STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345561	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Fuquay-Varina	**410 S Judd Parkway SE , Fuquay Varina, North Carolina, 27526**

(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
F0000	INITIAL COMMENTS The survey team entered the facility on 12/3/25 to conduct a complaint investigation survey and were unable to return to the facility on 12/5/25 due to adverse winter weather threats of freezing rain/ice causing unsafe travel conditions. Additional information was obtained on 12/5/25 and 12/8/25. The survey team returned to the facility on 12/10/25 and completed the survey on 12/10/25. Therefore, the survey exit date was changed to 12/10/25.Event ID 1DD306-H1. The following intakes were investigated: 2674032, 2623373, 2644604, 2608801, 2669426, 2673789, 2640774, 2622841, and 2608760. Three of eighteen complaint allegations resulted in deficiency.	F0000		12/19/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	"Past Noncompliance - no plan of correction required"	12/19/2025

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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F0550 SS = D	Continued from page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a resident was treated respectfully when a Nurse Aide was using her personal cell phone rather than responding to a resident's verbal yell for help and the activation of his call bell. This was for 1 of 15 sampled residents (Resident # 15). The findings included: Resident # 15 resided at the facility from 11/13/25 to 11/20/25. The resident was 92 years of age. Review of Resident # 15's 11/13/25 hospital discharge summary revealed the following information. Resident # 15 had undergone left hip surgery in February 2025 for a broken hip. He was admitted to the hospital again on 11/10/25 where he was identified to have a left acetabular fracture (a fracture in the socket in the left pelvis that forms the hip joint with the femur (leg bone) and also a sacral ala fracture (a fracture in the portion of the sacrum at the base of the spine and which can cause buttock and low back pain). Resident # 15 underwent conservative treatment and no surgery. Review of Resident # 15's 11/16/25 admission Minimum Data Set Assessment, dated 11/16/25, revealed the resident was moderately cognitively impaired. He required substantial to maximum assistance to turn in bed. He received pain medication. Review of Resident # 15's November 2025 Medication	F0550		

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F0550 SS = D	Continued from page 2 Administration record revealed Resident # 15 received a prescribed dose of Oxycodone on 11/16/26 at 9:30 AM by Medication Aide # 2 for a reported pain level of “6” on a pain scale of 1 to 10. Resident # 15’s family member was interviewed on 12/4/25 at 10:05 AM and reported the following information. He had arrived on 11/16/25 and could hear Resident # 13 yelling for help 200 to 300 feet before he reached the room. He could hear Resident # 13 yelling before he even passed the nursing desk. When he passed the nursing desk there was a staff member sitting at the desk who was “in some other world.” She had her head down and was looking at her phone and ignoring Resident # 15’s yelling. The staff member was so engrossed in her phone that she did not even see him (the family member) pass by. After arriving to Resident # 15’s room, he (the family member) found that the resident needed to be made comfortable and use the bathroom. He thought if the staff member ignored the verbal yelling, then the staff member would respond to the call light. He (the family member) turned on the call light. The call light stayed on for about 13 to 14 minutes. He tried to calm Resident # 15 down. No one came to assist Resident # 15. He approached the nursing desk and the same staff member, who he had passed at the nursing desk, was still seated at the nursing desk on her personal phone. He “called her out” for not doing her job. Two other staff members arrived and one of them went to take care of Resident # 15’s needs. One of the staff members whispered to him that, “She does this all the time” referring to the staff member who had been on her phone while Resident # 15 needed help. Nurse Aide # 2 (NA # 2) was interviewed on 12/4/25 at 9:05 AM and reported the following information. She had been working on another unit on 11/16/25 but she was passing by Resident # 15’s Nursing Station when she saw the call light was on in Resident # 15’s room. The resident was yelling, “help me, help me, get me up.” She saw a family member come out of the room and approach the nursing desk. At the time that the call light was on and Resident # 15 was yelling for help, NA # 4 had been at the nursing desk and using her personal phone. She had not attempted to go check on the resident. The family member started talking to NA # 4 and NA # 4 still did not go check on the resident. Instead NA # 4 cursed at the family member. Therefore, she (NA # 2) went to check on Resident # 15. She knew he had a fracture and seemed to be in pain and uncomfortable in the bed. She helped reposition him and meet his needs and then the resident stopped yelling. He was okay after care was rendered.	F0550		

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F0550 SS = D	Continued from page 3 Medication Aide # 2 was interviewed on 12/4/25 at 9:30 AM and reported the following information. She did not care for Resident # 15 “a lot” but she knew the resident would yell. She thought this was because of pain. On 11/15/25 she heard loud voices and was on the adjacent hall from Resident # 15’s hall. She went to the desk and saw that Resident # 15’s light was on. NA # 4 was at the desk and on her phone. The phone was a personal device and NA # 4 was not charting. Resident # 15’s family member was there and reported that the call light had been on for “awhile.” Nurse Aide # (NA) # 4 was interviewed on 12/5/25 at 11:19 AM and reported the following information. Resident # 15 was experiencing pain on 11/16/25 before she got him dressed. She had told the Medication Aide. She did not recall the specific Medication Aide. She assisted Resident # 15 up to the chair that morning and he yelled his “butt was hurting.” She therefore put him back in bed. She went to lunch. She came back from lunch and was entering the nursing station when Resident # 15’s family arrived at the nursing desk and wanted to know who she was and to which hall she was assigned. She was putting her personal phone down when she came into the nursing station. Resident # 15’s family member reported Resident # 15’s call light had been going off. She did not hear Resident # 15 yelling for help and she did hear the call light go off. She was not the one who went to care for Resident #15 that day. It was her intent to go and check on Resident # 15 but didn’t because the family member called her a name. During an interview with the Director of Nursing on 12/4/25 at 2:24 PM the DON reported that Resident # 15’s family member had reported Nurse Aide # 4 for failing to attend to Resident # 15 while she was on her personal phone. There were witnesses and Nurse Aide # 4 was terminated. During an interview with the Administrator on 12/8/25 at 12:38 PM the Administrator reported that the facility had taken correction action to ensure that all residents were treated in a dignified manner. The Administrator 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. On 11/16/2025 NA #4 was sitting at the nurse's station on her phone while resident #15 was yelling for help, and his call light was activated. NA #2 was on the hall, and she went into the resident’s room to answer	F0550		

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F0550 SS = D	Continued from page 4 his call light. NA #2 took care of the residents' needs while she was in the room. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 11/17/2025, the Unit Managers talked to residents on each unit to determine if their needs were met. No concerns were noted. On 11/17/25 the department heads completed angel rounds and communicated any identified concerns during the stand-up meeting. Angel rounds are completed Monday through Friday. Each room has an assigned department head who visits the room daily. During the rounds the department head monitors call bell location and response and listens for interactions between staff. All nurses' notes, physician orders, vital signs, x-ray and lab results are reviewed for previous 24 hours. This will help identify any residents who are not able to say they have a problem. The angel rounds were used to identify other at-risk residents in the facility. The initial audits did not indicate that any other residents had not been treated respectfully. On 11/24/25 the Unit Manager began a call light audit, to ensure lights are answered timely and residents' needs are met. During the audit it was identified that the call light response time was greater than 10 minutes. Verbal re-education was completed with identified staff. In April 2025, staff were educated on the use of cell phones. Education continues to be ongoing. Any staff who continue to use cellphones in inappropriate areas will be re-educated, and disciplinary action may be initiated. Ongoing observations by nursing administration and department heads provide continued monitoring of staff use of personal cell phone devices at nurses' station and resident care areas. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The daily angel rounds (Monday-Friday) will be used to identify any resident at risk for being treated disrespectfully, any dignity concerns, and call light not being answered in a timely manner. Managers will bring the Angel rounds to Morning meeting to address concerns. Unit manager and ADON, will complete call light audit, to ensure lights are answered timely and residents'	F0550		

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F0550 SS = D	Continued from page 5 needs are met, and free from any dignity concerns. If there are concerns identified the Unit manager, and ADON, and the Director of Nursing will address each concern individually, using 1:1 education, and including disciplinary action. The QAPI (Quality Assurance Performance Improvement) team met on 11/19/2025 and initiated a corrective action plan on call bell response time and dignity. The following members of the committee were present: Administrator, Director of Nursing, Regional Director of Clinical Services, MDS Coordinator, Recreation Director, Director of Rehabilitation, Pharmacist, Medical Director, Business Office Manager, Assistant Business Office Manager, and Unit Manager. The Unit Manager and RN supervisor began in-service education on 11/18/2025. The following topics were covered in education: answer call bells in a timely manner, give respect, speak kindly to our residents, staff to follow through with resident requests, and give PRN (as needed) pain medication when requested per order frequency. Staff who have not completed the training by 11/26/2025 were not allowed to work until they completed the training. The DON and ADON are designated to keep up with ongoing training. A data collection audit tool will be used to monitor that call lights are being answered in a timely manner and residents are free of any dignity issues. The Unit Managers will complete audit for 10 random residents 5 times per week for 2 weeks, then 3 times per week for 2 weeks, then 2 times per week for 4 weeks beginning 11/24/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. A data collection audit tool will be used to monitor that call lights are being answered in a timely manner and that residents are free of any dignity issues. The Unit Managers will complete the audits for 10 random residents 5 times per week for 2 weeks, then 3 times per week for 2 weeks, then 2 times per week for 4 weeks 11/24/25. The QAPI team met on 11/19/25 and initiated a corrective action plan on call bell response time and dignity. The following members of the committee were present: Administrator, Director of Nursing, Regional Director of Clinical Services, MDS Coordinator, Recreation Director, Director of Rehabilitation, Pharmacist, Medical Director, Business Office Manager,	F0550		

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F0550 SS = D	Continued from page 6 Assistant Business Office Manager, and Unit Manager. A summary of audit results will be presented by the Director of Nursing monthly for three months to ensure continued compliance. Compliance date: 11/26/25. The facility's corrective action plan was validated by the following: On 12/3/25, beginning at 8:25 AM an initial tour of the facility was conducted during which multiple residents and a family member were interviewed. Residents and the family member reported no concerns with staff treating residents respectfully. Although not all inclusive of interviews one randomly interviewed resident reported, "I am so thankful to the Lord to be in such a wonderful place." Staff members were observed during the survey, which began on 12/3/25, to interact with residents in a respectful manner and be responding to call bells and residents' requests for assistance. The facility provided documentation of their in-service and audits. Staff members were interviewed and reported they had received training regarding dignity, and they were knowledgeable that the facility's policy was that they were not to be on their personal phones when they were accountable for responding to residents' needs. One of the staff members, who was interviewed, was a staff member designated to make "Angel Rounds." This staff member reported he checked on his assigned residents daily, talked to them about any concerns and observed staff interactions with his assigned residents' needs. The facility's corrective action plan compliance date of 11/26/25 was validated.	F0550		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0602	F-602 Misappropriation/Exploitation 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The med cart (where the suspected diversion occurred) was counted by two-unit managers on 9/12/2025. Resident #1 was assessed for pain on 9/12/25 by the hall nurse. She initially did not complain of pain but was later administered Oxycodone 5mg at 1:43 PM.	12/29/2025

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F0602 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to protect a resident's right to be free from misappropriation. This was for 1 of 1 sampled resident who was reported to have possible diversion of her pain medication (Resident #2). The findings included: Record review revealed Resident # 2 resided at the facility from 9/11/25 until 9/23/25. According to Resident # 2's hospital discharge summary Resident # 2 had undergone surgical repair of a fractured femur on 9/4/25 and was transferred to the facility for rehabilitation. The resident also had a diagnosis of dementia according to the discharge summary. Facility admission orders included Oxycodone 5 mg (milligrams) every six hours as needed for pain. Additionally, Resident # 2 was ordered to receive Acetaminophen 500 mg (milligrams) on a scheduled basis every eight hours for 10 days. Review of pharmacy delivery records revealed on 9/12/25 at 4:20 AM 28 tablets of Oxycodone 5 mg were delivered and received by the facility. Review of Resident # 2's September 2025 MAR (Medication Administration Record) revealed Nurse # 13 signed she administered Oxycodone 5 mg to Resident # 2 on 9/11/25 at 9:44 PM and again on 9/12/25 at 3:46 AM. Resident # 2's controlled drug receipt record was reviewed. (A controlled drug receipt record contains documentation of all controlled medication pills that are removed from storage. Nurses are required to sign the date and time when controlled medications are removed from storage, the amount of controlled pills removed, and sign their name on the controlled drug receipt sheet. The number of pills on the drug receipt record is then reconciled at the end of each shift when another nurse becomes accountable for the controlled medications by counting and reviewing the sheets with the actual number of pills in locked storage). A review of Resident # 2's Oxycodone controlled drug receipt record revealed the number of tablets that were labeled by the pharmacy had been marked through. Nurse # 13 had signed at the top of the controlled drug receipt record that the initial count of pills was 26 rather than the 28 that had been delivered from the pharmacy. On 9/11/25 Nurse # 13 signed that she removed 2 tablets at 9:30 PM from Resident # 2's Oxycodone supply which then	F0602	Continued from page 7 An initial report was filed with NCDHHS (North Carolina Division of Health and Human Services) by the DON (Director of Nursing) on 9/12/25, DEA (Drug Enforcement Administration) on 9/12/25 and NCBON (NC Board of Nursing) on 10/27/25. On 9/12/25 the Board of Nursing Probationary Oversight contact person was notified Nurse #13 was suspended due to narcotic diversion allegation. The local police department was notified on 9/12/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All remaining medication carts were counted on 9/12/25 by the unit managers and no discrepancies were noted. The DON reviewed all declining count sheets on 9/13/25 with no other suspicions of diversion noted. The RDCS (Regional Director of Clinical Services) reviewed all declining count sheets and Medication Administration Records to ensure that they matched on 9/15/2.5. No further discrepancies were noted. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. A Diversion QAPI (Quality Assurance and Performance Improvement) plan was initiated on September 16, 2025. The following members were present: Administrator, DON, Activities Director, Medical Records, Business Office Manager, Central Supply, Dietary Manager, Maintenance Director, Staffing Coordinator, Director of Rehab, and Assistant Business Office Manager. On 9/16/2025 the QAPI team met and decided to initiate a corrective action plan. The SDC (Staff Development Coordinator) and DON began education for all licensed nurses and medication aides on 9/12/25. The education topic included: diversion, the definition and consequences of diversion, how to correctly complete a declining count sheet and counting medication carts every shift. Abuse education for all staff to include misappropriation will be completed by the SDC by December 29, 2025. No one will be allowed to work until education is completed. HR personnel and department heads will be in-serviced that any applicant with substantiated abuse, neglect,	

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F0602 SS = D	Continued from page 8 left 24 tablets. On 9/12/25 at 3:50 AM, Nurse # 13 signed that she removed two tablets from Resident # 2's supply which then left 22 tablets. Therefore, the accounting sheet showed that during Nurse # 13's shift six tablets from Resident # 2's 28 dose supply had been removed while Nurse # 13 worked with Resident # 2 and four of these tablets which were removed were at a documented time on the accounting sheet prior to the Oxycodone being delivered to the facility (which was at 4:20 AM). Nurse # 10 was interviewed on 12/4/25 at 9:50 AM and reported the following information. She had relieved Nurse # 13 on 9/12/25 at 7:00 AM. Nurse # 13 was counting fast as they reconciled controlled medications. The count was correct. (The number of pills on the controlled drug receipt record matched the number in the resident's supply.) Resident # 2's Oxycodone was in a bubble pack card, and each dose was individually in its own bubble storage. Later in the day she noticed that the punches on the card seemed odd and that Nurse # 13 had signed out for two each time when the order was for only one. The resident also tended to ask for only acetaminophen. She also noticed that the number of pills which the pharmacy had put on a label when they filled the medication had been crossed out. Therefore, she reported the issue to the supervisor. The MDS (Minimum Data Set) assessment Nurse was interviewed on 12/4/25 at 5:00 PM and reported the following. She was acting DON (Director of Nursing) on 9/12/25 when Nurse # 10 reported a problem with the accounting of Resident # 2's Oxycodone. She had taken a picture of the card. The number of tablets that Nurse # 13 noted at the top of the drug receipt record by her signature was 26. The number on the label was marked through. She verified with the pharmacy that they had sent 28. The MDS Nurse also saw there had been four doses documented as removed from the supply at a time when the Oxycodone had not even been delivered to the facility. She also saw on the times that the medication was removed that Nurse # 13 had removed two tablets rather than one as ordered. She talked to Nurse # 13 and Nurse # 13 reported she had gotten the Oxycodone tablets from the facility's back up medication supply. There was no record of any Oxycodone being removed from the back up supply for Resident # 2. Nurse # 13 was questioned why she would have documented the removal of the Oxycodone in an amount more than prescribed and documented a time on the removal when the Oxycodone had not been available to administer. According to the MDS Nurse, Nurse # 13 did not have an explanation which would reconcile and account for the missing Oxycodone.	F0602	Continued from page 8 misappropriation, or active disciplinary action will not be eligible for hire. The DON and Unit Manager will review 5 declining narcotic count sheets 5 times per week for 2 weeks, 5 narcotic count sheets 3 times per week for 2 weeks, then 5 narcotic count sheets 2 times per week for 4 weeks to ensure accuracy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON and Unit Manager will review 5 declining narcotic count sheets 5 times per week for 2 weeks, 5 narcotic count sheets 3 times per week for 2 weeks, then 5 count sheets 2 times per week for 4 weeks to ensure accuracy. The QAPI Committee will meet monthly to review audits and make recommendations to ensure ongoing compliance is maintained. The QAPI Committee will determine the need for further intervention and auditing to ensure ongoing compliance is sustained ongoing. Completion 12/29/2025	

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F0602 SS = D	Continued from page 9 She was suspended and then terminated and the Department of Drug Enforcement, North Carolina Division of Health and Human Services, and the North Carolina Board of Nursing (NCBON) were notified. At attempt was made to Interview Nurse # 13 on 12/5/25 at 10:45 AM and Nurse # 13 could not be reached for interview. Interview with the facility's Pharmacy Director on 12/5/25 at 3:16 PM revealed the following information. The pharmacy had sent 28 tablets of Oxycodone 5 mg for Resident # 2 on 9/12/25 and their records showed it was received by the facility at 4:20 AM. The pharmacy records showed there were no Oxycodone tablets signed out from the facility's back up supply on 9/11/25 and 9/12/25 for Resident # 2. Interview on 12/8/25 at 10:49 AM with the NCBON's assigned investigator to Nurse # 13's case revealed the investigator was still awaiting paperwork and had not interviewed Nurse # 13 yet to obtain a statement from her. Interview with the Administrator on 12/8/25 at 12:38 PM revealed she had been out on leave during the time period when Resident # 2's Oxycodone had been unaccounted for. A report had been filed with all the required entities. The facility had completed a corrective action plan. The Administrator provided the facility's corrective action plan. The facility's alleged corrective action plan was reviewed and found unacceptable.	F0602		
F0606 SS = D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F0606	F-606 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. An initial report was filed with NCDHHS (North Carolina Division of Health and Human Services) by the DON (Director of Nursing) on 9/12/25, DEA (Drug Enforcement Administration) on 9/12/25 and NCBON (NC Board of Nursing) on 10/27/25. On 9/12/25 the Board of Nursing Probationary Oversight contact person was notified Nurse #13 was suspended due to narcotic diversion allegation. 2. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	12/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345561	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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F0606 SS = D	Continued from page 10 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff and staff members at the North Carolina Board of Nursing, the facility failed to ensure it did not employ a nurse who currently had disciplinary action in effect against her professional license secondary to a history of drug diversion. This was for 1 of 2 staff members whose personnel information was reviewed (Nurse # 13). The findings included: Record review revealed Resident # 2 resided at the facility from 9/11/25 until 9/23/25. On 9/12/25 the facility reported an incident of suspected controlled pain medication diversion by Nurse # 13 to the state agency when multiple Oxycodone tablets could not be accounted for while Resident # 2 was under the care of Nurse # 13. The facility's MDS (Minimum Data Set) assessment Nurse was interviewed on 12/4/25 at 5:00 PM and reported the following. She was acting DON (Director of Nursing) on 9/12/25 and had completed the investigation while the Administrator was on a leave of absence. There had been problems with the following: 1) the number of tablets, which were filled and delivered by the pharmacy, was marked through on a pharmacy label located on the Oxycodone drug receipt record 2) Nurse # 13 had signed on the drug receipt record she had received 26 tablets which was less than the 28 tablets the pharmacy had records of sending 3) Nurse # 13 could not account for the extra tablets the pharmacy showed as sending 4) Nurse # 13 signed out more tablets at a time than Resident # 2 was ordered to receive 5) Nurse # 13 had no explanation which could reconcile the issues that had been found. Interview with the facility's Human Resources Director on 12/5/25 at 4:00 PM revealed the following information. Nurse # 13 had been hired on 8/12/25 and	F0606	Continued from page 10 On 12/19/25 the Administrator and Regional Director of Clinical Services reviewed the hiring and pre-employment screening policy and submitted policy revision to Regional Vice President of Operations to include any applicant with substantiated abuse, neglect, or misappropriation findings and active disciplinary actions through state licensure registries is ineligible for hire. HR reviewed personnel files of all current licensed nurses to ensure no other nurse is presently working and should not be hired based on the regulation in F-606. Any applicant with substantiated abuse, neglect, misappropriation, or active disciplinary action will not be eligible for hire. Human Resources may not finalize hiring unless all background checks are complete, reviewed, and cleared by the Administrator or designee. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The administrator or designee will audit 100% of new hires for compliance with background check requirements for the next 90 days. Thereafter random audits of 10% of personnel will be conducted for six months. HR personnel and department heads will receive mandatory education on; Abuse, neglect, and misappropriation regulations, hiring standards and exclusion criteria, and reporting obligations. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The administrator or designee will audit 100% of new hires for compliance with background check requirements for the next 90 days. Thereafter random audits of 10% of personnel will be conducted for six months. The QAPI Committee will meet monthly to review audits and make recommendations to ensure ongoing compliance is maintained. 5. Date of compliance: 12/29/2026	

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F0606 SS = D	Continued from page 11 had restrictions on her license per the North Carolina Board of Nursing (NCBON). The facility had screened Nurse # 13 prior to hiring her and found that she had worked at two other skilled nursing facilities earlier in 2025 and was eligible for rehire at both of the facilities where she worked in 2025. They had obtained the restrictions from the NCBON for her employment at their facility (Facility # 1) when they hired her on 8/12/25. The facility provided Nurse # 13's license restrictions which had been given to them (the facility) when Nurse # 13 was hired. A review of the information which the facility (Facility #1) was given by the North Carolina Board of Nursing (NCBON) on 8/12/25 revealed Nurse # 13 had been disciplined for diverting Oxycodone while employed at a facility (Facility # 2) in 2021. Facility # 2 and Facility #1 were under the same corporation. A review of the information and orders from the NC Board of Nursing, dated 1/11/22, revealed the following information. The NCBON found that Nurse # 13's conduct constituted grounds for discipline based on their investigation into the case of diversion of Oxycodone in 2021 at Facility # 2. The NC Board of Nursing interviewed Nurse # 13 on 12/21/21. At that time Nurse # 13 admitted to the NC Board of Nursing that she had diverted 90 Oxycodone 10 mg pills from Skilled Nursing Facility # 2 and that she had begun diverting Oxycodone in the summer of 2021. Nurse # 13 also admitted she had a substance abuse disorder. The NCBON document included the following statements: "1. This matter is properly before the Board and the Board has jurisdiction over Licensee and the subject matter of this case. 2. Licensee's conduct, as set out in the findings of fact above, constitutes grounds for discipline pursuant to N.C. Gen. Stat. §90-171.37 as follows: (6) Engages in conduct that deceives, defrauds, or harms the public in the course of professional activities or services; (7) Has violated any provision of this Article or any provision of the rules adopted by the Board under this Article;	F0606		

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F0606 SS = D	Continued from page 12 and 21 N.C. Admin. Code 36 .0217(a) (3) illegally obtaining, possessing, or distributing drugs or alcohol for personal or other use, or other violations of the North Carolina Controlled Substances Act, G.S. §90-86 et seq. 3. Grounds exist pursuant to N.C. Gen. Stat. §90-171.37 for the Board to revoke or suspend a license to practice nursing and invoke other such disciplinary measures, such as censure or probative terms, against a Licensee as it deems fit and proper." One of the orders by the NC Board of Nursing was that Nurse # 13 enter the Alternative Program for Chemical Dependency. The order also noted Nurse # 13's license would have restrictions. The restrictions were categorized based on the number of years Nurse # 13 was employed in an approved nursing position. On 12/5/25 at 2:50 PM a member of the NC Board of Nursing, who was serving as the compliance case analyst and overseeing Nurse # 13's participation in the Alternative Program, was interviewed and reported the following. There were different encumbrances (restrictions) on a nurse's license based on the number of years within the program. Stricter encumbrances were during the first year of being in the program. This meant that a nurse had to complete a full year of employment while under the one year's restrictions set forth by the NCBON. Nurse # 13 had "spotty" employment from 2021 through 2023 and therefore did not meet the full one-year employment history to drop the one-year restrictions set forth by the NC Board of Nursing until December 2023. At that point (in December 2023) her license was restricted with certain requirements for 2 years. It had been permissible for her to be working at night following December 2023 and be accountable for controlled medications. On 9/12/25 Facility # 1 had reported the nurse was suspended and then terminated on 9/18/25. A formal complaint intake was received from the facility on 10/27/25 and the NC Board of Nursing had not completed their investigation. A review of the documented license restrictions set forth by the NCBON and provided to Facility # 1 when the nurse was hired at Facility # 1 included that the nurse still had restrictions on her license when hired	F0606		

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F0606 SS = D	Continued from page 13 by Facility # 1. The restrictions as of Nurse # 1's hire date on 8/12/25 mandated that she should not work for a staffing agency, as a traveler nurse, be employed at a home health agency or hospice home care provider. The nurse was also not to work in a supervisory capacity. These restrictions were part of the "two year" encumbrances on her license which had begun in December 2023. Interview with the current DON (Director of Nursing) on 12/4/25 at 6:10 PM revealed she had not been the DON when Nurse # 13 was hired or when she was suspended and terminated for suspected drug diversion. She was not familiar with why the nurse had been hired.	F0606		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2)	F0607	CMS F-Tag 607 1. Immediate corrective action taken for the identified deficiency On 11/19/2025, the facility reported the alleged abuse to DHHS, Adult Protective Services (APS), and local law enforcement in accordance with CMS and state reporting requirements. On 11/18/2025, the Administrator and Director of Nursing immediately initiated an internal investigation. The resident was assessed for safety and well-being, and protective interventions were implemented to prevent further potential harm. The facility reviewed the incident with leadership to identify failures in the reporting process and to ensure compliance with F-Tag 607 requirements. 2. Identification of other residents potentially affected by the same practice On 11/19/2025, the facility completed a review of all incident reports, grievances, and abuse or neglect allegations from the previous 30 days to determine whether any incidents were not reported timely. Residents with similar risk factors and staff associated with the incident were identified and monitored for signs of abuse or neglect. No additional residents were identified as being affected by delayed reporting. 3. Measures implemented to prevent recurrence (Education and policy reinforcement)	12/29/2025

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F0607 SS = D	Continued from page 14 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident and staff, the facility failed to implement their abuse policy when they 1) failed to suspend a staff member who was accused of slapping a resident and 2) ensure the incident was reported to the Administrator in order that regulatory reporting timeframes to other agencies were met and an investigation was initiated on the day of the allegation. This was for 1 of 3 sampled residents who alleged abuse had occurred (Resident # 1). The findings included: Review of the facility's policy entitled "Abuse, Neglect, Misappropriation, Crime" which was dated 10/17/23, revealed the following information. All employees were responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury) to report to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse. Allegations of abuse would result in staff suspension, and an investigation would take place. Also, the policy directed that after notification to the Administrator of alleged abuse, the Administrator would immediately report to the state agency, but not later than two hours after the allegation is made, regarding the events that caused the abuse allegation. Adult protective services, the local ombudsman, and the appropriate local law enforcement authorities would be notified of resident abuse also. Record review revealed Resident #1 was admitted to the facility on 3/7/18. Review of a facility investigation report into alleged abuse for Resident # 1 revealed the alleged incident occurred on 11/18/25 and the facility Administrator became aware of the incident the following day. According to the investigation report, Resident # 1 had alleged she was hit in the face by Nurse Aide (NA # 4). Resident # 1 was interviewed on 12/3/25 at 11:25 AM regarding whether anyone had ever mistreated her or abused her in anyway. Resident # 1 reported the following. Two people would whip her. Resident # 1 did not mention being hit in the face. She could not give a specific day. When directly asked if she had been hit in the face, Resident # 1 responded she "believed" she	F0607	Continued from page 14 On 11/20/2025, all staff—including licensed nurses, certified nurse aides, and department heads—received re-education on the facility's Abuse, Neglect, and Exploitation Policy. Education included: Immediate reporting requirements for all allegations CMS-required reporting timeframes Chain of command for reporting Recognition of abuse, neglect, and injuries of unknown origin Requirement to report immediately and no later than two (2) hours when serious bodily injury is suspected This education is now part of new hire orientation, and all staff will receive annual abuse prevention training. 4. Ongoing monitoring to ensure compliance with F-Tag 607 The Administrator or designee will conduct daily reviews of all incident reports, grievances, and allegations of abuse to verify timely reporting. A weekly audit of incidents and reporting timeframes will be completed for four (4) weeks, followed by monthly audits for three (3) months. Audit findings will be documented, trended, and reviewed. Any identified failures will result in immediate corrective action, additional education, and disciplinary action if warranted. Quality Assurance and Performance Improvement (QAPI) oversight Audit results and trends will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee on a monthly basis. The committee will review findings to ensure sustained compliance with CMS F-Tag 607. Once the committee determines that	

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F0607 SS = D	Continued from page 15 had been hit in the face. Resident # 1 did not report that she had been cursed or that derogatory language had been used towards her. According to Resident # 1, the police came and then everything stopped and she felt safe and without problems currently. Nurse # 1 was interviewed on 12/3/25 at 2:08 PM and reported the following information. On 11/18/25 Resident # 1 was yelling to the point that it was disruptive to other residents and could be heard in the hallway. She was yelling, “Help. Get that b…..out of here.” Resident # 1 did not normally yell to the degree that she was doing. She (Nurse # 1) went to check on Resident # 1 and Resident # 1 reported she did not want that b…….Nurse Aide in the room and that the Nurse Aide had slapped her in the face twice. The resident was assessed and found to have no injuries. There were no marks on her face. NA # # 4, who was assigned to Resident # 1, was in the next room with NA # 1 and another resident. She (Nurse # 1) called them out of the room and asked them what happened. NA # 4 reported that the resident had said that she did not want that b….. in her room while referring to her (NA # 4) when she entered the room to care for Resident # 1. NA # 4 reported to her (Nurse # 1) that she then “called her back out of her name,” and this meant that NA # 4 had been derogatory and not used the resident’s name when replying to the resident’s remark about not wanting that b….. in the room. She (Nurse # 1) had also talked to NA # 1 who had been in the room, and NA # 1 reported that NA # 4 had made racial slurs and called Resident # 1 a fat b……. She (Nurse # 1) reported the situation to Unit Manager # 1 and she thought the DON (Director of Nursing) was made aware of the situation. She had followed the chain of command. Unit Manager # 1 reported that she had spoken to the DON and that sometimes Resident # 1 made up things. She (Nurse # 1) was directed by the Unit Manager that two staff members needed to be in the room when providing care to Resident # 1. She (Nurse # 1) thought this was an unusual situation because it had been her experience that if a resident alleged that they were hit, then the accused staff member would not be allowed to stay. On that date, she changed the assignment after the incident so that NA # 4 was no longer assigned to Resident # 1. NA # 1 was interviewed on 12/3/25 at 1:05 PM and reported the following about the incident on 11/18/25. She had gone in the room with NA # 4 to care for Resident # 1. NA # 4 had made derogatory comments before approaching the resident by saying, “Let’s get this fat white racist b…..done.” She (NA # 1) informed NA # 4 that they “were not doing this” which she (NA #	F0607	Continued from page 15 compliance has been achieved and maintained, monitoring will continue on a random basis. 5. Date of Compliance Date of Compliance: 12/29/2025	

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F0607 SS = D	Continued from page 16 1) reported meant she wanted NA # 4 to stop using unkind remarks. Resident # 1 tried to swing at NA #4, but she did not see NA # 4 hit Resident # 1. NA # 4 stood back while she (NA # 1) cared and provided care for Resident # 1 in a calm manner. After completion of care, she (NA # 1) was gathering used care items and headed out the door. NA # 4 was still behind her and had not exited the room. As she (NA #1) headed out the door she heard Resident # 1 say to stop hitting her in the face. She said it twice. She (NA # 1) turned around but did not see or hear Resident # 1 being hit or slapped. The resident next door was needing immediate assistance, and they had to immediately go and check on him. While in the room, she was called out by Nurse # 1 and told her what had occurred. Unit Manager # 1 was interviewed on 12/3/25 at 12:30 PM and reported the following information. On 11/18/25, Nurse # 1 called her to come to the room because Resident # 1 was saying that she had been hit. Resident # 1 told her (Unit Manager # 1) that she had been slapped in the face by one of the Nurse Aides. She (Unit Manager # 1) saw no red marks. She talked to NA # 4 about the incident and NA # 4 reported the resident was not telling the truth and that she had not hit the resident. NA # 4 reported she had been trying to provide care and that the resident routinely had behaviors and would call her (NA # 4) names. On the day of the incident NA # 4 reported Resident # 1 was swinging the bed remote control and it had hit her (NA # 4), and therefore she had removed it from Resident # 1. NA # 4 further reported that when she removed the remote from Resident # 1's hand the resident reported that she was going to tell that she (NA # 4) would take things and that she (NA # 4) had hit her. She (Unit Manager # 1) had also talked to NA # 1, who had been in the room. NA # 1 had commented, "I don't really know about [NA # 4]" and then had made general negative remarks about NA # 4 that were unrelated to the incident and seemed vague and not specific. After the incident she (Unit Manager # 1) went to tell the DON about what had been reported. She was not sure why NA # 4 was allowed to stay and work following the incident. NA # 4 was interviewed on 12/3/25 at 12:07 PM and reported the following information. Resident # 1 was "known for lying" and she and NA # 1 had gone in together to care for her on 11/18/25. At first the resident did not want to be changed and hit her with a remote control. The resident needed to be checked and finally agreed to have care. She had not hit the resident. The resident would call staff derogatory names such as fat a…….. She had never said anything derogatory to the resident. The only thing she had said	F0607		

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F0607 SS = D	Continued from page 17 was that God did not like for her (the resident) to talk like she did. She and NA # 1 had left the room together at the same time. The DON (Director of Nursing) was interviewed on 12/4/25 at 2:24 PM and reported the following information. She had been helping on the medication cart where a Medication Aide was assigned on 11/18/25. There was a resident who was having chest pain and not doing well. She had been very busy getting orders and getting medications for administration. She did not recall Unit Manager # 1 telling her about the incident of alleged hitting on 11/18/25. The next day (11/19/25) she was making rounds and checking in with the nursing staff. At that time Nurse # 1 said to her, “I just want you to know about an incident because I think you would have done something about this.” Then Nurse # 1 told her about the incident that had occurred the previous day (11/18/25) when Resident # 1 alleged she was hit. At that point she (the DON) suspended NA # 4, notified the Administrator, and started an investigation. During the investigation Resident # 1 never brought up that any disrespectful words had been used towards her. She alleged she had been hit and there was no witness or evidence of that. The DON further reported that Unit Manager # 1 should have gone to the Administrator if she (the DON) was too busy to take care of the matter on 11/18/25 or did not understand there was an allegation of abuse. The Administrator was interviewed on 12/4/25 at 11:26 AM and reported the following information. She learned Resident # 1 alleged she was hit the day following the incident. She had been on her way to work, and the DON had called her on her cell phone. The DON was also just learning about the incident. Unit Manager # 1 had mentioned the incident to the DON the previous day, but Unit Manager # 1 did not make it seem significant and the DON had been busy at the time. According to the Administrator, this had resulted in the suspension of NA # 4 not being immediate and that the investigation and reporting of the incident in required regulatory timeframes was not started until the day following the incident. After the investigation was started the police were called and she had been present when they talked to the resident. At that time, the resident reported to the police that she had not been hit and was lonely and could not get out of her room. Regarding NA # 1’s comments that NA # 4 had said in the presence of Resident # 1 before the alleged incident, “Let’s get this fat white racist b…..done” the Administrator reported NA # 4 and NA # 1 did not get along and she had in past times had to move them to separate halls. This statement had not come up in their investigation.	F0607		

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Universal Health Care/Fuquay-Varina	**410 S Judd Parkway SE , Fuquay Varina, North Carolina, 27526**

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F0607 SS = D	Continued from page 18 They had identified a problem with abuse reporting through their quality assurance program and implemented a corrective action plan. The facility provided a corrective action plan which did not include the education of all facility staff members. During an interview with the Administrator via phone on 12/8/25 at 4:05 PM the Administrator reported that they had done in-service training about abuse with their nursing staff but had not included all facility staff.	F0607		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with staff, Registered Dietician (RD), and Nurse Practitioner (NP), the facility failed to discontinue a previous enteral feeding (tube feeding) order when a new order was initiated which resulted in the resident not receiving the enteral feeding as most recently ordered. This was for 1 of 3 sampled residents who received nutrition by an enteral feeding (Resident #12). The findings included:	F0693	F-Tag 693 Enteral Feeding 1. How the Corrective Action Was Accomplished for the Resident Affected: Resident #12 medical record was immediately reviewed. The outdated enteral feeding order was discontinued, and the most current enteral feeding order was verified with the physician and Registered Dietician and implemented. Unit Manages and the Registered Dietician (RD) ensured the resident received enteral nutrition as ordered. 2. How the Facility Will Identify Other Residents at Risk for the Same Deficient Practice: The facility conducted a review of all residents currently receiving enteral feedings to ensure orders were current, accurate, and that discontinued orders were not active. Any discrepancies identified were corrected promptly. No issues identified 3. What Measures Will Be Put into Place to Ensure the Deficient Practice Will Not Recur: The facility revised its enteral feeding order management process to require order reconciliation whenever a new enteral feeding order is initiated. The Unit Managers and ADON, Admissions Nurse was re-educated on reviewing and discontinuing prior orders upon receipt of new	12/29/2025

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F0693 SS = D	Continued from page 19 Record review revealed Resident # 12 was admitted to the facility on 11/1/25. Resident # 12's diagnoses included stroke, dysphagia, cognitive communication problems, and renal disease. Resident # 12's admission Minimum Data Set assessment, dated 11/6/25, coded the resident as moderately cognitively impaired. Resident # 12 was also coded to receive part of his nutrition by an enteral feeding as well as receiving a mechanically altered diet. His height was 66 inches, and his weight was 134 pounds. Resident # 12's care plan, dated 11/1/25, included that the resident had an enteral feeding. The care plan directed to consult with the RD (Registered Dietician) as needed and to administer tube feedings as ordered. On 11/3/25 a physician's order was written for Novasource Renal (tube feeding formula) bolus 200 ml (milliliters) after each meal if the resident ate less than 50 percent of his meal and 200 ml at 8:00 PM. The resident was to have 50 ml of water flush before and after each bolus feeding. Resident # 12 was also ordered to receive a Renal Dysphagia diet on 11/3/25. On 11/27/25 the RD noted the following information in a progress note. The resident's current enteral feeding order was for bolus enteral feedings of 200 ml (milliliters) Novasouce Renal three times after meals and 200 ml at bedtime. She was seeing Resident # 12 because he had been refusing his bolus feedings. The resident also had some nausea. The resident had poor oral intake for the last seven days. Therefore, she recommended that the bolus feedings be discontinued and that the resident start on Novasource Renal at 60 ml/hour for fourteen hours to be infused between the hours of 8:00 PM to 10:00 AM. She also recommended Resident # 12 had a 150 ml flush every four hours. On 11/27/25 an order was entered into the electronic system for an Enteral Feeding order of Novasource Renal at 60 ml per hours times 14 hours to be infused from 8:00 PM to 10:00 AM. Resident # 12 was also ordered to have a 150 ml water flush every four hours. According to the electronic system the orders were per the physician and created in the electronic system by the RD. Review of Resident # 12's November and December 2025 MARs (Medication Administration Records) revealed beginning on 11/27/25 the MARs had both the 11/3/25 orders for bolus feedings which were contingent on his intake and the MARs also included the new 11/27/25 order for the continuous feeding to run from 8:00 PM to	F0693	Continued from page 19 enteral feeding orders. The Unit Managers, ADON, Admissions Nurse was educated on printing the Order Summary to identify any concerns and/or duplicate enteral orders and review them during clinical meeting RD was instructed to verify active enteral feeding orders with nursing prior to initiation, or discontinuation of tube feeding (via email) 4. How the Facility Will Monitor Its Performance to Ensure the Solution Is Sustained: The Unit Managers, and/or the ADON Will audit enteral feeding orders to ensure prior orders are discontinued appropriately when new orders are initiated. Daily for 2 weeks Weekly for 4 weeks Monthly x 2 Months Or until compliance is reached Audit findings will be documented and reviewed by the Director of Nursing and reported through the Quality Assurance and Performance Improvement (QAPI) process. Corrective action will be implemented as needed. 5. Completion 12/29/25	

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F0693 SS = D	Continued from page 20 10:00 AM. The 11/3/25 bolus feeding had not been discontinued off the MARs. There was no place on Resident # 12's November and December 2025 MARs for the 7:00 A and 7:00 PM nurses to document about the continuous enteral feeding order which was ordered on their shift to infuse from 7:00 AM to 10:00 AM. The specific documentation by the latest 11/27/25 enteral feeding order included a scheduled time to document at 8:00 PM by this order. The specific documentation with this order was as follows: On 11/27/25-initials for a nurse that did not correspond to a nurse's signature at the bottom of the MAR were entered. On 11/28/25 Nurse # 5 documented Resident # 12 refused. On 11/29/2 Nurse # 5 documented the enteral feeding was given. On 11/30/25 Nurse # 4 documented the enteral feeding was given. On 12/1/25 Nurse # 2 documented Resident # 12 refused. On 12/2/25 Medication Aide # 1 documented the enteral feeding was given. On 12/3/25 Nurse # 3 documented the enteral feed was given. Resident # 12 was observed on 12/4/25 at 8:07 AM. This observation time correlated to a time the resident was ordered to receive a continuous enteral feeding per the last order dated 11/27/25. It was observed at this time that there was no continuous enteral feeding infusing. Resident # 12 replied to simple questions and was able to say nurses gave him an enteral feeding but did not report if it was per bolus or continuous, and he was not able to give times. Nurse # 6 was observed to be assigned to Resident # 12 on 12/4/25. Nurse # 6 was interviewed on 12/4/25 at 8:09 AM and reported the following. Resident # 12 did not receive a continuous enteral feeding. He was ordered bolus enteral feedings and that was why there was no enteral feeding infusing. Nurse # 4, who had documented that the continuous enteral feeding was administered beginning at 8:00 PM on 11/30/25 was interviewed on 12/5/25 at 9:22 AM by phone and reported the following information. On 11/30/25 she had provided a bolus feeding at bedtime	F0693		

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F0693 SS = D	Continued from page 21 because that was what showed on the MAR to be administered. She did not recall the continuous enteral feeding order showing on the MAR to be started on 11/30/25 at 8:00 PM and therefore she had not administered the continuous feeding. Nurse # 7 had cared for Resident # 12 on 12/1/25 and 12/2/25 during the 7:00 AM to 7:00 PM shift. Nurse # 7 was interviewed on 12/5/25 at 11:40 AM by phone and reported the following information. She had given Resident # 12 a bolus feeding on 12/1/25 and 12/2/25 based on his meal intake parameters and per the 11/3/25 order. Also at times, the resident would refuse the bolus because he would say he was nauseated. She had not known anything about a continuous enteral feeding order that was supposed to be infusing on her shifts until 10:00 AM. She did not recall anything showing on the MAR that the resident was to have an enteral feeding infusing up until 10:00 AM or she would have questioned it. The order had not appeared on the MAR for her shift for her to question the order. The resident also ate food that his family brought and therefore he had not been going without nutrition. Nurse # 2, who had documented a refusal of the continuous enteral feeding on 12/1/25 at 8:00 PM, was interviewed on 12/5/25 at 2:09 PM and reported the following. The resident had refused an enteral feeding on the night of 12/1/25 because he said that it made him stay up at night going to the bathroom. She did see both the bolus enteral feeding and the continuous enteral feeding order populate on the MAR and should have sought clarification from the provider about the two orders but did not do so. Medication Aide # 1 was interviewed on 12/5/25 at 9:45 AM and reported the following. Resident # 12 had never received an enteral continuous feeding when she worked. She did not know why her initials were on the MAR signifying this had been given. The nurse who had been covering for her (Nurse # 3) had not given it. Nurse # 3, who had documented that the continuous enteral feeding was administered beginning at 8:00 PM on 12/3/25 and who had been responsible for doing nursing tasks that MA # 1 was not licensed to do on 12/2/25, was interviewed on 12/5/25 at 5:20 PM via phone and reported the following information. When she covered for MA # 1 on 12/2/25 the continuous enteral feeding was not mentioned to her and therefore she did not give it. On 12/3/25 she gave the bolus bedtime enteral feeding per the 11/3/25 order but did not start a continuous feeding at 8:00 PM per the new 11/27/25 order. She saw the new order and was going to clarify	F0693		

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F0693 SS = D	Continued from page 22 what to do but then had an emergency to deal with and did not get around to clarifying the orders. Unit Manager # 1 was interviewed on 12/5/25 at 1:00 PM and reported the following information. The RD wrote orders for the enteral feedings, and she had written a new order on 11/27/25 for the Enteral Feeding order of Novasource Renal at 60 ml per hours times 14 hours to be infused from 8:00 PM to 10:00. When the RD did that she forgot to discontinue the old bolus enteral feeding orders from 11/3/25. No one had brought it to anyone's attention until 12/4/25 and therefore the resident had continued to get bolus feedings and was not switched to the continuous feeding from 8:00 PM to 10:00 AM. The RD was interviewed on 12/5/25 at 10:50 AM and reported the following information. The order should be for the continuous Novasource Renal at 60 ml per hours times 14 hours to be infused from 8:00 PM to 10:00. The problem that the bolus enteral feeding had not been discontinued had not been recognized until 12/4/25. Resident # 12's intake varied over the last seven days but had picked up in the most recent last days. His weights had been stable. The DON (Director of Nursing) was interviewed on 12/5/25 at 5:00 PM and reported the following information. The RD had permission from the providers to write the orders based on her recommendations. There had been a mistake in that the bolus feeding order had not been discontinued but Resident # 12 ate in addition to having bolus feedings. Family members also brought him food in addition to his meals at the facility. NP # 2 was interviewed on 12/8/25 at 2:45 PM and reported the following. The providers had approved the RD to write orders for enteral feedings based on her assessment of the residents' needs. Then the nurse would confirm the order, and the physician would sign it. Resident # 12 had not lost weight and suffered any negative outcome from not having a continuous enteral feeding as ordered on 11/27/25. The bolus feedings had continued along with water flushes.	F0693		