STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 survey and complaint investigation survey was conducted on 06/08/25 through 06/11/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: M1IC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 06/08/25 through 06/11/25. Event ID #M1IC11. The following intakes were investigated: NC00218674, NC00221412, NC00221499, NC00222351, NC00226866, NC00228307 and NC00229115. Two (2) of the 25 allegations resulted in a deficiency.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.	F 552		7/2/25

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

Electronically Signed | 07/01/2025

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F 552	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of psychotropic medications prior to initiation for 1 of 5 residents reviewed for unnecessary medications (Resident #32). The findings included: Resident #32 was admitted to the facility on 10/18/24 with diagnoses that included generalized anxiety disorder, and depression. The significant change in status Minimum Data Set (MDS) assessment dated 3/28/25 indicated Resident #32 was severely cognitively impaired, had no behavioral symptoms, and received antipsychotics on a routine basis only. Resident #32's Medication Administration Record for June 2025 indicated an active order which started on 6/6/25 for Lorazepam (an anti-anxiety medication) 0.5 milligrams 1 tablet by mouth as needed for anxiety for 14 days. The order had a stop date of 6/20/25. A review of Resident #32's medical record indicated no information whether Resident #32's representative was informed in advance of the risks and benefits of initiating Lorazepam. An interview with the Director of Nursing (DON) on 6/11/25 at 11:45 AM revealed they had not been getting consents on psychotropic medications other than antipsychotic medications because their current consent forms were only for	F 552	F- 552 Right to be Informed/Make Treatment Decisions 483.20 1. The facility failed to obtain consent for one resident for use of psychotropic medication use. Consent obtained for resident #32 for use of psychotropic medication on 6/19/2025 2. All residents have the potential to be affected by this deficient practice. The Director of Nursing and the Assistant Director of Nursing will complete 100 % audit of all residents receiving psychotropic medications to ensure consents are in place. Audit completed on 6/17/2025 and identified issues were corrected. 3. Education was provided to Director of Nursing by corporate Clinical Consultant on 6/27/2025 and then she provided education to all nurses to ensure consent for psychotropic medication was obtained prior to usage. This education was completed on 6/19/2025. This education will be provided to any new hires by DON/ADON . 4. Director of Nursing (DON) will conduct 5 random audits weekly to ensure all orders for psychotropic medications have a consent x 12 weeks and the results of these audits will be reported to Quality Assurance Performance Improvement meeting to evaluate the	

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F 552	Continued From page 2 antipsychotic medications. The DON stated that they had just started working on obtaining consents for psychotropic medications after their current forms were revised to include all psychotropic medications.	F 552	effectiveness. The QAPI will make recommendations/changes as needed. 5. The Administrator is responsible for ensuring this plan of correction is completed effective 7/2/2025.	
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.	F 605		7/3/25

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F 605	Continued From page 3 . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 605		

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F 605	Continued From page 4 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Nurse Practitioner (NP) interviews, the facility failed to ensure an as needed (PRN) psychotropic medication, lorazepam (medication used to relieve anxiety), had a stop date of 14 days for 1 or 5 residents reviewed for unnecessary medications (Resident #7). The findings included: Resident #7 was readmitted to the facility on 07/19/24 with diagnoses that included anxiety.	F 605	F- 605 right to be free from Chemical Restraints 483.45 1. The facility failed to ensure and as needed psychotropic medication had a stop date. Immediately this medication was reviewed and then scheduled twice daily. 2. All residents received as needed psychotropic medication have the potential to be affected by this deficient practice. The Director of Nursing	

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F 605	Continued From page 5 Review of Resident #7's physician orders dated 04/23/25 indicated lorazepam 0.25 milligrams (mg) every 8 hours as needed (PRN) for anxiety. There was no stop date. Review of Resident #7's quarterly Minimum Data Set dated 03/20/25 revealed the Resident's cognition was severely impaired and he received an antianxiety medication. Review of Resident #7's May 2025 Medication Administration Record (MAR) revealed the lorazepam 0.25 mg every 8 hours PRN for anxiety remained an active order and was administered 21 times. Review of Resident #7's June 2025 Medication Administration Record (MAR) revealed the lorazepam 0.25 mg every 8 hours PRN for anxiety remained an active order and was administered 11 times. An interview was conducted with the Nurse Practitioner on 06/11/25 at 9:34 AM. The NP explained that she typically wrote the prn psychoactive medication orders for 14 days then she would evaluate the resident's need for the medication. The NP continued to explain that Resident #7 had a lot of behaviors, so she usually wrote the lorazepam script for 30 days at a time. The NP reported she did not put the order in the system, so she did not know why there was not a 30 day stop date on the order. An interview conducted with the Director of Nursing (DON) on 06/11/25 at 11:24 AM. The DON explained that she was aware that the PRN psychoactive medications required a stop date designated by the physician and her staff were	F 605	completed 100 % audit of all as needed psychotropic medications to ensure they had stop dates. Audit completed on 6/26/2025 and no further issues noted. 3. Education was provided to Director of Nursing by Corporate Clinical consultant and then she provided education to all nurses to ensure as needed psychotropic medications have stop dates. This education was completed on 6/26/2025. This education will be provided for any new hires by the DON/ADON. The Director of Nursing provided education to providers on 14 day stop date for any as needed psychotropic medications on 7/2/2025. 4. Director of Nursing (DON) will conduct 5 random audits weekly to ensure all as needed orders for psychotropic medication will have a stop date x 12 weeks and the results of these audits will be reported to Quality Assurance Performance Improvement meeting to evaluate the effectiveness. The QAPI will make recommendations/changes as needed. 5. The Administrator is responsible for ensuring this plan of correction is completed effective 7/3/2025.	

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F 605	Continued From page 6 educated on that as well. The DON indicated it was an oversight that Resident #7's lorazepam had been effective since 04/23/25 without a stop date.	F 605		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 641	F- 641 D Accuracy of assessment 483.20	7/2/25

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F 641	Continued From page 7 facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of hospice care and medications for 2 of 6 residents whose MDS were reviewed (Resident #16 and Resident #7). The findings included: 1. Resident #16 was admitted to the facility on 3/16/22 with chronic obstructive pulmonary disease. A Hospice Initial Certification dated 1/12/24 indicated Resident #16 was certified as eligible for hospice care based on her diagnosis and current condition, and that she was expected to have a limited life expectancy of 6 months of less if the terminal illness ran its course. The benefit end date was 4/10/24. A Hospice Note Attestation dated 4/8/25 by the Hospice Nurse Practitioner indicated that she confirmed she had a face-to-face encounter with Resident #16 on 4/8/25 at 11:10 AM and that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. The quarterly Minimum Data Set (MDS) assessment dated 4/21/25 indicated Resident #16 received hospice care while a resident at the facility. However, the MDS did not indicate that Resident #16 had a condition or chronic disease that might result in a life expectancy of less than 6 months. An interview with the MDS Coordinator on 6/11/25	F 641	1. The facility failed to accurately code a quarterly Minimum data set (MDS) for the presence of a chronic condition or disease that might result in life expectancy less than 6 months and failed to code an antipsychotic medication. Assessment for resident #7 was modified on 6/11/2025 and assessment for Resident # 16 on 6/26/2025. 2. All residents have the potential to be affected by this deficient practice. The MDS nurses will complete a 100% audit of the current hospice residents to ensure accuracy of coding and 100% audit of all residents receiving antipsychotic medication to ensure accuracy of coding. Audit completed 6/26/2025 and any other noted issues were corrected. 3. Education was provided to MDS nurses by corporate consultants on 6/27/2025 using the RAI manual on Sections J & N. This education will be provided to any new MDS by the Lead MDS nurse. 4. Director of Nursing (DON) will conduct 5 random audits on the MDSs weekly to determine if it was coded accurately x 12 weeks and the results of these audits will be reported to Quality Assurance Performance Improvement meeting to evaluate the effectiveness. The QAPI will make recommendations/changes as needed.	

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F 641	Continued From page 8 at 9:28 AM revealed Resident #16's quarterly MDS was not marked in error because she didn't have the hospice recertification on hand at the time of the MDS assessment, and it wasn't uploaded into the system until 4/29/25. She stated that this was why she had marked Resident #16 for not having life expectancy of less than 6 months. The MDS Coordinator further stated that not all hospice residents had a life expectancy of less than 6 months. An interview with the Administrator on 6/11/25 at 11:52 AM revealed the information on Resident #16's MDS regarding life expectancy and hospice care should have been coded correctly. 2. Resident #7 was admitted to the facility on 07/19/24 with diagnoses that included major depressive disorder with major neurocognitive disorder due to Alzheimer's Disease. Review of Resident #7's medical record revealed an order dated 03/17/25 for quetiapine 50 milligrams (mg) by mouth twice a day for major depressive disorder with major neurocognitive disorder due to Alzheimer's Disease. Review of Resident #7's Medication Administration Record for 03/2025 indicated the Resident received 50 mg quetiapine by mouth twice a day beginning 03/17/25. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated 03/20/25 revealed the Antipsychotic Medication Review section indicated the Resident had not received antipsychotic medication since readmission/reentry or since the last assessment.	F 641	5. The Administrator is responsible for ensuring this plan of correction is completed effective 7/2/2025.	

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F 641	Continued From page 9 On 06/11/25 at 10:06 AM an interview was conducted with the Minimum Data Set Nurse who reviewed Resident #7's 03/20/25 quarterly MDS and acknowledged she had marked the wrong answer in the Antipsychotic Medication Review section when she checked NO on the MDS. The MDS Nurse explained that the correct answer should have been YES since Resident #7 was receiving an antipsychotic medication. The MDS Nurse stated she was normally very careful when completing the MDS and the error was a mistake. On 06/11/25 at 1:30 PM during interviews with the Director of Nursing and the Administrator simultaneously, the Administrator indicated she expected the MDS process to be appropriately completed.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews resident and staff interviews, the facility failed to secure an oxygen cylinder stored in Resident #11's room for 1 of 4 residents reviewed. The findings included: Resident #11 was admitted to the facility on	F 689	F- 689 D Free of Accident Hazards/Supervision/Devices 483.25 1. The facility failed to secure an oxygen cylinder stored in a residents room. Immediately upon notification from the surveyor the oxygen cylinder was stored in its proper location.	7/2/25

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F 689	Continued From page 10 09/27/24. Review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated 03/12/25 indicated the Resident's cognition was moderately impaired and she did not receive oxygen therapy. Review of Resident #11's care plan reviewed 03/12/25 indicated the Resident did not receive oxygen. Review of Resident #11's current monthly (06/2025) physician orders indicated there was no order for oxygen. On 06/08/25 at 2:31 PM an observation and interview were conducted with Resident #11 who was sitting in her wheelchair in her room. During the interview an oxygen cylinder was stored upright near the window sill that was approximately ¾ full of oxygen according to the gauge. The Resident stated she did not know why the oxygen cylinder was in her room and she did not know if she was supposed to be receiving oxygen. The Resident indicated she did not know how long the oxygen cylinder had been in her room. On 06/09/25 9:40 AM the oxygen cylinder remained stored in Resident #11's room next to the window sill. The Resident was not in her room. On 06/09/25 12:10 PM the oxygen cylinder remained stored in Resident #11's room near the window sill. On 06/09/25 12:15 PM interviews were conducted with Nurse Aides (NA) #1 and NA #2 who were	F 689	2. All residents have the potential to be affected by this deficient practice. The Maintenance director completed 100 % audit on 6/9/2025 to ensure no other cylinders were left in the residents room. Any other issues identified were corrected immediately. 3. Education was provided to all staff on proper storage of oxygen cylinders by the DON and ADON completed 6/10/2025. This education will be provided to any new member of staff during orientation. 4. The Director of Maintenance will conduct 5 random room audits weekly x 12 weeks and the results of these audits will be reported to the Quality Assurance Performance Improvement meeting to evaluate the effectiveness. The QAPI will make recommendations/changes as needed. 5. The Administrator is responsible for ensuring this plan of correction is completed effective 7/2/25 6.	

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F 689	Continued From page 11 the full time NAs responsible for Resident #11. The NAs were asked to observe the oxygen cylinder stored in Resident #11's room. The NAs acknowledged the oxygen cylinder was approximately ¾ full and explained that the oxygen cylinder should be stored in the oxygen storage room. The NAs continued to explain that the cylinder should be safely stored in a holder to protect it from falling over and potentially causing an explosion. The NAs reported the oxygen cylinder was placed on Resident #11's wheelchair when she needed the oxygen, but they indicated they could not recall how long ago that had been. NA #1 removed the oxygen cylinder and returned it to the oxygen storage room. Both NAs indicated they had not noticed the oxygen being stored in the Resident's room or how long it had been in the room. On 06/09/25 12:20 PM an interview was conducted with the Director of Nursing (DON) who explained that the oxygen cylinders should not be stored in the residents' rooms and should be secured in the oxygen storage room until they were needed.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2	F 759	F- 759 Free of Medication Error Rates 5% or more 483.45 1. The facility failed to have a medication	7/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 759	Continued From page 12 medication errors out of 31 opportunities, resulting in a medication error rate of 6.45% for 2 of 6 residents observed during the medication administration (Resident #52 and Resident #49). The findings included: 1. Resident #52 was admitted to the facility on 10/14/24 with diagnoses that included gastroesophageal reflux disease. Review of Resident #52's physician orders dated 10/14/25 revealed give metoclopramide (gastrointestinal stimulant and antiemetic) 5 milligrams (mg) by mouth before meals. An observation was made of Medication Aide (MA) #1 on 0610/25 at 8:47 AM during a medication administration of Resident #52. The MA prepared Resident #52's medications which included metoclopramide 5 mg. The MA took the morning medications to Resident #52 who was sitting on the side of her bed eating her breakfast which was approximately 50% consumed. An interview was conducted with MA #1 at 11:15 AM on 06/10/25. The MA was asked to review the metoclopramide card read the directions out loud. The MA read "to give the medication half an hour before meals" and instantly stated she did not give Resident #52 the medication before she ate that she was eating when she administered the medication that morning. The MA stated she did not read the directions close enough when she poured up the medications that morning. An interview was conducted with the Director of Nursing (DON) on 06/10/25 at 12:00 PM. The DON indicated the MA should read the	F 759	error rate of less than 5 % resulting in a medication error rate of 6.45%. Immediately we completed medication error forms and informed the family, medical director and pharmacist. Immediately this medication aide received education on medication rights. Immediately the proper dose was given. 2. All residents have the potential to be affected by this deficient practice. An audit of nurse and medication aides knowledge of Rights of Medication for Medication pass was completed on 7/1/2025. Any issue noted were addressed immediately. 3. Education was provided to this medication aide immediately by the Director of Nursing. All Nurses and medication aides received training on Medication Rights by DON and ADON. This was completed on 7/1/2025. This education will be provided to any new hires in orientation. 4. Director of Nursing (DON) and/or ADON will conduct 3 random audits on the medication passes weekly x 12 weeks to ensure medication rights being observed. and the results of these audits will be reported to the Quality Assurance Performance Improvement meeting to evaluate its effectiveness. The QAPI will make recommendations/changes as needed. 5. The Administrator is responsible for	

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F 759	Continued From page 13	F 759		

medication cards and orders closer when she passes the residents' medications.

2. Resident #49 was admitted to the facility on 03/13/23 with diagnoses that included depression.

Review of Resident #49's quarterly Minimum Data Set assessment dated 03/29/25 revealed the Resident received an antidepressant medication.

Review of Resident #49's physician orders dated 05/20/25 for escitalopram (antidepressant) 20 milligrams (mg) by mouth once a day for depression.

An observation was made of Medication Aide (MA) #1 during a medication pass on 06/10/25 at 9:01 AM. The MA prepared Resident #49's medications for administration which included escitalopram 5 mg by mouth once a day and administered the medications to Resident #49.

An interview was conducted with MA #1 on 06/10/25 at 11:20 AM. The Medication Aide was asked to review the escitalopram 5 mg medication card again. The MA removed two escitalopram medication cards from the medication cart. One card was for 5 mg and one card was for 15 mg. The MA explained that if she had read the directions on the medication card carefully she would not have made the mistake, so she would slow down and read the directions more carefully.

During an interview with the Director of Nursing (DON) on 06/10/25 at 12:00 PM the DON explained that she had already been made aware

ensuring this plan of correction is completed effective 7/ 2/2025.

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F 759	Continued From page 14 of the medication error that MA made during the medication pass. The DON indicated that the MA needed to be more careful when reading the directions on the orders and the medication cards.	F 759		