STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345526	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carolina Rehab Center of Burke	**3647 Miller Bridge Road , Connelly Spring, North Carolina, 28612**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 08/17/25 through 08/20/25. The corrective action plan was validated on 08/25/25, therefore the exit date was changed to 08/25/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D4069-H1	E0000		
F0000	INITIAL COMMENTS The survey team entered the facility on 08/17/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 08/17/25 through 08/20/25. The corrective action plan was validated on 08/25/25 therefore, the exit date was changed to 8/25/25. Event ID# 1D4069-H1. 1 of the 47 complaint allegations did result in a deficiency. Past-noncompliance was identified at: CFR 483.15 at tag F628 at a scope and severity (J) IJ began on 06/22/25. IJ removed on 07/11/25.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I	F0578		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0578 SS = D	Continued from page 1 (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and physician assistant (PA) and staff interviews, the facility failed to maintain accurate advance directives throughout the medical record for 1 of 5 residents reviewed for advance directives (Resident #46). Resident #46 was admitted to the facility on 8/7/2025. Review of an admission progress note dated 8/7/2025 indicated Resident #46 was alert and oriented to person, place, time and situation. Review of Resident #46's Physician's orders, revealed an order dated 8/7/2025 that read code status (DNR). Review of a provider progress note dated 8/8/2025 indicated Resident #46 was seen by the Physician Assistant (PA) and the PA discussed advance directives with Resident #46 and verified Resident #46 wanted to be a Do Not Resuscitate (DNR) and that a MOST form and goldenrod (DNR form) was signed.	F0578		

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F0578 SS = D	Continued from page 2 Resident #46's advance directives care plan, initiated on 8/10/2025 specified the Resident was Full Code. Care plan goals listed as: Honor residents advance directive choices, referral to physician as needed for advanced directive changes, review advance directives with resident as needed. Review of the Code Book (a binder that contained paper copies of residents' advance directives and code status) revealed Resident #46's paper medical record contained a signed Medical Orders for Scope of Treatment (MOST) form that indicated Resident #46's preference for a Do Not Resuscitate (DNR) status in the event he had no pulse and was not breathing. The form was signed by Resident #46 and dated 8/8/2025. Review of the profile page of Resident #46's electronic health record revealed Resident #46's code status was listed as a "DNR". During an interview on 8/18/2025 at 1:14 PM Nurse #4 stated a Resident's advance directives/code status was located on a resident's profile in the electronic medical record, or a paper copy in the Code Book at the nurse's station. Nurse #4 verified Resident #46 had "DNR" listed on his profile in his electronic medical record and had a MOST form and DNR form in the Code Book. During an interview on 8/19/2025 at 9:23 AM Nurse #6 stated when a resident was admitted if they don't have advance directives in place, they are a full code until advanced directives could be discussed with the resident or the residents Responsible Party (RP). Nurse #6 recalled when Resident #46 admitted, no advance directives arrived with the resident, the following day the PA had a discussion with Resident #46 and the MOST form and DNR form was completed and signed. Nurse #6 stated she thought the MDS nurses updated the advance directive care plan when a resident's code status changed. Nurse #6 stated she thought the Unit Managers passed on the change in code status. During an interview on 8/19/2025 at 10:15 AM Nurse #5 stated you could find residents' Code status in the Code Book or in their electronic medical record. Nurse #5 stated if a resident had a change in condition, the nurse was responsible for updating the new order in the computer so the resident's profile would be correct and stated it was reported at shift change. Nurse #5 stated she thought the unit managers would report the change in status. Nurse #5 stated she was not aware that an email needed to be sent to the Social Worker if a resident had a change in code status.	F0578		

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F0578 SS = D	Continued from page 3 During an interview on 8/19/2025 at 9:43 AM the MDS Nurse stated the Social Worker was responsible for updating advance directive care plans. During an interview on 8/19/2025 at 9:45 AM the Social Worker stated when a resident had a change in code status, she was normally notified by the unit manager and then updated the care plan. The Social Worker verified Resident #46's care plan read Full Code, but there was an order for DNR, and Resident #46's electronic medical record read DNR. The Social Worker stated she had not been notified of the change, but it would be corrected. During an interview on 8/19/2025 at 9:49 AM Unit Manager #1 stated an email should be sent to the Social Worker when a resident had a change in code status, so the care plan can be updated. The Unit Manager #1 stated any nurse or unit manager could send the email to the Social Worker. During an interview on 8/19/2025 at 11:13 AM the Physician Assistant (PA) stated she had a discussion with Resident #46 regarding his advance directives on 8/8/2025. The PA stated the MOST form was discussed with Resident #46 in detail and Resident #46 understood and wanted to be a DNR. The PA stated she expected a resident's code status to be correct and match throughout the entire paper and electronic medical record. During an interview on 8/19/2025 1:15 PM the Director of Nursing (DON) stated when a resident has a change in code status that typically the nurse will go in and change the order and make sure the paper forms are completed. The DON stated most of the time she was notified, and it would be discussed in the morning meeting, and the Social Worker could make needed changes to the care plan. The DON stated that any nurse or unit manager should let the Social Worker know and the nurse who changed the order was responsible. The DON stated a resident's code status should match throughout the entire medical record. During an interview on 8/19/2025 at 11:18 AM the Administrator stated she was not completely familiar with the process nursing followed for changes in resident code status, but she expected it to be correct and consistent throughout the entire medical record.	F0578		
F0628 SS = J	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2);	F0628	"Past Noncompliance - no plan of correction required"	

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F0628 SS = J	Continued from page 4 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628		

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F0628 SS = J	Continued from page 5 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F0628		

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F0628 SS = J	Continued from page 6 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan,	F0628		

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F0628 SS = J	Continued from page 7 under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and Responsible Person and staff interviews, the facility failed to ensure a resident’s Do Not Resuscitate (DNR) goldenrod form (a portable physician’s order printed on “goldenrod” colored paper that communicates an individual’s wishes regarding resuscitation efforts for emergency responders) and Medical Orders for Scope of Treatment (MOST) form (outlines health care and end-of-life care instructions) stating DNR and Do Not Intubate (DNI) (intubation is a medical procedure where a tube is inserted into the airway to support breathing) were provided to Emergency Medical Services (EMS) upon	F0628		

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F0628 SS = J	Continued from page 8 emergent transfer to the hospital on Sunday 6/22/25. As a result of the resident having no advance directive information conveyed to the hospital, the resident was listed as a full code (all possible life saving measures), was intubated and placed on a mechanical ventilator (a machine that moves air in and out of the lungs) as part of his treatment. The resident's Responsible Person stated that Resident #101 was very specific about not wanting to be resuscitated or intubated and wished to have comfort measures only due to having to previously witnessed a family member intubated and not wanting that for himself. The facility later provided the hospital with resident's DNR and MOST form paperwork, he was extubated (medical procedure where the breathing tube is removed from the airway), and comfort measures were put into place as per his advance directive wishes. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #101). Findings included: Resident #101 was admitted to the facility on Friday 6/20/25 with diagnoses including dementia, history of falls, and muscle weakness. A physician order located in the electronic health record dated 6/20/25 revealed Resident #101's code status was DNR. A telephone interview conducted with the Director of Marketing on 8/19/25 at 9:10 PM revealed she reviewed Resident #101's completed and signed original portable DNR goldenrod form and MOST form showing he was a DNR and DNI inside the facility's medical records box on 6/22/25. A change in condition progress note written by Nurse #1 dated 6/22/25 revealed Resident #101 had a change in condition that included altered level of consciousness and a fall. Resident #101 was located on the floor at his bedside, lying face down with profuse bleeding from right forehead, pressure was applied to head, and Emergency Medical Services (EMS) was called to transport the resident to the hospital emergently. Attempted to contact Nurse #1 for interview and she was unable to be reached.	F0628		

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F0628 SS = J	Continued from page 9 The EMS record dated 6/22/25 revealed EMS was dispatched for emergency response related to a fall with possible head injury. EMS arrived on the scene to find Resident #101 lying face down on the floor with staff holding pressure to the resident's head with a towel. Facility staff advised that while they were passing trays to other residents outside Resident #101's room they heard him fall and went in to find him on the floor. Facility staff stated that when they first arrived Resident #101 was awake and speaking to them and as time progressed, he became less responsive to any stimuli. Resident #101 had equal and reactive pupils but were noted to be sluggish, he would open eyes to painful stimuli but had no other responses. Vital signs were obtained and were within normal limits. Facility staff handed the crew a packet of paperwork that had a face sheet and a medication list. EMS questioned the facility staff regarding code status of Resident #101 and any related paperwork. The facility staff on scene advised that Resident #101 was full code to the best of their knowledge as they had no other paperwork. EMS confirmed and facility staff advised they had not been told or given paperwork to suggest anything other than a full code status. Resident #101 was transferred to the stretcher and secured with assistance from facility staff on scene and without incident. The hospital was notified of incoming trauma patient and updates provided. Resident #101 was monitored throughout transport with no significant changes noted. Bleeding remained controlled with no changes noted. Vital signs were monitored throughout transport with no significant changes noted. Resident #101 was transferred into room with assistance from hospital staff on scene without incident. Report was given to hospital staff on scene and facility paperwork was copied by hospital registration for staff. Attempts to contact EMS for interviews were unsuccessful. Hospital records dated 6/22/25 revealed Resident #101 presented for evaluation after an unwitnessed fall at his rehabilitation living facility. Facility staff found Resident #101 unresponsive and not communicating. Upon EMS arrival, Resident #101 was responsive to pain only and had a large scalp laceration. On hospital arrival, Glasgow Coma Scale (clinical tool used to measure level of consciousness) was 4 (score of 8 or less indicates more severe injury) and Resident #101 was promptly intubated, placed on mechanical	F0628		

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F0628 SS = J	Continued from page 10 ventilation, and stabilized. However, later when the paperwork was brought from the facility it was realized that Resident #101 was a DNR and DNI. Resident #101 was extubated, family wishes were honored, and Resident #101 was made comfort care. A telephone interview was conducted with Resident #101's Responsible Person (RP) on 8/19/25 at 4:29 PM revealed Resident #101 was admitted to the facility on 6/20/25. He stated on 6/22/25 he had just returned home from visiting with Resident #101 when he received a telephone call around 5:30 PM from Nurse #1 stating Resident #101 had fallen inside of his room, hit his head, and was bleeding from a cut on his head. He revealed Nurse #1 stated Resident #101 was being transported by EMS to the nearest hospital. The RP revealed that once he arrived at the hospital and was allowed back to see Resident #101, he observed the resident had been intubated and placed on a ventilator. He stated Resident #101 had completed his advance directives paperwork prior to being admitted to the facility and was very specific about not wanting to be resuscitated or intubated and wished to have comfort measures only due to having to watch a family member be intubated and not wanting that for himself. He (the RP) revealed they asked the hospital staff about Resident #101's DNR form and MOST form stating that he did not want to be resuscitated or intubated and the hospital staff stated they did not receive any paperwork from the facility regarding Resident #101's advance directives and as a result he was being treated as a full code (all life save measures). The RP was familiar with the Director of Marketing from the facility, so he called her (the Director of Marketing) to see if there was a way to have the facility to send over Resident #101's advance directive paperwork. The RP indicated the Director of Marketing went to the facility herself and picked up the original paperwork and brought it over to the hospital. He revealed once the hospital received the advance directive paperwork, they discussed with him (the RP) and his family if they still wanted to proceed with Resident #101's advance directive wishes. They all agreed to proceed as the resident wished, and Resident #101 was then extubated. The RP stated seeing anyone be intubated and then having to be extubated would be awful enough but having to watch his mother sit and cry while his father was being put through the procedure was something he would not wish for anyone. He revealed he did not understand why the facility did not send the advance directive paperwork for Resident # 101, especially since those had been completed prior to his admission to the facility and were his wishes.	F0628		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0628 SS = J	Continued from page 11 A telephone interview conducted with the facility Director of Marketing on 8/19/25 at 9:10 PM revealed she was familiar with Resident #101 and his family. She stated on the evening of 6/22/25 she had received a telephone call from Resident #101's RP stating the facility did not send the advance directive paperwork to the hospital that stated Resident #101 was a DNR and DNI and that because the hospital had not received the paperwork they had to treat Resident #101 as a full code, had intubated him, and placed him on a ventilator. She revealed Resident #101's RP stated he had tried to call the facility several times with no answer and asked if she could locate Resident #101's advance directives paperwork and have it sent to the hospital to show Resident #101's advance directive wishes. The Director of Marketing stated she attempted to call the facility with no answer, so she drove to the facility to locate Resident #101's advance directive paperwork and take it to the hospital herself. The Director of Marketing revealed when she arrived at the facility she did speak with Nurse #1 who stated she had sent the facility transfer paperwork with Resident #101 but did not include his advance directives paperwork as she was not able to locate them. The Director of Marketing stated after locating Resident #101's advance directives paperwork she was able to take the original forms to the hospital herself. She revealed once the hospital received the original advance directive forms, they were able to discuss Resident #101's wishes with his family and Resident #101 was extubated and placed on comfort care. The Director of Marketing revealed that to her knowledge original advance directive forms were to be placed inside of the advance directive books located at each nurse station and she did not know why the originals for Resident #101 had been placed inside of the medical record box. An interview conducted with the Administrator on 8/20/25 at 11:06 AM revealed she was familiar with Resident #101 and the incident that occurred on 6/22/25. She stated she believed Nurse #1 did send transfer paperwork with Resident #101 but was aware she did not include the advance directives. The Administrator stated Nurse #1 could not locate Resident #101's advance directives paperwork prior to him leaving for the hospital which caused Resident #101 to be treated as a full code until the facility was able to locate the paperwork and provide it to the hospital. She revealed typically when the facility had a new admission, and the advance directive was completed at	F0628		

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F0628 SS = J	Continued from page 12 the facility then the paperwork would be placed inside of the physician notebook to be signed. She stated once the advance directive paperwork was signed by the physician the paperwork was placed into the medical records box to be scanned into the resident's electronic health record, and the original was then placed inside of the advance directive notebook located at the nurse's desk. The Administrator revealed she believed Resident #101's advance directives were completed and signed prior to his admission to the facility and were placed into the medical records box to be scanned into Resident #101's electronic health record (EHR) instead of being placed inside the advance directive notebook. She stated she would expect advance directive forms to be placed inside of the advance directive notebook by the licensed nursing staff so they can be accessed. Licensed nursing staff should also make sure advance directives were sent with residents to appointments, transfers, or discharges. The Administrator stated Nurse #1 should have reviewed EHR to ensure Resident #101's code status and if she had any questions she should have contacted her supervisor. The facility was notified of immediate jeopardy on 8/20/25 at 7:04 PM. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure that Resident #101's Do Not Resuscitate (DNR) goldenrod and Medical Order of Scope of Treatment (MOST) form was sent with him upon emergent transfer to the hospital on 6-22-25 between 5:30pm and 6:00pm. He had a fall earlier in the day that resulted in a laceration to his head and had to be sent out to the hospital. The family was notified of the need to send Resident #101 to the hospital due to the fall, as well as the Medical Provider by Nurse #2. Nurse # 1 communicated to the Emergency Medical Service (EMS) staff he was a DNR but could not produce the actual DNR document for EMS staff, who then treated him as a full code. When he was treated at the hospital, initially he was treated as a full code and was intubated. The Director of Marketing later found the DNR/goldenrod and took it to the hospital around 11:30	F0628		

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F0628 SS = J	Continued from page 13 pm when it was located. We were unable to determine who actually put the documents in the medical records box, however only licensed nursing staff receive and process the admission packet. The DNR had been put in the medical records box to scan into the record, but because of the patient being admitted around 6:15PM on Friday the 20th, it was not scanned into the medical record and then placed in the DNR binder at the nurses' station therefore at the time of the emergent need, it was not available. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with a code status of "Do No Resuscitate" and "Do Not Intubate" were at risk with this deficient practice. All residents with code status were audited by reviewing the Physician's order for the patient's code status in the electronic medical record against the documents contained in the DNR book located at each nurses' station on 7-10-25. This was completed by the Director of Nursing (DON) to ensure that the DNR/goldenrod and MOST Form is available in the DNR book. No negative findings noted upon completion of the audit for code status. An Audit for advance directives including FULL CODE/ DNR and/or MOST forms was completed on 7-10-25 by the Director of Nursing and ongoing with any new admissions /readmissions/ significant changes. The audit was performed by checking the current patient charts in the facility for advance directive orders for FULL CODE/ DNR and MOST form. If it was indicated for the resident to have a DNR and/or MOST form, there was an audit of the original forms that are kept in DNR book to ensure that the orders and the DNR and/or MOST forms matched. No other discrepancies were found. All orders for DNR and/ or a MOST form matched with the resident order indicated. The DNR/MOST Book contains the DNR and/ or MOST form and are located at each nurses station. All Advance Directives are also scanned in the Medical Records under the Document Tab by the Medical Records Coordinator. Code status for each patient whether DNR or Full Code are in the electronic Physician orders and is visible under the information bar on the electronic Medication Administration Record (eMAR) and the electronic Kardex. The medical record box was checked and there were no	F0628		

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F0628 SS = J	Continued from page 14 DNRs and/ or MOST forms in the box waiting to be uploaded to the medical record by the Director of nursing on 6-23-25 and continues daily. The Director of Nursing or designee also checks this box on the weekends and after hours by coming in or calling the facility. All new admissions/readmissions/ significant changes after the 100% audit completed on 7-10-25 were audited for compliance by the DON from 7-11-25 onward and continues at this time. Director of Nursing also completed an audit of all admissions/re-admissions/significant changes from the last 30 days (6-11-25 to 7-10-25) to identify any issues with the DNR and/or MOST form not being available. Quality Assurance and Process Improvement (QAPI) determined that the root cause was placing the original copy of the DNR in the Medical Record Box instead of placing the original in the DNR/MOST book when reviewed on 6-26-25 during QAPI. Therefore, the new process of copying the original DNR and / or MOST form to put in the Medical Records Box instead of the original will alleviate not having the original readily available to be sent for any transfers. No other emergent transfers were affected as evidenced by no issues reported to the facility and documents in the eMAR. An audit of all emergent transfers to the hospital was completed for the last 30 days to validate there were no issues was also completed by the Director of Nursing on 7-10-25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Education will be completed by 7-10-25 by Director of Nursing for all licensed nurses to ensure that if a patient comes in with a DNR/Goldenrod and /or a MOST form upon admission, it is immediately placed in the DNR book, and a copy is provided to medical records. If a patient transfers out of the facility for a medical need, the original Goldenrod and/or MOST form must accompany that patient to the hospital. The Director of Nursing used the following education based on nursing policy and procedure #303. The DON provided the following education to all licensed nurses: 1. If a resident admits with a signed DNR and /or MOST, a copy of the DNR is to be made and placed in the medical record box for uploading instead of the	F0628		

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F0628 SS = J	Continued from page 15 original form. 2. The ORIGINAL DOCUMENT is to then be placed in the DNR book immediately located at each nurse's station. 3. If the patient is transferred out for any reason, the ORIGINAL DOCUMENT will be sent with the patient Based on #1 education listed above, the process of having a copy of the DNR and/ or MOST form to be placed in the medical record box for uploading will ensure having the DNR and/ or MOST form also noted in the medical record aside from the original being in the DNR book located at each nurses' station. Not putting the original copy in the medical record box for uploading will ensure that the original is not lost and is readily available in the DNR Book for any transfers. The code status will be placed on the 24- hour report sheet by the admitting licensed nurse upon admission/ readmission or any significant changes. The licensed nurse will verify the DNR and / or MOST status, then update the physician order in the medical record. The licensed nurse will then place the original copy in the DNR Book at the nurses' station and update the 24- hour report sheet that nurses utilize when giving shift reports. Licensed nursing staff were educated by the Director of Nursing began on 6-30-25 with completion by 7-10-25. The orders are reviewed by the nursing leadership team (consisting of the DON, SDC, Unit Manager #1 and Unit Manager #2) during the Monday to Friday clinical morning meeting and update the DNR Book and the report sheets at that time as needed. The Night Supervisor and Weekend Supervisor and On-call Nurse will review and report to DON as needed for any off hours and weekend admissions/readmissions / significant changes. The Regional Director Clinical services (RDCS) provided this education on 6-30-25. Licensed floor nursing staff, including any nurse manager or nurses assigned to a cart who has not received education by 07/10/25 will not be allowed to work until education is completed. Education will be provided by the Director of Nursing or designee. A roster of all licensed staff maintained by the Director of Nursing are checked off as they are educated. Any PRN (as needed by licensed staff) or agency licensed nurse working within the building must acknowledge understanding prior to working their shift	F0628		

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F0628 SS = J	Continued from page 16 as evidenced by being able to state the location of the DNR Binder and awareness of sending the DNR and /or MOST form with any transfers. The education will be completed by the Director of Nursing or designee prior to their first shift. New licensed floor nursing staff will receive education within the orientation process by the Staff Development Coordinator (SDC) or designee. The Director of Nursing informed the SDC of the need to include this in orientation class for any licensed nurse on 7-9-25 to start with the next orientation class. Any PRN (as needed licensed staff) and agency licensed nurse working within the building must acknowledge understanding before working. Each new licensed employee will be able to state their awareness of following process #1 to #3: 1. If a resident admits with a signed DNR and /or MOST, a copy of the DNR is to be made and placed in the medical record box for uploading instead of the original form. 2. The ORIGINAL DOCUMENT is to then be placed in the DNR book immediately located at each nurse's station. 3. If the patient is transferred out for any reason, the ORIGINAL DOCUMENT will be sent with the patient Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Quality Assurance and Process Improvement (QAPI) meeting was held on 6-26-25 with the Interdisciplinary Team (IDT) that consists of the Administrator, Medical Director, Director of Nursing, Discharge Director, Medical Records Director, Dietary Manager, Director of Rehabilitation, Minimum Data Set (MDS) Nurse, Human Resource Manager, Activities Director). The IDT team determined that a Plan of Correction was needed and developed the Plan of Correction for approval to follow for QAPI to ensure monitoring and compliance. The IDT team decided to audit and monitor FULL CODE /DNR /MOST documents in the DNR/MOST book and in the Electronic Medical Record for all new admissions/readmission / significant changes daily for 4 weeks, then 5 times per week for 4 weeks, then 3 times per week for 4 weeks for 4 weeks to ensure ongoing compliance. The audit will be completed by matching the Physician order for all code status to the electronic medical record and the DNR/MOST book located	F0628		

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F0628 SS = J	Continued from page 17 at each nurse's station. The DON or designee will complete the required audits as outlined above. Results will be reviewed upon completion of audits with QAPI team monthly for the next 3 months minimum to determine success and potential need for continuation or until substantial compliance is achieved. Alleged Date of Immediate Jeopardy Removal and Compliance: 7/11/25 The facility's corrective action plan was validated on 8/25/25 by the following: Interviews with licensed nursing staff, admissions coordinator, Director of Marketing, Social Worker, and medical records revealed they had received education on resident advanced directives paperwork. They stated when a new admission arrived at the facility with completed advanced directive paperwork, a copy of the paperwork was to be placed inside the medical records box to be scanned into the resident's electronic health record (EHR) and the original was to be placed inside of the advanced directive notebook located at each nurse desk. They revealed if a resident completed their advanced directive paperwork upon their arrival to the facility or anytime during their stay at the facility the original paperwork was to be placed inside the physician notebook located at each nurse desk and then once signed by the physician the original would then be placed inside the advanced directive notebook and a copy of the paperwork placed inside the medical records box to be scanned into the resident's EHR. They stated the original advanced directive was to be sent as part of the facility packet anytime a resident was leaving the facility for an appointment, transfer to the hospital, or discharged from the facility. They were able to demonstrate the process, and observations were made of all residents original advanced directive forms located in the advanced directive notebook at each nurse desk and copies of advanced directives were located inside the medical records box waiting to be scanned into the resident's EHR. Review of facility orientation education for new hires and contract staff included education on advanced directive process. Reviewed the audit and monitoring tools with no issues noted. Interviews with the Administrator and the DON revealed they had received training from their corporate regarding the advanced directive process and making sure all original advanced directives were placed inside the advanced directive notebooks, copies were placed inside the medical records box for scanning, only advanced directives that needed a physician signature were placed inside the physician	F0628		

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F0628 SS = J	Continued from page 18 notebook, and original advanced directive was included with facility paperwork for any resident appointments, transfers, or discharges. The facility's immediate jeopardy removal date and compliance date of 7/11/25 was validated.	F0628		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(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(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(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, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F0732		

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F0732 SS = C	Continued from page 19 §483.35(i)(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 and observation, the facility failed to post census information for 322 of 323 days reviewed for daily nurse staffing (October 2024, November 2024, December 2024, January 2025, February 2025, March 2025, April 2025, May 2025, June 2025, July 2025 and 8/1/2025-8/19/2025). Review of the daily nurse staffing sheets from 10/1/2024 through 8/18/2025 revealed there was no census information entered. Observation of the daily nurse staffing sheet dated 8/19/2025 revealed the census was entered. During an interview on 8/19/2025 at 11:30 AM the Scheduler stated she was responsible for completing and posting the daily nurse staffing sheet. The Scheduler stated she had been in her current position for about two years and was not aware until 8/19/2025 that the census needed to be completed on the daily nurse staffing sheet and the Director of Nursing (DON) had informed her this morning that the census needed to be completed on the daily nurse staffing sheet for all three shifts. The Scheduler stated she had completed the census section today and would continue to fill the form out completely. During an interview on 8/19/2025 at 1:00 PM the DON stated she was not aware the census had to be completed for all three shifts, or that it had not been completed on any daily nurse staffing sheets since 10/1/2025. The DON stated the Scheduler would enter the census on the daily nurse staffing sheets from now on. During an interview on 8/19/2925 at 1:15 PM the Administrator stated she was unaware the census had not been entered on the daily nurse staffing sheets. The Administrator stated she thought it was adjusted throughout the day as residents were admitted and discharged. The Administrator stated she expected the daily nurse staffing sheets to be filled out completely and correctly.	F0732		
F0761 SS = D	Label/Store Drugs and Biologicals	F0761		

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F0761 SS = D	Continued from page 20 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to discard expired vials of influenza vaccine in 1 of 3 medication rooms (Jasmine medication room), failed to date an opened insulin pen and discard loose pills in 1 of 4 medication carts (Dogwood medication cart). The findings included: 1.An observation of the Jasmine medication room with Unit Manager (UM) #1 on 8/19/25 at 1:50 PM revealed five unopened vials and two opened vials of influenza vaccine labeled with an expiration date of 6/30/25. These influenza vaccine vials were available for use in the medication room refrigerator. An interview with UM #1 on 8/19/25 at 1:58 PM revealed the Infection Preventionist or the third shift nurses were responsible for checking the medication room for expired medications. UM #1 stated she knew they had just ordered some influenza vaccine from the pharmacy for the upcoming flu season. During the interview,	F0761		

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F0761 SS = D	Continued from page 21 further observation of the pharmacy label on the bag which contained the expired influenza vaccine vials indicated the vials were delivered to the facility from the pharmacy on 11/7/24. UM #1 stated the expired vials should have been sent back to the pharmacy after they expired. An interview with the Infection Preventionist (IP) on 8/20/25 at 10:20 AM revealed she had just checked the medication rooms on 8/17/25 and she did not observe the expired influenza vials inside the Jasmine medication room refrigerator. The IP stated she checked the medication rooms for expired medications at least once a week or as needed whenever a resident was discharged. She stated that she would have gotten rid of the expired influenza vials if she had observed them during her weekly audits. An interview with the Director of Nursing (DON) on 8/20/25 at 10:30 AM revealed the IP cleaned out the medication rooms weekly and whenever there were discharges. The DON stated the IP normally looked for any expired medications and she would return them to the pharmacy or destroy them if they could not be returned. The DON further stated that she was surprised about hearing about the expired flu vials because the IP told her that she had just checked the Jasmine medication room, and they had not given a flu shot since May 2025 because it was not flu season. 2.An observation of the Dogwood medication cart with Nurse #1 on 8/19/25 at 1:59 PM revealed an undated opened Insulin lispro pen available for use in the top drawer. Review of the manufacturer's instruction for Insulin lispro indicated it expired 28 days after opening, whether it was in a vial, cartridge, or pen, as long as it was stored at room temperature. After 28 days, any remaining insulin should be discarded, even if it still looks and feels normal. Further observation of the Dogwood medication cart revealed a plastic cup with a handwritten resident name containing 18 loose pills stored inside the narcotic drawer. An interview with Nurse #1 on 8/19/25 at 2:00 PM revealed she didn't notice the undated open pen of Insulin lispro, but that it should have been dated when it was opened because it expired 28 days after opening. Nurse #1 stated she was not aware of the loose pills in the narcotic drawer and did not notice them whenever she counted the narcotics with the outgoing nurse. Nurse #1 stated the loose pills looked like morning	F0761		

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F0761 SS = D	Continued from page 22 medications for Resident #124 but denied that she placed the loose pills in the narcotic drawer and that she gave Resident #124 his morning medications. An interview with the Director of Nursing (DON) on 8/20/25 at 10:30 AM revealed the insulin pen should have been dated when it was opened because it was only good for 28 days after opening. The DON stated that the nurses were not supposed to keep loose pills in the medication carts, and that the nurses were supposed to be checking the medication carts daily.	F0761		