation of the event which included a review of the camera footage for Nurse #6's work area. The DON stated Nurse #6 came in to work her scheduled shift on 8/11/24 but left before it was finished. She indicated that Nurse #6 left her cart down the hall where she was working and that an NA noticed about 16 cups lined up on top of the cart with medications in them. She stated NA #4 reported to the nurse when he saw the medication cups and the nurses on duty counted the medications in the cart when they went to the hall. She further stated after counting, the nurses noted a significant number of narcotics were missing and the nurses called Nurse #6 to ask where the missing medications were. She stated Nurse #6 told the nurses she would be back to "handle it". The DON stated she called the Administrator to notify her of the events. The DON reported that she collected the medication

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F 602	Continued From page 24 cups full of pills from the medication cart and tried to identify the pills in the cups and to whom they might have belonged. She noted all the cups had initials written on them. She stated that Nurse #6 never could tell her what happened to the missing narcotics when she spoke with her by phone. The DON stated all the nurses know to count on and off narcotics at shift change. The nurses know if there are any discrepancies, they need to notify the DON. She further stated the nurses received medication administration training after the event. The Pharmacist was interviewed on 2/19/25 at 4:02 PM. She stated she was notified of the missing narcotics at the facility, but she couldn't recall the date she was notified. The Pharmacist stated it was "completely inappropriate". She indicated she visited the facility shortly after the event and completed a medication pass in-service with the nursing staff and taught what was appropriate and what was inappropriate when passing medications. Administrator #3 was interviewed on 2/20/25 at 12:10 PM. She stated she had just taken the interim role of Administrator a day or two before the incident occurred. She indicated the DON had notified her regarding a nurse who left mid-shift leaving medications on the cart and of missing narcotic medications. She stated the DON contacted the Drug Enforcement Administration, the North Carolina Board of Nursing and reported the incident to the State. She stated that the DON was the one who worked on the event.	F 602		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		3/13/25

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§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

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F 656	Continued From page 26 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an individualized and comprehensive care plan in the area of anticoagulant medication (Resident #25). This was for 1 of 21 residents whose care plans were reviewed. The findings included: Resident #25 was admitted to the facility on 11/23/22 with diagnoses that included congestive heart failure and atrial fibrillation. A review of the active medication orders for Resident #25 for February 2025 revealed an order for Xarelto (an anticoagulant medication) 20 milligrams, one tablet once a day for atrial fibrillation. The medication had a start date of 4/7/23. A quarterly Minimum Data Set (MDS) assessment for Resident #25 dated 1/7/25 indicated Resident #25 was cognitively intact. He was coded as receiving an anticoagulant. Resident's #25's active care plan updated 1/8/25 did not have a focus for anticoagulant medication. On 2/20/25 at 2:40 PM an interview was conducted with the MDS nurse. She verified Resident #25 did not have a focus for anticoagulant therapy on the care plan and that it	F 656	Corrective action for the residents found to be affected by the deficient practice. Based on record review and staff interviews, the facility failed to develop an individualized and comprehensive care plan in the area of anticoagulant medication (Resident #25). This was for 1 of 21 residents whose care plans were reviewed. On 02-20-25, the MDS nurse updated Resident #25□s care plan to reflect the use of anticoagulant medication. All residents with the potential to be affected: On 02-20-25, the Case Mix Director (CMD) reviewed 100% of all residents□ physician□s medication orders. The Case Mix Director (CMD) reviewed 100% of all residents□ care plans to ensure any resident on the use of anticoagulants was care planned with interventions. No corrections were required. Systemic changes implemented to ensure practice will not occur: All the Minimum Data Set/Care Plan Nurses were educated by the Administrator on 03-10-25, to ensure all residents on an anticoagulant have a comprehensive care plan in the area of anticoagulant medication.	

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F 656	Continued From page 27 should have included one. She stated that the missing medication focus was an oversight, and she would correct the care plan. The Director of Nursing was interviewed on 2/20/25 at 2:53 PM and stated that Resident #25 should have had an accurate care plan that included a focus that he was taking an anticoagulant medication.	F 656	All new Minimum Data Set/Care Plan Nurses will receive this education during orientation. Monitor corrective actions and performance: On 03-10-25, the Director of Health Services will begin auditing all new admissions and re-admissions via the Medication Reconciliation Audit to ensure all residents on an anticoagulant is care planned: 2 residents daily x 5 days week for 2 weeks. 2 residents 3 x weekly for 2 weeks. 2 residents weekly for 1 month. Beginning March 20, 2025, the Director of Health Services will review the results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Date of compliance: 03-13-2025	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, Pharmacist, and staff	F 658	Corrective action for the residents found	3/12/25

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F 658	Continued From page 28 interviews, the facility failed to follow professional standards to prepare and administer medications to residents one at a time and had pre-poured pills in medication cups left on top of a medication cart (D hall) prepared by Nurse #6 for dispensing during the 9:00 PM medication pass. This affected 13 of 27 residents residing on D hall (#40, #226, #228, #58, #54, #227, #223, #225, #7, #36, #224, #55, and #20). The findings included: A review of the facility policy titled Medication Administration: General Guidelines effective 4/1/98, revised 4/10/24 and reviewed 7/22/24 read in part under the headline titled Procedure: Medications are administered at the time they are prepared. Medications are not pre-poured/pre-set/pre-crushed. Only one patient/resident's medications are prepared and administered at a time. Only the licensed or legally authorized personnel that prepare a medication may administer it. This individual records the administration on the patient/resident's MAR (medication administration record) at the time the medication is given. At the end of each medication pass the person administering the medications reviews the paper MAR or the electronic version of e-MAR (electronic medical administration record) to ascertain that all necessary doses were administered, and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.	F 658	to be affected by the deficient practice: All affected residents (#40, #226, #228, #58, #54, #227, #223, #225, #7, #36, #224, #55, and #20) medications that were pre-poured were kept by Director of Health Services for evidence and later were destroyed. Once the Director of Health Services validated medications had not been administered, all affected residents were administered their medications as ordered. Corrective action for other residents having the potential to be affected by the same deficient practice: The Director of Health Services validated no other pre-pouring incident that night. Systemic changes made to ensure that the deficient practice will not recur: The Director of Health Services will educate 100% nurses on medication administration and no pre-pouring of medications by 03-12-25. Medication administration and no pre-pouring of medication training will be completed 100% and any nurse will be trained prior to their next scheduled shift if not in the facility. Medication administration and no pre-pouring of medications training will continue for new employees during orientation. Beginning 03-10-25, the Assistant Director of Health Services will complete random medication administration times audits for residents to ensure compliance with all medications not being pre-poured and administering one resident at a time. There have been no further pre-pouring of	

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F 658	Continued From page 29 The following residents were identified during the facility's investigation completed by the Director of Nursing (DON) as having cups of their evening medications pre-poured and left on top of the D hall medication cart. a. Resident #40 was admitted to the facility on 7/21/23. A review of Resident #40's August 2024 active physician orders revealed the following medications: -An order dated 7/25/24 for Doxepin capsule 25 milligrams (mg) 50 mg, 2 capsules by mouth at bedtime. -An order dated 8/3/24 for doxycycline hyclate capsule 100 mg, 1 capsule by mouth twice a day for 10 days to be given at 9:00 AM and 9:00 PM. b. Resident #226 was admitted to the facility on 1/18/24. A review of Resident #226's August 2024 active physician orders revealed the following medications: -An order dated 6/14/24 for atorvastatin tablet 10 mg, 1 tablet by mouth once a day at bedtime. -An order dated 6/17/24 for buspirone tablet 7.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM. -An order dated 6/14/24 for gabapentin capsule 100 mg, 1 capsule by mouth three times a day at 09:00 AM, 02:00 PM and, 09:00 PM.	F 658	medications. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services will ensure substantial compliance with medication administration through completing medication pass audits to ensure there is no pre-pouring of medications. The Assistant Director of Health Services will complete the F658 Services provided meet Professional Standards audit for residents receiving medications, during random administration times, as ordered and not pre-poured: 5 residents randomly weekly for 2 weeks, then 5 residents randomly 3 x week for 2 weeks, then 5 residents randomly weekly for 2 months. Any identified deficiency will immediately be reported to the Administrator. The Nurse with the deficient practice will have immediate corrective actions taken. Effective March 20, 2025, the Director of Health Services will review audit results at the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Date of compliance: 03-12-2025	

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-An order dated 6/14/24 for hydralazine tablet 50 mg, 1 tablet by mouth twice a day at 09:00 AM and 9:00 PM.

-An order dated 6/14/24 for magnesium oral tablet 400 mg, 1 tablet by mouth once a day at bedtime.

-An order for methocarbamol tablet 500 mg, 1 tablet by mouth three times a day at 9:00 AM, 1:00 PM, and 9:00 PM.

-An order dated 6/14/24 for metoprolol tartrate tablet 50 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

-An order dated 6/14/24 for omeprazole capsule, delayed release 20 mg, 1 capsule by mouth twice a day at 6:00 AM and 9:00 PM.

-An order dated 6/14/24 for potassium chloride tablet extended release 10 milliequivalents (mEq), 1 capsule by mouth twice a day at 09:00 AM and 09:00 PM.

-An order dated 6/14/24 for tramadol 50 mg, 1 tablet by mouth once a day at bedtime.

-An order dated 6/14/24 for Zyrtec (cetirizine) tablet 10 mg, 1 tablet once a day at 9:00 PM.

c. Resident #228 was admitted to the facility on 4/14/23.

A review of Resident #228's August 2024 active physician orders revealed the following medications:

-An order dated 1/22/24 for atorvastatin tablet 80

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mg, 1 tablet by mouth once a day at bedtime.

-An order dated 1/22/24 for duloxetine capsule, delayed release 60 mg, 1 capsule by mouth once a day at bedtime.

-An order dated 1/22/24 for ferrous sulfate tablet 325 mg (65 mg iron), 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

-An order dated 3/27/24 for Remeron oral 22.5mg tablet,1 tablet by mouth once a day at bedtime.

d. Resident #58 was admitted to the facility on 3/28/24.

A review of Resident #58's August 2024 active physician orders revealed the following medications:

-An order dated 3/28/24 for Atorvastatin tablet 40 mg, 1 tablet by mouth once a day at bedtime.

-An order dated 4/28/24 for colchicine tablet 0.6 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

-An order dated 5/29/24 for melatonin tablet 3 mg, 3 tablets (9 mg) by mouth once a day at bedtime.

-An order dated 3/28/24 for metoprolol tartrate tablet 25 mg, 1 tablet by mouth every 12 hours at 09:00 AM and 09:00 PM.

-An order dated 5/11/24 for omeprazole capsule, delayed release 20 mg, 1 tablet by mouth twice a day at 6:00 AM and 9:00 PM

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e. Resident #54 was admitted to the facility on 11/1/23.

A review of Resident #54's August 2024 active physician orders revealed the following medications:

-An order dated 3/15/24 for atorvastatin tablet 80 mg, 1 tablet by mouth once a day at bedtime.

-An order dated 6/13/24 for Colace (docusate sodium) capsule 100 mg, 1 capsule by mouth twice a day at 9:00 AM and 9:00 PM.

-An order dated 3/15/24 for Depakote (divalproex) tablet, delayed release 250 mg, 1 tablet by mouth once a day at 9:00 PM.

-An order dated 6/2/25 for Senna-S (sennosides-docusate sodium) 8.6-50 mg tablet, 2 tablets by mouth once a day at bedtime.

f. Resident #227 was admitted to the facility on 6/6/23.

A review of Resident #227's August 2024 active physician orders revealed the following medications

-An order dated 7/27/24 for benztropine tablet 1 mg, give 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM

-An order dated 7/27/24 for gabapentin capsule100 mg, 1 capsule by mouth twice a day at 9:00 AM and 9:00 PM

-An order dated 7/27/24 for potassium chloride capsule, extended release 10 mEq, give 2

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capsules by mouth every 12 hours at 9:00 AM and 9:00 PM

-An order dated 7/27/24 for senna tablet 8.6 mg, give 1tablet by mouth once a day at bedtime.

-An order for Tylenol Extra Strength (acetaminophen) tablet 500 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM

g. Resident #223 was admitted to the facility on 8/14/23

A review of Resident #223's August 2024 active physician orders revealed the following medications:

-An order dated 8/6/24 for acetaminophen extra strength 500 mg tablet, 2 tablets by mouth twice a day at 9:00 AM and 9:00 PM.

-An order dated 8/6/24 for atorvastatin tablet 40 mg, 1 tablet by mouth once a day at bedtime.

-An order dated 8/6/24 for buspirone 7.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

-An order dated 8/6/24 for doxazosin 2 mg, 1 tablet by mouth once a day at bedtime.

-An order dated 8/6/24 for duloxetine capsule, delayed release, 1 capsule by mouth once a day at bedtime.

-An order dated 8/6/24 for gabapentin caplet 300 mg, 1 caplet by mouth twice a day at 9:00 AM and 9:00 PM.

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-An order dated 8/6/24 for Seroquel (quetiapine) tablet 25 mg, 1 tablet by mouth three times a day at 9:00 AM, 2:00 PM, and 9:00 PM.

h. Resident #225 was admitted to the facility on 2/16/23.

A review of Resident #225's August 2024 active physician orders revealed the following medications:

-An order dated 2/11/23 for baclofen tablet 20 mg, 1 tablet twice a day at 9:00 AM and 9:00 PM.

-An order dated 1/19/24 for divalproex tablet, delayed release 125 mg, 1 tablet by mouth once a day at bedtime.

-An order dated 6/28/24 for ferrous sulfate tablet 325 mg (65 mg iron), 1 tablet by mouth three times a day at 9:00 AM, 2:00PM, and 9:00 PM.

-An order dated 2/9/23 for gabapentin capsule 300 mg, 1 capsule three times a day at 9:00 AM, 1:00 PM, and 9:00 PM.

-An order dated 2/11/23 for metformin tablet 1,000 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

-An order dated 2/11/23 for metoprolol succinate tablet extended release 24-hour 50 mg, 1.5 tablets twice a day at 9:00 AM and 9:00 PM.

-An order dated 3/22/23 for Vitamin C (ascorbic acid(vitamin C) tablet 500 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

i. Resident #7 was admitted to the facility on

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F 658	Continued From page 35 3/30/23. A review of Resident #7's August 2024 active physician orders revealed the following medications: -An order dated 11/8/23 for atorvastatin 10 mg, 1 tablet by mouth once a day at bedtime. -An order dated 11/8/23 for Protonix (pantoprazole) tablet, delayed release 40 mg, 1 tablet by mouth twice a day at 6:30 AM and 9:00 PM. j. Resident #36 was admitted to the facility on 4/26/23. A review of Resident #36's August 2024 active physician orders revealed the following medication: -An order written 7/25/24 for Risperdal (risperidone) tablet 0.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM. k. Resident #224 was admitted to the facility on 4/30/24. A review of Resident #36's August 2024 active physician orders revealed the following medications: -An order dated 7/29/24 for Eliquis (apixaban) tablet 2.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM. -An order dated 7/29/24 for sennosides-docusate sodium tablet 8.6-50 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.	F 658		

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l. Resident #55 was admitted to the facility on 1/17/24.

A review of Resident #55's August 2024 active physician orders revealed the following medications:

-An order written on 4/18/24 for tamsulosin 0.4 mg, 1 tablet by mouth once a day at 9:00 PM.

-An order written on 4/25/24 for trazodone 100 mg, 1 tablet by mouth once a day at bedtime.

m. Resident #20 was admitted to the facility on 1/9/24.

A review of Resident #20's August active physician orders revealed the following medications:

-An order written on 5/28/24 for calcitriol capsule 0.25 mg, take 1 capsule by mouth every 12 hours at 9:00 AM and 9:00 PM.

-An order written on 5/28/24 for docusate sodium capsule 100 mg, take 1 capsule by mouth every 12 hours on 9:00 AM and 9:00 PM.

-An order written on 5/28/24 for donepezil 5 mg, take 1 tablet by mouth once a day at bedtime.

-An order written on 6/18/24 for ferrous sulfate tablet 325 mg (65 mg iron), 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

-An order written on 5/28/24 for memantine tablet 5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

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-An order written on 5/28/24 for metoprolol tartrate 12.5 mg take 12.5 mg by mouth twice a day at 9:00 AM and 9:00 PM.

-An order written on 5/28/24 for pantoprazole tablet delayed release 40 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

-An order written on 7/8/24 for potassium chloride tablet extended release 20 mEq, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.

A review of Nurse #6's timecard for 8/11/24 revealed she was scheduled to work from 7:00 PM to 7:00 AM. According to the time captured, she clocked in at 7:05 PM and clocked out at 9:03 PM.

A witness statement dated 8/11/24 by Nurse #3 read she was made aware Nurse #6 left the facility. The statement read around 10:00 PM she walked to the D hall and noted the medication cart was sitting at the top of the C hall with cups of pills sitting on top of the cart. Because of the pills in cups on top of the cart Nurse #3 called Nurse #7 to help go through the pills to see if they matched the narcotics in the cart drawer.

An interview with Nurse #3 occurred on 2/19/25 at 5:50 AM, and she stated she worked on the A hall the night of 8/11/24 and was training Nurse #4 regarding the medication pass. She indicated Nurse #6 worked the D hall and was the lead nurse that night. Nurse #3 stated that Nurse #6 had called her at some point during the night and wanted Nurse #4 to pass the pills for her before she left the facility. Nurse #3 stated she informed her that Nurse #4 could not pass pills for her.

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Nurse #3 further stated she had received a text message from Nurse #7 later that evening notifying her that Nurse #6 left her cart and went to the hospital. Nurse #3 indicated she did not make it to the D hall until 9:00 or 10:00 PM after she finished the medication pass on the A hall. She stated Nurse #7 had pushed the cart to the top of the hall where she could watch it since the cart had cups of pills on top of it and had noted the keys to the cart were sitting on top of it. Nurse #3 stated she reported the incident to the DON who then came to the facility. She stated the DON removed the cups of pills from the cart and had Nurse #3 and Nurse #7 interview the alert and oriented residents to determine if they had received their evening medications. The DON also reviewed the camera footage of the D hall to determine if the medication pass had been done. After verifying the medication pass had not been done, Nurse #3 and Nurse #7 administered the evening medications to the residents on the D hall from their medications in the cart.

A witness statement dated 8/11/24 by Nurse #7 read around 8:30 she was approached by Nurse #6 who told her she was going to the emergency room across the street for a migraine cocktail and she would return shortly after. Nurse #7 wrote she informed Nurse #6 that her cart needed to be counted, and Nurse #7 was unable to accept the keys to the cart until this was done. Nurse #7 wrote she continued to pass the medications on the C hall. Nurse #7 further wrote between 8:45 PM and 9:00 PM she received a call from Nurse #6 stating she had left and was at the emergency room and would not be returning to the facility because she was loopy from the medications she received for her migraine. Nurse #7's statement indicated Nurse #6 had slurred speech.

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According to the statement, Nursing Assistant (NA) #4 notified Nurse #7 he had seen the D hall medication cart with 25-30 medication cups on top without supervision. Nurse #7 wrote she and NA #4 pulled the medication cart to the top of C hall within her sight while she continued to pass medications to the residents on the C hall.

An interview was conducted with Nurse #7 on 2/20/25 at 11:48 AM, she stated Nurse #6 had reported her head was hurting on the night of 8/11/24. She indicated one of the NAs informed her the medication cart on the D hall had a bunch of medications on top of it. Nurse #7 stated she thought Nurse #6 might be outside smoking so she pulled the medication cart to the hall where she was working so she could keep an eye on it. Nurse #7 indicated she later found out that Nurse #6 had left the facility without asking anyone to count the cart with her. She stated at some point she had received a text from Nurse #6 saying she was not going to return to the facility. Nurse #7 stated until she walked to the D hall cart, she was unaware there were cups of pills or anything laying on that cart. She indicated she also found the keys to the cart lying underneath the straws. Nurse #7 stated Nurse #3 called the DON who came into the facility. Nurse #7 stated she, the DON, and Nurse #3 found a bunch of medications had been pulled but not given. After counting the narcotics, the cart was left in the DON's hands.

A witness statement dated 8/15/24 by NA #4 read on the evening of 8/11/24 he spoke with Nurse #6 who complained to him about having a headache. He wrote he was walking the halls performing his duties of "Firewatch" when he became concerned after he saw the D hall medication cart in the

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middle of the hall with at least 25-30 cups full of pills. His statement reflected he notified Nurse #7, and she walked with him to the cart and took control of the situation where she pushed the D hall cart over to the C hall where Nurse #7 was working where the cart remained as far as he knew.

NA #4 could not be reached for an interview after multiple attempts were made.

Nurse #6 was called for an interview on 2/20/25 at 10:42 AM. After initial phone greetings and introductions she refused to be interviewed and hung up the phone.

The Director of Nursing was interviewed on 2/18/25 at 1:30 PM, and she stated Nurse #6 came in to work her scheduled shift on 8/11/24 but left before it was finished. She indicated that Nurse #6 left her medication cart down the hall where she was working and that an NA noticed about 16 cups lined up on top of the cart with medications in them. She stated the NA #4 reported to the nurse when he saw the medication cups and the nurses on duty counted the medications in the cart when they went to the hall. The DON reported that she collected the medication cups full of pills from the medication cart and took them to her office where she tried to identify the pills in the cups and to whom they might belong and noted all the cups had initials written on them. The DON stated she instructed Nurse #3 and Nurse #7 to administer the medications to the residents on the D hall from the medication cart once they determined the medication pass had not been completed by Nurse #6. She stated medications should not have been sitting on top of the cart without

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F 658	Continued From page 41 supervision. She further stated the nurses received medication administration training after the event. The Pharmacist was interviewed on 2/19/25 at 4:02 PM. She stated she was notified about the cups of pills sitting on the medication cart at the facility, but she couldn't recall the date she was notified. The Pharmacist stated it was "completely inappropriate". She indicated she visited the facility shortly after the event and completed a medication pass in-service with the nursing staff and taught what was appropriate and what was inappropriate when passing medications. Administrator #3 was interviewed on 2/20/25 at 12:10 PM. She stated she had just taken the interim role of Administrator a day or two before the incident occurred. She indicated the DON had notified her regarding a nurse who left mid-shift leaving medications on the cart. The facility's investigation documentation provided during the survey was reviewed. The documentation did not reveal a process for ongoing monitoring to ensure professional standards were observed and met by the nursing staff who were responsible for administering medications to residents which would have allowed the survey team to evaluate if the facility would be eligible for past non-compliance.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		3/12/25

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F 686	Continued From page 42 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, and Wound Care Practitioner and staff interviews, the facility failed to obtain treatment orders when pressure areas were identified on readmission from the hospital and nursing staff provided treatments without a physician's order. This deficient practice affected 1 of 7 residents reviewed for pressure ulcers (Resident #221). The findings included: Resident #221 was originally admitted to the facility on 3/3/23. She required hospitalization from 4/22/24 to 5/1/24 for acute stroke. Resident #221 had other diagnoses that included peripheral vascular disease, Alzheimer's disease and congestive heart failure. A nursing progress note dated 5/3/24 indicated that Resident #221 had two small skin openings noted on the buttocks. Barrier cream applied during incontinence care. A significant change in status Minimum Data Set (MDS) assessment dated 5/5/24 indicated that Resident #221 was moderately impaired with decision making skills. She required maximum	F 686	Corrective action for the residents found to be affected by the deficient practice. During the annual survey of facility, the facility failed to obtain treatment orders when pressure areas were identified on readmission from the hospital and nursing staff provided treatments without a physician's order. This deficient practice affected 1 of 7 residents reviewed for pressure ulcers (Resident #221, no longer in facility). Resident #221 was readmitted on 05-09-24. The nurse reported placing a clean dry dressing in place for pressure areas on the sacral and left heel to keep areas clean but failed to obtain an order. Resident #221 was seen by Wound Management on 05-14-24 and reported no signs of acute soft tissue infection. At that time wound care orders were provided to both areas. Corrective action for other residents having the potential to be affected by the same deficient practice. The Director of Health Services completed an audit for the look back period from 02-10-25 through 03-10-25, to	

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assistance with bed mobility and was dependent on staff for toileting hygiene and transfers. She was coded with pressure ulcer over a bony prominence and two stage two pressure ulcers.

Resident #221's care plan included a problem area dated 5/6/24 for having wounds and was at risk for deterioration in wound status or wound infection. The interventions included provide wound care as ordered and wound consult as ordered and as needed.

Resident #221 was hospitalized from 5/7/24 to 5/9/24.

A nursing progress note dated 5/9/24 indicated that Resident #221 had a wound to the sacral area and red area to the left outer heel.

A review of the hospital discharge and after visit summaries dated 5/9/24, included no treatment orders for a wound to the sacral area or red area to the left outer heel.

A review of the physician orders for Resident #221 from 5/9/24 to 5/13/24 did not include any treatment orders for a sacral wound or red area to the left outer heel.

Resident #221 was transferred to the hospital on 5/27/24 for mental status changes and did not return to the facility.

A phone interview occurred with Nurse #10 on 2/20/25 at 3:45 PM. She completed the readmission assessment on 5/9/24 and was assigned to care for Resident #221 on 5/10/24. Nurse #10 stated she couldn't recall Resident #221 or what might have happened when she

ensure all admissions and readmissions that may have had pressure ulcers/skin integrity issues were documented and orders completed for treatments. There were no areas noted.
For all residents that have the potential to be affected with skin breakdown, a 100% education with nurses was completed on 03-12-25 by Director of Health Services.

Systemic changes made to ensure that the deficient practice will not recur.
On 03-10-25, the Administrator educated the Director of Health Services and Assistant Director of Health Services on the importance of ensuring admissions audits are completed within 24 hours of admission.
The Director of Health Services educating 100% nurses on skin and pressure ulcer observation and obtaining orders for treatment: to be completed 03-12-25.
Skin and pressure ulcer observation and obtaining orders for treatment training will be completed 100% and any nurse will be trained prior to their next scheduled shift if not in the facility. Skin and pressure ulcer observation and obtaining orders for treatment training will continue for new employees during orientation.

Plans to monitor its performance to make sure that the solutions are sustained.
The Skin Integrity Nurse will audit all new admissions for 2 months to ensure skin and pressure ulcers are assessed and treatment orders are in place.
The Skin Integrity Nurse will complete the F686 Treatment/Services to Prevent/Heal

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F 686	Continued From page 44 was readmitted to the facility. Nurse #10 further explained that she no longer was employed at the facility but when a resident returned from the hospital with a wound, she would dress the area with a dry dressing to make sure it was clean. She was unable to explain why a physician order was not obtained for treatment to care for the sacral wound or left heel redness on readmission to the facility. On 2/21/25 at 11:48 AM, an interview occurred with Nurse #11 who was assigned to care for Resident #221 on 5/11/24 and 5/12/24. She was unable to recall if Resident #221 had any wounds when she returned from the hospital on 5/9/24. She explained that typically she would make sure a dry dressing was in place until a resident was seen by the wound care provider if someone returned from the hospital with any wounds. She could not recall if she had provided any wound care to Resident #221 on the days she was assigned to care for her. Attempts were made to contact Nurse #12 without success. She had been assigned to care for Resident #221 on 5/13/24. A Wound Care progress note dated 5/14/24 indicated that Resident #221 was seen for evaluation and management of a wound to the sacrum and left heel. Both wounds were classified as pressure in origin. The sacral wound was classified as a Stage 3 wound and measured 4.2 centimeters (cm) in length, 3.8 cm in width and 0.3 cm in depth. There were no signs of acute soft tissue infection. Wound care orders were provided to apply silver alginate daily. The left heel wound was classified as a deep tissue pressure injury and measured 4.2 cm in length	F 686	Pressure Ulcers audit: 3 random residents completed nursing skin assessments for 2 weeks 03-10-25 and 03-17-25. 2 random residents completed nursing skin assessments for 2 weeks 03-31-25 and 04-07-25. 1 random resident completed nursing skin assessment weekly 3 weeks for 04-14-25, 04-21-25, and 04-28-25. Beginning March 20, 2025, the Skin Integrity Nurse will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for two months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. The Director of Health Services will ensure substantial compliance with residents skin and wound conditions. Any concerns will be immediately reported to the Administrator and the Director of Health Services will take immediate corrective action. Date of compliance: 03-12-2025	

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and 4 cm in width. Wound care orders were provided to apply Betadine daily.

A review of Resident #221's physician orders included the following orders:
- An order dated 5/14/24 for Betadine to the left heel every day.
- An order dated 5/15/24 to cleanse the sacrum with wound cleanser, apply silver alginate and a foam dressing every day.

On 2/20/25 at 11:11 AM, a phone interview occurred with Wound Care Provider #1 who completed the initial evaluation for Resident #221s wounds on 5/14/24. He stated he believed there was a dressing present on the sacrum but didn't document that and was unsure what the facility was using as a treatment prior to his evaluation. He explained that Resident #221 had a stage 3 sacral wound and a deep tissue pressure injury on the left heel. At the time of the evaluation there was no concern for infection. The Wound Care Provider #1 stated he would have expected the facility to obtain wound care orders for the sacral wound and left heel wound prior to her being evaluated on 5/14/24.

The Director of Nursing (DON) was interviewed on 2/20/25 at 1:01pm via phone. She verified there was a nursing progress note dated 5/9/24 indicating that Resident #221 readmitted from the hospital with a wound to her sacrum and redness to her left heel. She stated she was unable to find a physician order for the treatment of the sacral wound and left heel redness from 5/9/24 to 5/14/24. The DON stated she had a lot of new nurses during May 2024 and was unable to explain why there was no treatment order obtained for Resident #221 when she was

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F 686	Continued From page 46 readmitted from the hospital with skin breakdown to her sacrum and redness to her left heel. The DON stated that in May 2024 she did not have a wound care nurse. She recalled being present with the Wound Care Provider on 5/14/24 and felt like there was a dressing on the sacral wound but was unable to state who or when it was placed on the sacral wound.	F 686		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		3/12/25

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	345378	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 732	Continued From page 47 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure accurate daily Posted Nurse Staffing sheets for 3 of 30 days reviewed (01/24/25, 01/27/25, and 02/07/25). The findings included: A review of the daily Posted Nurse Staffing sheets compared to the Staff Schedule/Assignment sheets from 01/18/25 through 02/18/25 revealed discrepancies in the area of actual unlicensed Nursing Assistants (NAs) that worked. On 01/24/25 during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 7 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5 unlicensed staff worked. On 01/27/25 during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 8 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5 unlicensed staff worked. On 02/07/25 during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 7 unlicensed staff worked and the Staff	F 732	Corrective action for the residents found to be affected by the deficient practice. Facility failed to ensure accurate daily Posted Nurse Staffing sheets for 3 of 30 days reviewed (01/24/25, 01/27/25, and 02/07/25). On 01/24/25, during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 7 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5 unlicensed staff worked. This inaccurate posting was secondary to the Scheduler counting unlicensed staff as 2 instead of 1 for the shift was covered with 2 unlicensed staff. This was corrected upon the Scheduler being notified during the survey. On 01/27/25, during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 8 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5unlicensed staff worked. This inaccurate posting was secondary to the Scheduler counting unlicensed staff as 4 instead of 2 for the shift was covered with 4	

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F 732	Continued From page 48 Schedule/Assignment sheet revealed 5 unlicensed staff worked. A phone interview was conducted on 02/21/25 at 11:48 AM with the NA #2/Staffing Scheduler. She verified that the daily Posted Nurse Staffing sheets compared to the Staff Schedule/Assignment sheets for 01/24/25, 01/27/25, and 02/07/25 reflected the incorrect number of unlicensed staff. She stated she was unaware she was to count 2 staff as 1 if they were splitting a shift. A phone interview was conducted on 02/21/25 at 11:55 AM with the Administrator. She stated she was unaware the daily Posted Nurse Staffing sheets were incorrect. She indicated the daily Posted Nurse Staffing sheets should accurately reflect the correct number of staff working.	F 732	unlicensed staff. This was corrected upon the Scheduler being notified during the survey. On 02/07/25, during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 7 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5 unlicensed staff. This inaccurate posting was secondary to the Scheduler counting unlicensed staff as 2 instead of 1 □ for the shift was covered with 2 unlicensed staff. This was corrected upon the Scheduler being notified during the survey. Corrective action for other residents having the potential to be affected by the same deficient practice. The Scheduler is completing an audit for the rest of the month of Feb. 2025 to the current of March to ensure accuracy of the Posted Nurse Staffing sheet vs the Schedule. Any days that require corrections will be corrected. Date of compliance: 03-12-25. Systemic changes made to ensure that the deficient practice will not recur. On 03-10-25, the Administrator educated the Scheduler on how to count each shift covered, not each unlicensed staff and the RN managing schedule on weekends. Plans to monitor its performance to make sure that the solutions are sustained. The F732 Posted Nurse Staffing Information audit will be completed by the weekend RN of the Posted Nurse Staffing	

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F 732	Continued From page 49	F 732	vs the Staff Schedule: 5 random days per week for 2 weeks, then 3 random days for 2 weeks, then 2 random days per week 1 month. Any identified deficiency will immediately be reported to the Administrator. The Scheduler with deficient practice will have immediate corrective actions taken. Effective March 20, 2025, the Weekend RN will review audit results at the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Date of compliance: 03-12-2025	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		3/12/25

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F 761	Continued From page 50 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 observations, record review, and Pharmacist and staff interviews, the facility failed to label an open and in use insulin pen with the resident's name or prescribing information that was stored in 1 of 2 medication carts (D hall cart) and the facility failed to keep unopened insulin pens refrigerated per manufacturer instructions and discard expired medications in 1 of 2 medication carts (A hall cart). The findings included: a. An observation was conducted on 2/18/25 at 11:20 AM of the D hall medication cart with Nurse #2. The observation revealed one (1) Lantus Solostar insulin pen with an open date of 2/10/25, but it did not have a label indicating the resident's name or prescribed dose for whom it was being used. An interview with Nurse #2 conducted at the same time revealed insulin pens should be labeled with the resident's name and the date it was opened. She stated insulin pens should be discarded 28 days after opening. The insulin pen was given to Nurse #2 to discard. b. An observation was conducted on 2/21/25 of the A hall medication cart at 8:15 AM with Nurse #5. The observation of the cart revealed one (1) Tresiba Flex insulin pen that was sealed and one	F 761	Corrective action for the residents found to be affected by the deficient practice: The Director of Health Services discarded the open and in use insulin pen without the resident's name or prescribing information on pen. The Director of Health Services discarded unopened insulin pens that had not been refrigerated and removed the expired medication pen. Pharmacy reissued the medication pens. Corrective action for other residents having the potential to be affected by the same deficient practice: The Director of Health Services validated no other insulin pens were unopened or expired on the other med carts. Systemic changes made to ensure that the deficient practice will not recur: The Director of Health Services will educate 100% of nurses on medication labeling and proper storage of medications by 03-12-25. Medication labeling and proper storage of medications education will be completed 100% and any staff will be trained prior to their next scheduled shift if not in the	

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F 761	Continued From page 51 (1) Lantus Solostar insulin pen that was also sealed. A blue sticker on the packages for both insulin pens stated, "refrigerate until opened". The observation also revealed an opened and available for use Lantus Solostar insulin pen that was dated 12/12/24. Nurse #5 was interviewed at the time of the observation and stated that unopened insulin pens should be stored in the refrigerator per the manufacturer's instructions until they were opened and in use. She also stated that insulin pens should be discarded 28 days after opening. The medications were given to Nurse #5 to discard. An interview was conducted with the Director of Nursing on 2/21/25 at 8:20 AM. She stated that unopened insulin should be stored in the refrigerator until it was opened and insulin pens should be labeled with the resident's name, prescribing information, and the date they were opened. She stated insulin should be discarded 28 days after opening. The Director of Nursing stated she had the third shift nursing staff check the medication carts, and she had been training the Assistant Director of Nursing to check the carts every week. She further stated that the pharmacist checked the carts when she visited every month. An interview was conducted with the Pharmacist on 2/21/25 at 10:14 AM. She stated that she visited the facility each month to review medications. She stated insulin pens should be stored in the refrigerator until they were opened per the manufacturer's instructions and opened insulin pens should be disposed of after 28 days. She stated during her visit to the facility in January this year that she had removed an insulin pen from one of the carts with a date of 12/12/24,	F 761	facility. Resident Rights/Self-Determination training will continue for new employees during orientation. Beginning 03-10-25, the Assistant Director of Health Services will complete medication audits for residents to ensure compliance with all medications labeled and stored properly during random medication administration times, as ordered. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services will ensure substantial compliance with medication administration through completing medication pass audits to ensure there is no unlabeled, expired or medications requiring refrigeration. The Assistant Director of Health Services will complete the F761 Label/Store Drugs and Biologicals audit for residents receiving medications, during random administration times, as ordered and no unlabeled, expired or medications requiring refrigeration. 5 residents randomly weekly for 2 weeks, then 5 residents randomly 3 x week for 2 weeks, then 5 residents randomly weekly for 2 months. Any identified deficiency will immediately be reported to the Administrator. The Nurse with the deficient practice will have immediate corrective actions taken. Effective March 20, 2025, the Director of	

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F 761	Continued From page 52 and that staff must have added it back to the cart instead of disposing of it. She stated that insulin pens should be labeled with a resident identifier, and the resident's name is best.	F 761	Health Services will review audit results at the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Date of compliance: 03-12-2025	