

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 04/01/2026
NAME OF PROVIDER OR SUPPLIER Fuquay-Varina Health and Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/29/26 through 4/1/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22C260-H1.	E0000		04/10/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/29/26 through 4/1/26. Event ID# 22C260-H1. The following intakes were investigated: 2790922, 2738793, 2735749, 2735847, 2711788, 2715664, 2711857, 2687376, 2681575, 2626735, 2611360, 2607998, 2590044, 2590458, 2590470, 2574169, and 838240. 2 of the 43 complaint allegations resulted in deficiency.	F0000		04/10/2026
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 (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.	F0578	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F-Tag 578 (Advance Directives) 1. Corrective Action for Affected Residents On 3-30-26 the Advance directive status for residents #52 and #7 was clarified by the Social Serviced Director. No advance directives were present. The comprehensive care plan was reviewed and revised to reflect advance directive status. 2. Identification of Other Residents Who May Be Affected All residents residing in the facility have the potential to be affected by this deficient practice.	04/17/2026

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	<p>Continued from page 1</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and Resident Representative (RR) and staff interviews, the facility failed to provide written information about advance directive and/or an opportunity to formulate an advance directive and to obtain advance directive and maintain the advance directives in the medical record for 2 of 4 residents reviewed for advance directives (Residents #52 and #7).</p> <p>The findings included:</p> <p>Resident #52 was admitted to the facility on 1/23/26.</p> <p>A review of Resident #52's admission Minimum Data Set (MDS) assessment dated 1/29/26 revealed she was severely cognitively impaired.</p> <p>Review of the Care Plan dated 1/26/26 revealed Resident #52 had an advance directive of full code.</p> <p>Record reviews revealed there was no documentation in the record regarding providing information to the RR about the right to refuse medical or surgical treatment and formulate an advance directive for Resident #52.</p> <p>An interview with the Resident Representative (RR) on 3/31/26 at 9:30 AM revealed she had not had a</p>	F0578	<p>Continued from page 1</p> <p>Beginning on 4-2-26, the Social Services Director conducted a 100% audit of all current residents to ensure residents were offered the opportunity to formulate advance directives. Any identified deficient practices were corrected at the time of discovery.</p> <p>3. Measures/Systemic Changes Put Into Place to Ensure Deficient Practice Does Not Recur</p> <p>Upon admission, Social Services will complete the discharge psychosocial assessment to ensure the resident's decision regarding advance directives is documented and provide written information regarding advance directives.</p> <p>A designated, clearly identifiable section for advance directives has been established in the electronic medical record (EMR).</p> <p>On 4-15-2026, Social Service staff were in-serviced by the Administrator on North Carolina statutory requirements for advance directives.</p> <p>Advance directive status will be reviewed during: Admission, Quarterly Minimum Data Set (MDS) assessments, and Significant change in condition Care plan meetings.</p> <p>4. Monitoring of Corrective Action</p> <p>The Director of Nursing (DON) or designee will audit admission records to ensure documentation of resident opportunity to formulate advance directives is completed upon admission. The audit will verify that written information was provided on admission, presence and accessibility of advance directive documentation in the medical and consistency between EMR, physician orders, and care plan. The audit will be completed 3 times per week for 4 weeks then weekly for 2 months.</p> <p>Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee) monthly. The QAPI Committee will evaluate effectiveness and implement additional interventions as needed to ensure ongoing compliance.</p> <p>5. Date of Compliance 4-17-26</p>	04/17/2026

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F0578 SS = D	<p>Continued from page 2 representative from the facility discuss any information regarding an advance directive for Resident #52.</p> <p>An interview with the Social Worker was conducted on 3/31/26 at 9:40 AM, she stated she was out on leave during the time of Resident #52's admission and it would have been the previous Social Worker's responsibility to discuss advance directives with Resident #52's RR.</p> <p>An interview with the previous Social Worker was not obtained during this investigation process.</p> <p>An interview with the Administrator was held on 3/31/26 at 9:45 AM, she stated she would have expected the Social Worker to discuss advance directives with the resident or RRs within three days of admission into the facility.</p> <p>2. Resident #7 was admitted to the facility on 12/4/25.</p> <p>A care plan meeting note dated 12/5/25 revealed Social Worker #2 documented that a care plan meeting was held with Resident #7's Responsible Party by phone. During the meeting the Responsible Party confirmed Resident #7's full code status and stated he had guardianship paperwork he would bring in.</p> <p>A Discharge Planning Psychosocial Assessment dated 12/5/25 signed by Social Worker #2 revealed the resident was assessed to have an advance directive per the Responsible Party.</p> <p>A care plan meeting note dated 12/18/25 revealed Social Worker #2 documented that a care plan meeting was held with Resident #7's Responsible Party by phone. The Social Worker documented there were no changes to code status or funeral arrangements and there was no documentation that the Social Worker requested the advance directive.</p> <p>A Discharge Planning Psychosocial Assessment dated 12/23/25 signed by Social Worker #2 revealed the resident was assessed to have advance directives per the Responsible Party. There was no documentation that the Social Worker requested the Responsible Party provide Resident #7's advance directives.</p> <p>A Discharge Planning Psychosocial Assessment dated 3/12/26 signed by Social Worker #2 revealed the resident was assessed to have an advance directive per the Responsible Party.</p>	F0578		04/17/2026

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F0578 SS = D	<p>Continued from page 3</p> <p>A care plan meeting note dated 3/12/26 revealed Social Worker #2 documented that a care plan meeting was held and Resident #7's Responsible Party did not answer the phone call, and a voice message was left.</p> <p>A care plan meeting note dated 3/17/26 revealed Social Worker #2 documented that a care plan meeting was held and Resident #7's Responsible Party did not answer the phone call, and a voice message was left.</p> <p>Resident #7's medical record on 3/29/26 revealed no advance directives were in Resident #7's medical record.</p> <p>During an interview on 3/30/26 at 10:19 AM Social Worker #1 stated if a resident already had an advance directive in place upon admission, the social workers request the resident or responsible party to bring the advance directive to the facility so they can keep a copy in the resident's medical records. If the resident or responsible party does not provide the advance directives prior to the next time the social workers meet with the resident or responsible party during a care conference, they again request the advance directives. With Resident #7, her Responsible Party stated during a care plan meeting on 12/5/25 that he had an advance directive for Resident #7 and Social Worker #2 requested the advance directive be brought to the facility. Social Worker #1 further stated the Responsible Party had not brought Resident #7's advance directive to the facility. Social Worker #1 stated she did not follow up with the family to acquire Resident #7's advance directive, and there was no documentation that any other staff had followed up with Resident #7's Responsible Party to acquire Resident #7's advance directive.</p> <p>During an interview on 3/30/26 at 3:09 PM, Social Worker #2 stated when Resident #7 first admitted, she spoke on the phone with the resident's Responsible Party who indicated at that time Resident #7 had an advance directive and would provide a copy to the facility. She stated the Responsible Party had been present on the phone for one other care conference on 12/18/25 and she did not remember but believed she did not follow up with Resident #7's Responsible Party about providing Resident #7's advance directive. She concluded that the Responsible Party was difficult to get ahold of and she had not followed up to obtain a copy of Resident #7's advance directive.</p>	F0578		04/17/2026

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F0578 SS = D	Continued from page 4 During an interview on 3/30/26 at 3:03 PM the Administrator stated upon admission, the Social Worker discusses advance directives with the resident or responsible party to identify if the resident had advance directive in place or if they would like to create an advance directive. If the resident does have an advance directive, the staff then request a copy of the advance directive. She concluded that if the resident or responsible party does not provide a copy of the advance directives prior to the next care conference, this should be followed up during the next care conference and a copy of the advance directives should be obtained and maintained in the resident's medical records.	F0578		04/17/2026
F0658 SS = D	<p>Services Provided Meet Professional Standards</p> <p>CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Number of Residents Sampled - 6</p> <p>Number of Residents Cited - 1</p> <p>Based on record reviews, and staff, Guardian and physician interviews, the facility failed to ensure a resident was not prescribed a medication to which the resident had a documented allergy for 1 of 6 residents reviewed (Resident #115).</p> <p>Findings included:</p> <p>Record review of the hospital after-care summary dated 8/27/2025 through 8/30/2025 showed an allergy to Doxycycline causing shortness of breath.</p> <p>Record review of allergies listed on the resident banner in the electronic medical record (EMR) included Doxycycline.</p> <p>Review of nursing progress notes dated 1/19/2026, written by Nurse #3, stated Resident #115 tested positive for an infectious disease. The physician was made aware and a new order for Doxycycline 100 milligrams (mg) twice daily for seven days was received.</p> <p>Review of physician orders dated 1/19/2026 showed</p>	F0658	<p>F-0658 Services Provided Meet Professional Stand</p> <p>1. What was done immediately for the problem identified?</p> <p>Resident #115 Medication Administration Record was immediately reviewed and reconciled by the Director of Nursing and clinical team with the Physician's orders to ensure accuracy. When an order for Doxycycline was noted, the investigation was initiated by the Director of Nursing due to the resident's documented allergy. The pharmacy was contacted to verify whether the medication had been dispensed, and the Nexsys (back up pharmacy supply in facility) system was reviewed to determine if the medication had been removed for administration. It was confirmed that the medication had not been delivered by the pharmacy and had not to been pulled from the Nexsys system for resident #115.</p> <p>2. How were other residents who had the potential to be affected identified.</p> <p>On 01/22/2026, the Assistant Administrator and the Director of Nursing conducted a 100% census, facility-wide allergy audit along with a full medication reconciliation review to identify any other residents who may be at risk. No other residents were identified.</p> <p>3. Education- What is being done to prevent recurrence</p> <p>On 01/22/2026, the Regional Director of Clinical Services in-serviced the Director of Nursing on reviewing all admission allergies and medication administration rights. On 01/28/2026, an in-service was initiated by the Director of Nursing for all licensed nurses focusing on proper medication reconciliation, rights to medication administration,</p>	04/20/2026

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F0658 SS = D	<p>Continued from page 5 a telephone order for Doxycycline 100 mg twice daily written by Nurse #3.</p> <p>During an interview on 3/31/2026 at 2:05 PM, Nurse #3 stated she sent the physician a text message about the positive test results and did not have the EMR open to see the resident allergies. The physician texted message back the Doxycycline 100 milligrams order. Nurse #3 reported she did not recall any allergy alert appearing when she entered the Doxycycline order into the EMR. The medication had not yet been delivered, so none was administered.</p> <p>During an interview on 3/31/2026 at 6:15 AM, Nurse #4 stated allergies were listed in the EMR beneath the resident name. She stated an allergy alert appears when entering a contraindicated medication.</p> <p>During a telephone interview with the physician on 3/31/2026 at 9:30 AM, he stated he was unaware of the allergy to the Doxycycline and that the EMR was unavailable to him. He stated nursing staff normally informs him of allergies.</p> <p>During a telephone interview with the resident's Guardian on 3/31/2026 at 12:10 PM, she stated she went to the facility and requested medical records that included the medication administration record (MAR). Upon review of the MAR, the Guardian noted the order for Doxycycline and notified the facility of the allergy to Doxycycline. The Guardian stated Doxycycline should never have been ordered by the physician.</p> <p>During an interview with the Director of Nursing (DON) on 4/1/2026 at 10:00 AM, she stated nurses should have the resident EMR open when contacting physicians and that the EMR provided allergy alerts.</p> <p>During an interview with the Administrator on 4/1/2026 at 10:15 AM, she stated she was aware the physician prescribed a medication to which the resident was allergic and that Nurse #3 did not inform the physician when the physician prescribed the medication.</p>	F0658	<p>Continued from page 5 and allergy verification when receiving and transcribing new orders. All licensed nurses and certified medication aides were educated on ensuring that medications are signed off when given. This education will also be provided to all newly hired licensed nurses and certified medication aides during orientation.</p> <p>4. How this will be monitored ongoing</p> <p>The DON/designee will conduct daily reviews of all new medication orders to ensure there are no allergy discrepancies. This monitoring will be completed</p> <p>5x weekly for 12 weeks</p> <p>Director will report audit findings to be reviewed monthly in the QAPI program. The QAPI Committee will evaluate effectiveness and implement additional interventions as needed to ensure ongoing compliance.</p> <p>Compliance Date: 04/20/2026</p>	04/20/2026
F0695 SS = D	<p>Respiratory/Tracheostomy Care and Suctioning</p> <p>CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and</p>	F0695	<p>F-0695 483.25 Respiratory care, including tracheostomy care and tracheal suctioning</p> <p>1. What was done immediately for the problem identified?</p> <p>Resident #109 has expired and is no longer residing in the facility. A clinical record review was conducted to determine if the deficient practice</p>	04/20/2026

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F0695 SS = D	<p>Continued from page 6 tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, and staff and Medical Director interviews, the facility failed to provide tracheostomy (an opening into the neck through the windpipe) care consistent with professional standards of practice when Nurse #2 cleaned and reused a single use disposable tracheostomy inner cannula when she provided tracheostomy care. This was for 1 of 3 residents reviewed for respiratory care (Resident #109).</p> <p>Findings included:</p> <p>Resident #109 was admitted to the facility on 7/18/25 with a diagnosis of acute respiratory failure with hypoxia (a state in which oxygen present in a tissue or the whole body is insufficient).</p> <p>A physician's order for Resident #109 dated 7/18/25 was for tracheostomy care every shift and as needed, clean or change inner cannula as applicable.</p> <p>Resident #109's comprehensive care plan revealed a focus area for her risk of complications related to tracheostomy. The goal dated as initiated on 7/22/25 was for Resident #109 to have no complications related to her tracheostomy. An intervention was tracheostomy care as ordered.</p> <p>Resident #109's admission Minimum Data Set (MDS) assessment dated 7/27/25 revealed she was severely cognitively impaired. She received oxygen therapy and tracheostomy care while a resident.</p> <p>Resident #109's August 2025 Treatment Administration Record (TAR) revealed documentation on 8/11/25 that Nurse #2 had provided tracheostomy care to Resident #109 on the night shift.</p> <p>A nursing progress note for Resident #109 dated 8/11/25 at 1:11 AM written by Nurse #2 revealed Nurse #2 provided tracheostomy care to Resident #109. This care had been well tolerated.</p> <p>Resident #109's August 2025 TAR further revealed documentation on 8/12/25 that Nurse #2 provided tracheostomy care to Resident #109 on the night shift.</p>	F0695	<p>Continued from page 6 contributed to the resident's condition or outcome. The IDT team, including MD, DON, reviewed findings and no evidence collected that the practice contributed to the resident's expiration. The Director of Nursing and SDC educated the involved staff members on April 2, 2026, to ensure competency validation on tracheostomy care, including proper disposal of single-use equipment.</p> <p>2. How does facility identify other residents having the potential to be affected?</p> <p>A 100% audit of all residents receiving tracheostomy and respiratory care was performed, and observation of technique, equipment uses, infection control, and supply availability was also checked to ensure no deficient practice.</p> <p>3. What measures will be put in place to prevent reoccurrence</p> <p>SDC educated all licensed nurses April 13, 2026 via a mandatory in-service on tracheostomy care technique, Infection control practices (hand hygiene, PPE use), Proper handling and disposal of single-use respiratory equipment. Also, the facility designated Respiratory Therapist (Ray Gilpin) was contacted and came into the facility on April 15, 2026, and April 16, 2026, where a 2-day trach care/suctioning education class for all licensed nursing staff was completed with a competency checkoff. All new hires will receive training and be checked off by SDC prior to working in the facility. The SDC and Admin verified central supply stock levels were in facility and readily available for nursing needs.</p> <p>4. How facility will monitor ongoing compliance</p> <p>The DON or assigned designee will be present during direct observation of tracheostomy care for all trach residents on all shifts: 3x weekly for 4 weeks, then weekly for 8 weeks. Audits will focus on proper technique, no reuse of disposable equipment, and infection control compliance.</p> <p>The DON will bring audit findings to be reviewed monthly in the QAPI program. The QAPI Committee will evaluate effectiveness and implement additional interventions as needed to ensure ongoing compliance.</p> <p>Compliance Date: 04/20/2026</p>	04/20/2026

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F0695 SS = D	<p>Continued from page 7</p> <p>A nursing progress note for Resident #109 dated 8/12/25 at 3:02 AM written by Nurse #2 revealed she had provided tracheostomy care to Resident #109. This care had been well tolerated.</p> <p>In a telephone interview on 3/31/26 at 1:55 PM Nurse #2 stated she recalled Resident #109. She reported Resident #109's tracheostomy inner cannulas had always been the disposable single use type. She indicated she recalled providing tracheostomy care to Resident #109 on 8/11/25 and 8/12/25 on the night shifts (7PM-7AM). Nurse #2 stated tracheostomy care included changing Resident #109's disposable tracheostomy inner cannula. She went on to say Resident #109 usually had extra disposable tracheostomy inner cannulas in her room. She reported on either 8/11/25 or 8/12/25, she could not recall which, there had been no extra inner cannulas in Resident #109's room. She indicated Resident #109 had needed tracheostomy care, and so she had used a tracheostomy care kit which included sterile (completely free from living microorganisms and bacteria) gloves, sterile water, and a sterile brush to clean Resident #109's disposable tracheostomy inner cannula. She reported she then re-inserted this back into Resident #109's tracheostomy rather than disposing of it and inserting a new one. Nurse #2 stated she had felt bad doing it at the time because she knew she was not supposed to. She reported reusing a disposable tracheostomy inner cannula could risk infection. Nurse #2 stated she had been very careful to use sterile technique. She indicated she had not looked anywhere other than Resident #109's room for additional disposable tracheostomy inner cannulas. She stated she did not have access to the supply room where there might have been some. She reported she had never done this before during tracheostomy care for Resident #109 or any other resident. She indicated she had never done it again. Nurse #2 stated she thought she had reported the incident to an administrative staff member, but she could not recall who. She stated since then, she made sure she had all the supplies she needed for tracheostomy care at the start of her shift.</p> <p>On 4/1/26 at 9:03 AM an interview with the Director of Nursing (DON) indicated she had not been aware that Nurse #2 had cleaned and reused a disposable tracheostomy inner cannula when she provided Resident #109 tracheostomy care. She stated the facility only used the disposable type of inner tracheostomy cannula. She reported disposable inner cannulas were for one time use and should not be cleaned and reused. The DON indicated although</p>	F0695		04/20/2026

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F0695 SS = D	Continued from page 8 Nurse #2 should have ensured she had the supplies she needed to perform tracheostomy care, she thought Nurse #2 used her professional judgement because she didn't have another disposable inner cannula for Resident #109, and Resident #109 had needed tracheostomy care. On 3/31/26 at 2:57 PM an interview with the Administrator indicated she had not been aware that Nurse #2 had cleaned and reused a disposable tracheostomy inner cannula. She stated Resident #109's tracheostomy inner cannulas had been the disposable type. She reported these were for single use only and should not be cleaned and reused. She stated that while she did not think Nurse #2 cleaning and reusing Resident #109's disposable tracheostomy inner cannula was best practice she felt Nurse #2's goal had been to keep Resident #109 comfortable by providing the care. On 3/31/26 at 2:16 PM a telephone interview with the Medical Director indicated there would have been no risk to Resident #109 when Nurse #2 used sterile technique to clean and reuse a disposable tracheostomy inner cannula. He reported this single incident had not caused Resident #109 any harm.	F0695		04/20/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately 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	F0761	F-0761 483.45(g) Labeling of Drugs and Biologicals 1. What was done immediately for the problem identified The treatment cart was immediately secured upon identification. A complete inventory of the cart contents was conducted to ensure no items were missing, contaminated, or tampered with. No residents were identified as being adversely affected by the deficient practice. 2. How facility identified other residents having the potential to be affected An immediate facility-wide audit of all treatment carts and medication carts was conducted to ensure compliance with locking requirements. This audit ensured all residents had the potential to be protected from similar risks. No additional unlocked carts were found. 3. What measures will be put in place to prevent reoccurrence On 03/29/26, the facility began educating all licensed nurses on the facility's policy regarding securing treatment carts at all times when not under direct supervision. Education included infection	04/20/2026

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F0761 SS = D	<p>Continued from page 9 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to secure medications and treatment supplies in a locked wound care cart for 1 of 2 wound care carts observed (Station 2 Wound Care Cart).</p> <p>Findings included:</p> <p>During continuous observation on 3/29/26 (Sunday) from 10:29 AM until 10:36 AM the Station 2 Wound Care Cart was observed unlocked and unattended at the nursing station. There were no staff, residents, or visitors observed in sight of the wound care cart at that time. At 10:30 AM a housekeeping staff member walked past the unlocked wound care cart followed by a nurse aide who also walked past the unlocked wound care cart. At 10:31 AM three visitors walked past the unlocked wound care cart. At 10:32 AM Nurse #1 went to the nursing station, retrieved an item from the nursing station, and left visual range of the Station 2 Wound Care Cart which remained unlocked. At 10:33 AM a nurse aide walked past the unlocked wound care cart. At 10:34 AM three visitors walked by the unlocked wound care cart. At 10:35 AM a visitor walked past the unlocked wound care cart and a resident wheeled past the unlocked wound care cart. At 10:36 AM Nurse #1 returned to the nursing station.</p> <p>During an interview on 3/29/26 at 10:36 AM Nurse #1 stated the nurses on the hall completed wound care on the weekends. She stated someone must have used the cart and left it unlocked but she did not know who last accessed the Station 2 Wound Care Cart. She stated all nurses were responsible for the Station 2 Wound Care Cart and it should be locked when left unattended because there were medications in the cart and many confused residents resided in the facility so an unlocked wound care cart could be a safety issue.</p> <p>On 3/29/26 at 10:39 AM an observation was completed of the Station 2 Wound Care Cart with Nurse #1. The Station 2 Wound Care Cart was observed to contain calcium alginate dressing, iodoform packing strips, collagen wound filler, xeroform medicated petrolatum dressing, zinc oxide paste, Silvasorb gel, diclofenac sodium topical gel</p>	F0761	<p>Continued from page 9 control standards and safe storage practices. Policy was reinforced to require all carts to remain locked when not in the direct line of sight and active use of licensed nursing staff.</p> <p>4. How facility will monitor ongoing compliance</p> <p>The DON/designee will conduct audits of treatment carts as follows</p> <p>Five times a week x 4 weeks</p> <p>Three times a week x 2 weeks</p> <p>Weekly audits x 2 weeks</p> <p>Audit findings will be reviewed monthly in the QAPI program. The QAPI Committee will evaluate effectiveness and implement additional interventions as needed to ensure ongoing compliance.</p> <p>Date of Compliance : 04/20/2026</p>	04/20/2026

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F0761 SS = D	Continued from page 10 1%, 70% Isopropyl alcohol, lidocaine ointment USP 5%, carbamide Peroxide 6.5%, Ciclopirox olamine cream USP 0.77%, Nystatin cream USP 100,000, Gentamicin Sulfate Cream USP 0.1%, and nystatin topical powder. During an interview on 3/29/26 at 12:31 PM the Director of Nursing stated wound care carts should be locked at all times when not attended by a nurse due to safety concerns for confused residents.	F0761		04/20/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F0732	F-Tag 732 (Posted Nurse Staffing Information) 1. Corrective Action for Affected Residents On 3/29/26, the staffing posting was immediately reviewed by the Director of Nursing (DON). The required daily nurse staffing information was updated to ensure: Accurate census, Licensed nurse hours (RN, LPN) and Certified Nursing Assistant (CNA) hours. 2. Identification of Other Residents Who May Be Affected All residents in the facility have the potential to be affected by this deficient practice. A review of staffing postings for the previous 30 days was conducted to identify any additional instances of non-compliance. Any discrepancies identified were corrected, and current postings were verified for accuracy and completeness. 3. Measures/Systemic Changes Put into Place to Ensure Deficient Practice Does Not Recur The Scheduler or Nurse Supervisor is responsible for completing and ensuring that the staffing posting is posted daily. On 4-15-2026, Nursing Leadership and Staffing Coordinator were educated by the Administrator on the federal requirements for staffing postings, required elements of the posting, location and visibility requirements. Education will be included in new hire orientation for applicable staff. 4. Monitoring of Corrective Action The DON, or designee will complete an audit of daily staff postings 3 times per week including weekends for 4 weeks then weekly for 2 months thereafter. The audit criteria will include the following: Posting completed daily, presence of all required elements	04/20/2026

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F0732 SS = C	<p>Continued from page 11</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents, staff, and visitors.</p> <p>§483.35(g)(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.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and staff interviews, the facility failed to post daily staffing information in an area of the facility visible to residents and visitors on 1 of 4 days of the survey (3/29/26). In addition, the facility failed to have an effective process in place to ensure staffing information data was posted daily, including on the weekend.</p> <p>The findings included:</p> <p>On 3/29/26 (Sunday) at 10:00 AM an initial tour was conducted in the facility. The posted daily staffing information sheet was observed on the counter at the reception desk in lobby and was dated 3/26/26 (Thursday).</p> <p>On 3/30/26 at 3:15 PM an interview with the Scheduler revealed she was responsible for posting daily staffing information sheets. She reported she had not been in the office on 3/27/26 and she didn't work on the weekends. She stated although she knew that staffing information sheets were required to be posted daily, the facility did not have a process for ensuring this happened when she was out of the office or on the weekends. She reported she had not completed and posted the daily staffing information sheets for 3/27/26, 3/28/26 or 3/29/26. The Scheduler stated she had not had a conversation with the Administrator regarding the implementation of a process to ensure daily staffing information sheets were posted as required.</p> <p>On 4/1/26 at 10:20 AM a review of facility's previous 30 days of daily staffing information sheets</p>	F0732	<p>Continued from page 11</p> <p>(census, RN/LPN/CNA hours).</p> <p>DON will report the results to the Quality Assurance and Performance Improvement (QAPI) Committee monthly. The QAPI Committee will evaluate effectiveness and implement additional interventions as needed to ensure ongoing compliance.</p> <p>5. Date of Compliance</p> <p>The facility alleges compliance on 4/20/26</p>	04/20/2026

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F0732 SS = C	Continued from page 12 from 3/2/26 through 3/30/26 revealed them to be complete. In a follow up interview on 4/1/26 at 11:03 AM the Scheduler stated when she returned to the office, she would create the daily staff postings for the days she had been off, such as on weekends or when she was out of the office, based on the staffing schedules for those days to ensure the record of them was complete and accurate. She reported this is what she had done when she completed the daily staffing postings for 3/27/26, 3/28/26, and 3/29/26 when she returned to the facility on 3/30/26. On 3/31/26 at 2:57 PM an interview with the Administrator revealed the Scheduler was responsible for posting the daily staffing information sheets. She reported she was unaware that staffing information sheets were not being posted when the Scheduler was out of the office. The Administrator reported that anytime she reviewed the daily staffing information sheets, she found them to be complete. She stated the facility did not have a process in place to ensure staffing information sheets were posted when the Scheduler was out of the office or the weekends.	F0732		04/20/2026
F0842 SS = A	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F0842		04/10/2026

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<p>F0842 SS = A</p>	<p>Continued from page 13</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations</p>	<p>F0842</p>		<p>04/10/2026</p>

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F0842 SS = A	<p>Continued from page 14 conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to ensure the accuracy of the medication administration record (MAR) for 1 of 6 residents reviewed for medication administration documentation (Resident #115).</p> <p>The findings included:</p> <p>Resident #115 was admitted on 8/30/2025.</p> <p>Record review revealed that on 1/19/2026, Resident #115 had an active order for Doxycycline 100 mg twice daily. The MAR showed Nurse #3 documented the 8:00 PM dose on 1/19/2026 as administered.</p> <p>During an interview on 3/31/2026 at 2:05 PM, Nurse #3 stated she did not administer Doxycycline to Resident #115 on 1/19/26 and acknowledged she inaccurately documented that the dose had been given. She stated the medication was unavailable because it had not been delivered by the pharmacy and had not been removed from the facility's back-up supply.</p> <p>During a telephone interview on 3/31/2026 at 1:55 PM, Nurse #5 stated she removed Doxycycline on 1/19/2026 from the facility's back-up medication system for two other residents and confirmed no Doxycycline was removed for Resident #115.</p> <p>During an interview on 3/31/2026 at 12:30 PM, the Director of Nursing (DON) stated she was aware Nurse #3 documented administration of a medication that was not available. The DON confirmed the pharmacy had not delivered the medication and the back-up medication log showed no removal of Doxycycline for Resident #115. The DON stated Nurse #3 should not have documented the medication as administered.</p> <p>During an interview on 4/1/2026, the Administrator stated she was aware Nurse #3 documented a medication that had not been administered and stated the nurse should document only medications actually administered to residents.</p>	F0842		04/10/2026