STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345549	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Rehabilitation and Healthcare Center	**1070 Old Ocean Highway , Bolivia, North Carolina, 28422**

(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 The survey team entered the facility on 04/20/26 to conduct a recertification and complaint survey and exited on 04/24/26. Additional information was obtained on 05/04/26 and 05/05/26. Therefore, the exit date was changed to 05/05/26. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # 22EECC-H1.	E0000		05/11/2026
F0000	INITIAL COMMENTS The survey team entered the facility on 04/20/26 to conduct a recertification and complaint survey and exited the facility on 04/24/26. Additional information was obtained on 05/04/26 and 05/05/26. Therefore, the exit date was changed to 05/05/26. Event ID #22EECC-H1. The following intakes were investigated: 882697, 2668372, 2707845, 2969245, 2621924, 2689621, 2641227, 2809817, 2808032, 2809244, 2988086, 2988139, 2998069, and 2990293. 9 out of 33 complaint allegations resulted in deficiencies.	F0000		05/11/2026
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by:	F0881	Plan of Correction – F0081 Antibiotic Stewardship Program Deficient Practice: The facility failed to implement a facility-wide system to monitor the use of antibiotics as part of the facility's Antibiotic Stewardship Program. Corrective Action for Residents Found to Be Affected by deficient practice On 5/12/2026 the Director of Nursing and/or Infection Preventionist/designee initiated corrective	05/21/2026

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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F0881 SS = F	Continued from page 1 Based on record review and staff interviews, the facility failed to implement a facility-wide system to monitor the use of antibiotics. This was evident for 8 of 9 months (July 2025, August 2025, September 2025, October 2025, November 2025, December 2025, February 2026, March 2026) that surveillance data was reviewed. This practice had the potential to affect all residents in the facility. Findings included: The facility's Antibiotic Stewardship Program policy last revised on December 2016, indicated that all clinical infections treated with antibiotics will undergo review by the Infection Preventionist or designee. The Infection Preventionist will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. The antibiotic stewardship program will review essential data including antibiotic orders, clinical documentation, infection surveillance logs, microbiology testing, other tests to confirm infections, and trends in data including a listing of antibiotic orders, clinical documentation confirming the infection, surveillance logs and trending of infections. The facility was unable to provide any infection control data including no listing of antibiotic orders, clinical documentation confirming the infection, surveillance logs or trending of infections for July 2025, August 2025, September 2025, October 2025, November 2025, and December 2025. A review was conducted of resident infections reported in January 2026. The list included residents who exhibited symptoms and were treated with antibiotics during the month. The facility did not utilize a structured tool to track infection rates, antibiotic use, or to monitor, conduct surveillance, or identify trends related to infections or possible infections among residents during this period. The facility was unable to provide any infection control data including no listing of antibiotic orders, clinical documentation confirming the infection, surveillance logs or trending of infections for February 2026 and March 2026. An interview with the Director of Nursing (DON) on 4/22/26 at 11:50 AM revealed that she assumed the position on 4/13/26, following a period in which several interim Directors of Nursing had served. The	F0881	Continued from page 1 action upon identification of the deficient practice. On 5/12/26, the Director of Nursing and/or Infection Preventionist/designee completed a review of all current residents receiving antibiotic therapy to ensure: · Appropriate indication for antibiotic use was documented · Physician orders included diagnosis, dosage, duration, and stop date when applicable · Monitoring for effectiveness and adverse reactions was completed · Culture and sensitivity results were reviewed when available · Antibiotic therapy was reviewed for appropriateness by the Consultant Pharmacist and Medical Director Any identified discrepancies were immediately addressed by the Director of Nursing and/or Infection Preventionist/designee with the attending physician and corrected as indicated by 5/12/26. There were no discrepancies noted. On 5/12/26, the Director of Nursing and/or Infection Preventionist/designee implemented an Antibiotic Stewardship Monitoring Tool to track all residents receiving antibiotics, including indication, antibiotic start date, stop date, culture results, prescribing practitioner, and follow-up review. 2. Identification of Other Residents with the Potential to be Affected All residents residing in the facility have the potential to be affected by the alleged deficient practice. On 5/12/26, the Director of Nursing and/or Infection Preventionist/designee completed a review of all residents who received antibiotic therapy within the	05/21/2026

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F0881 SS = F	Continued from page 2 current DON stated that she was unable to locate Infection Control reports, surveillance records, or infection tracking data for the period of July 2025 through April 2026 except for the January list of residents that received antibiotics. The DON acknowledged that she was expected to function as the Infection Preventionist in addition to fulfilling her responsibilities as the DON. She explained that she had just begun reviewing the infection control information for April 2026 and stated that moving forward, she would implement a system to ensure infection surveillance data was compiled and reviewed monthly. An interview with the Administrator on 4/22/26 at 4:30 PM revealed that the facility had multiple interim Directors of Nursing since she started in her position at the facility in July 2025. The Administrator stated that the tracking of infection control data, including infection trends and antibiotic use, had not been completed. The Administrator explained that the Infection Control Program was intended to be a comprehensive system that included surveillance, tracking, and trend analysis. She stated that she had been in her role only a short time and had not had a consistent Infection Preventionist in place. The Administrator further noted that her expectation was for the Infection Preventionist to follow facility protocols and complete all tasks related to the antibiotic stewardship program, including surveillance and tracking of infection and antibiotic use trends.	F0881	Continued from page 2 previous 30 days to determine whether appropriate antibiotic monitoring and stewardship practices had been followed. This review included: · Verification of physician documentation supporting antibiotic use · Review of laboratory and culture data · Confirmation of stop dates and duration of therapy · Assessment for duplicate, prolonged, or potentially inappropriate antibiotic therapy Any concerns identified during the review were immediately addressed by the Director of Nursing and/or Infection Preventionist/designee with the attending physician and documented accordingly on 5/12/26. 3. Systemic Changes Made to Ensure the Deficient Practice Does Not Recur The Director of Nursing and/or Infection Preventionist/designee implemented a comprehensive facility-wide Antibiotic Stewardship System in accordance with CMS requirements and facility policy beginning 5/12/26. The following systemic changes were implemented: On 5/12/26, the Director of Nursing and/or Infection Preventionist/designee revised and reinforced the facility's Antibiotic Stewardship Policy and Procedure to include: Ongoing monitoring of antibiotic utilization Documentation requirements Tracking and trending of antibiotic prescribing patterns	05/21/2026

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F0881 SS = F		F0881	Continued from page 3 Monitoring of antibiotic start dates, indications, duration, and stop dates Review of culture and sensitivity reports Monitoring for adverse drug reactions and effectiveness On 5/12/26, the Director of Nursing and/or Infection Preventionist/designee implemented an Antibiotic Stewardship Log/Tracking Tool to monitor all residents receiving antibiotic therapy. The log will be maintained by the Director of Nursing and/or Infection Preventionist and reviewed weekly by the Director of Nursing beginning 5/12/26. Beginning 5/12/26, the Infection Preventionist, Director of Nursing, Medical Director, and Consultant Pharmacist will participate in monthly Antibiotic Stewardship reviews during Quality Assurance and Performance Improvement (QAPI) meetings to analyze: Antibiotic utilization trends Opportunities for antibiotic de-escalation Compliance with documentation standards Patterns of inappropriate prescribing On 5/12/26, the Director of Nursing and/or Infection Preventionist/designee initiated education for all licensed nurses, and contracted agency staff regarding: Facility Antibiotic Stewardship policies Appropriate antibiotic documentation requirements CMS regulatory requirements related to Antibiotic Stewardship	05/21/2026

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F0881 SS = F		F0881	Continued from page 4 Monitoring for effectiveness and adverse reactions related to antibiotic use Appropriate communication of changes in resident condition related to infection concerns Education for all licensed nurses, and contracted agency staff will be completed by 5/21/26. Staff not present during the initial education will be educated upon return to duty prior to assuming resident care responsibilities. Beginning 5/12/26, all newly hired licensed nurses, and contracted agency staff will receive education regarding the facility's Antibiotic Stewardship Program, monitoring requirements, and CMS regulatory expectations during orientation prior to providing resident care. Beginning 5/12/26, the Consultant Pharmacist will complete monthly reviews of antibiotic utilization and report findings and recommendations to the facility leadership team and QAPI Committee. 4. Monitoring Procedure to Ensure Compliance Is Maintained Beginning 5/12/26, the Director of Nursing and/or Infection Preventionist/designee will conduct audits of residents receiving antibiotics weekly for four weeks, then monthly for three months to ensure: Appropriate indication for antibiotic use is documented Antibiotic start and stop dates are present Culture results are reviewed when applicable Antibiotic monitoring documentation is completed Antibiotic use is tracked on the facility Antibiotic Stewardship Log	05/21/2026

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F0881 SS = F		F0881	Continued from page 5 Any concerns identified during audits will be immediately addressed by the Director of Nursing and/or Infection Preventionist through re-education, corrective action, and/or physician notification as indicated. Audit findings will be reviewed by the Director of Nursing, Infection Preventionist, Consultant Pharmacist, and QAPI Committee monthly for three months. Additional education and corrective action will be implemented as indicated based on audit findings. The facility alleges compliance on 5/21/26.	05/21/2026
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F0755	Plan of Correction – F0755 Pharmacy Services Deficient Practice: The facility failed to ensure effective safeguards and systems were in place to prevent diversion of discontinued controlled substances. The facility also failed to implement an effective tracking and monitoring system for declining narcotic count sheets and failed to timely remove discontinued controlled substances from medication carts. 1. Corrective Action for Those Residents Found to Be Affected On 5/12/26 All medication carts, medication rooms, narcotic storage areas, emergency drug kits, and discontinued medication storage bins were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or designee to identify any discontinued controlled substances remaining in active medication storage areas. All discontinued controlled substances identified were immediately removed from medication carts and secured in accordance with facility policy and pharmacy procedures pending destruction or return to pharmacy. A full reconciliation of controlled substance declining inventory sheets was completed by the DON/ADON on 5/12/26 for all nursing units to identify discrepancies, omissions, incomplete documentation, and unresolved variances.	05/21/2026

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F0755 SS = E	Continued from page 6 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with facility staff, the Nurse Practitioner, Pharmacy Consultant and the Pharmacy Director, the facility failed to 1) have effective safeguards and systems in place to prevent drug diversion of discontinued Oxycodone (narcotic pain medication), Hydrocodone/Acetaminophen (narcotic pain medicine with Tylenol) and Lorazepam (an antianxiety medication); and 2) failed to have an effective tracking system to monitor declining count sheets and remove discontinued controlled substances from the medication cart for 5 of 6 residents reviewed for drug diversion (Residents #9, #41, #69, #94, and #95). These failures resulted in inaccurate narcotic counts and had the potential for residents being administered incorrect medications, and receiving narcotics that were not physician ordered. Findings included: 1a. A physician's order was written on 07/18/25 to discontinue Lorazepam 0.5mg every 8 hours as needed for anxiety for Resident #9. The declining count sheet (an inventory log used to record a running total for each controlled medication) for 90 Lorazepam 0.5mg tablets with prescription #979977 for Resident #9 revealed the Lorazepam 0.5 mg was documented having a total of 83 tablets remaining on the count sheet. An undated note written on the count sheet revealed 82 tablets were returned, one tablet was missing. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation that she, the previous DON and the Administrator initiated on 12/30/25 it was found that Resident #9 had one tablet missing from the declining count sheet. The documented number of tablets left should have been 83 but the total count was 82 tablets. The Regional Clinical Director stated a total of 82 tablets were returned to the pharmacy. Review of the Prescriptions Returned To Pharmacy Log revealed the prescription for Resident #18 with prescription #979977 for Lorazepam 0.5 mg had a	F0755	Continued from page 6 Any identified discrepancies were immediately investigated by administration in collaboration with pharmacy consultant services and reported per facility policy and applicable state and federal requirements. No further discrepancies were noted. Licensed nursing staff identified as responsible for incomplete narcotic documentation or improper storage/removal practices received immediate re-education regarding controlled substance accountability, declining inventory procedures, discontinued medication removal, and diversion prevention protocols by the DON/ADON. 2. Identification of Other Residents Who Have the Potential to Be Affected All residents receiving controlled substances have the potential to be affected by the deficient practice. A 100% audit of all controlled substances on all medication carts and medication storage areas was completed by DON/ADON on 5/12/26 to verify accurate declining inventory documentation, presence of current physician orders, removal of discontinued controlled substances, appropriate storage and security of controlled medications, and shift-to-shift narcotic count completion. On 5/20/26 A retrospective audit of controlled substance records, destruction records, discontinued medication logs, pharmacy reconciliation reports, and narcotic count sheets was completed by the DON/ADON for the previous 30 days to identify unresolved discrepancies or trends. The Pharmacy Vice President of operations reviewed current systems for controlled substance monitoring on 5/4/26 and provided recommendations for process improvement and compliance oversight. 3. Systemic Changes Made to Ensure the Deficient Practice Does Not Recur On 5/12/26 the DON/Designee revised and/or reinforced policies and procedures related to	05/21/2026

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F0755 SS = E	Continued from page 7 quantity of 82 tablets recorded as returned on 01/17/26. A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that 82 tablets of Lorazepam were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received medications back from the facility, the medications were reviewed to verify contents and quantity returned. An interview with the current Director of Nursing (DON) on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance had been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated at the time of the investigation (12/30/25) it was the responsibility of all the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the system failure was that the controlled medication was discontinued on 07/18/25 and should have been returned back to the pharmacy when the order was discontinued. 1b.) A physician's order written on 04/23/25 which was discontinued on 07/24/25 for Resident #41 revealed Oxycodone 5 milligrams (mg) tablets, one tablet by mouth every 8 hours for pain as needed. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 04/28/25 a total of 90 Oxycodone 5 mg tablets for Resident #41 with prescription #991627 were delivered to the facility. The delivery receipt was signed off as received by night shift Nurse #12 on 04/28/25.	F0755	Continued from page 7 controlled substance management, diversion prevention, declining narcotic count documentation, removal and destruction of discontinued controlled substances, shift narcotic reconciliation procedures, and investigation and reporting of discrepancies. An enhanced narcotic accountability system was implemented on 5/12/26 which includes daily review of declining narcotic count sheets by unit managers/designee, end-of-shift controlled substance reconciliation by licensed nurses, immediate escalation of discrepancies to the DON/Administrator, tracking logs for discontinued controlled substances awaiting destruction or return, and a double verification process for removal and destruction of discontinued narcotics. Licensed nurses, contracted agency staff, unit managers, and supervisory staff were educated by DON on 5/12/26 regarding requirements of F0755 Pharmacy Services, controlled substance security and accountability, accurate declining inventory documentation, proper handling of discontinued medications, drug diversion recognition and reporting, and facility expectations for narcotic reconciliation and storage. The Director of Nursing and/or designee will conduct random medication cart inspections beginning 5/12/26 to verify compliance with controlled substance storage, inclusive of integrity of medication cards, and documentation requirements. The facility pharmacy consultant will participate in monthly reviews beginning May 2026 of controlled substance processes and provide recommendations to the Quality Assurance and Performance Improvement (QAPI) Committee. Pharmacy representative will send monthly report to DON discussing the integrity/concerns of returned medications from facility. Education for all licensed nurses and contracted agency staff, and applicable departmental staff was completed by 5/12/26 prior to staff assuming independent resident care responsibilities. Staff not present during the initial education were educated upon return to duty prior to providing resident care.	05/21/2026

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F0755 SS = E	Continued from page 8 The declining count sheet for 90 Oxycodone 5mg tablets with prescription #991627 that were delivered to the facility on 04/28/25 for Resident #41 revealed the first dose was signed off as removed on 09/14/25 at 12:00 PM leaving 89 pills remaining. The second dose was signed off as removed on 09/21/25 at 4:00 PM leaving 88 pills remaining, the third dose was signed off as removed on an illegible date at 5:10 AM leaving a total of 87 tablets remaining. There was no signature recorded indicating which nurse removed the medication on each day that the medications were removed. On 12/30/25 at 1:13 PM the count was noted to be 90 tablets and a note on the declining sheet indicated the count was corrected by the Regional Clinical Director and the previous Director of Nursing for 90 tablets. An undated note on the declining count sheet also revealed 87 pills returned and 3 pills did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed on 12/30/25 there were multiple incidents where blister packs were perforated and taped back up. She stated an investigation began due to the tampering of the narcotic blister packs and it was discovered that the narcotics were being replaced with other medications such as blood pressure medications. The DON could not recall if the Oxycodone blister pack she identified as being taped up and tampered with on 12/30/25 belonged to Resident #41, but she knew it was Oxycodone and that the replacement tablets that were noted in the blister packs were Metoprolol (a blood pressure medication) which made the count remaining look as though there were 90 tablets. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25 it was found that Resident #41 had 3 pills that were removed from the blister pack of Oxycodone 5mg and were replaced with 3 Metoprolol tablets. She stated when she and the previous DON did the count there were 90 tablets left, but it was realized 3 of the tablets were Metoprolol and were removed leaving a remainder of 87 tablets of Oxycodone which were returned back to the pharmacy. Review of the Prescriptions Returned To Pharmacy Log revealed the prescription date of 04/28/25 for Resident #41 with prescription #991627 for	F0755	Continued from page 8 Beginning 5/12/26, all newly hired licensed nurses and contracted agency staff will receive education during orientation prior to providing resident care services. 4. Monitoring to Ensure Compliance Is Maintained Beginning 5/12/26 The DON, ADON, and/or designee will complete audits of controlled substance declining inventory sheets, shift narcotic counts, medication cards for integrity, medication carts for discontinued controlled substances, controlled substance destruction records, and discontinued medication tracking logs. Audits will be conducted five times weekly for four weeks, weekly for four additional weeks, and monthly for three months thereafter. Any identified concerns will be addressed immediately through corrective action, staff counseling, re-education, and/or disciplinary action as appropriate. Results of audits, findings, trends, and corrective actions will be reviewed by the QAPI Committee monthly for 5 months for ongoing evaluation of compliance and effectiveness of systemic changes. The facility will maintain compliance through continued oversight, ongoing staff education, pharmacy consultant involvement, and routine monitoring of controlled substance management systems. Facility alleges compliance on 5/21/26	05/21/2026

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F0755 SS = E	Continued from page 9 Oxycodone 5 mg had a quantity of 87 tablets recorded as returned on 01/17/26. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #41 did not have a physician's order for Metoprolol. The Nurse Practitioner stated if Resident #41 had received the Metoprolol in error due to being replaced in the Oxycodone blister pack it may have lowered his blood pressure and heartrate and could have caused a syncopal event (a temporary loss of consciousness known as fainting or passing out caused by a sudden drop in blood pressure). A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that 87 Oxycodone tablets were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received medications back from the facility, the medications were reviewed to verify contents and quantity returned. The Pharmacy Director stated had Resident #41 received the Metoprolol in error it would have had the potential to lower his blood pressure and heartrate. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance had been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box on the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the secured controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the system failure was that the controlled medication for Resident #41 was discontinued on 07/24/25 and should have been returned back to the pharmacy when the order was discontinued.	F0755		05/21/2026

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F0755 SS = E	Continued from page 10 1c.) A physician's order written on 06/18/25 and discontinued on 11/12/25 for Resident #69 revealed Hydrocodone/Acetaminophen (Tylenol) 10mg/325mg one tablet by mouth every six hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 09/10/25 a total of 60 Hydrocodone/Acetaminophen 10mg/325mg tablets for Resident #69 with prescription #1144328 were delivered to the facility. The delivery receipt was not signed off as received by a nurse. The declining count sheet for 60 Hydrocodone/Acetaminophen 10mg/325 mg tablets that were delivered to the facility on 09/10/25 for Resident #69 with prescription #1144328 revealed the remaining count was recorded at 43 tablets. The declining count sheet had 17 doses signed out as being removed. An undated note on the declining count sheet indicated 42 pills were returned and 1 pill did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed she could not recall if the Hydrocodone/Acetaminophen 10mg/325mg blister pack she identified as being taped up and tampered with on 12/30/25 belonged to Resident #69, but she knew it was Hydrocodone/Acetaminophen and the replacement tablet was replaced with a lower dose of Hydrocodone/Acetaminophen 5mg/325mg. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25 it was found that Resident #69 had a blister pack of Hydrocodone/Acetaminophen 10mg/325mg but that there was one tablet removed and was replaced with Hydrocodone/Acetaminophen 5mg/325mg. She stated the remaining 42 tablets were returned back to the pharmacy. Review of the Prescriptions Returned To Pharmacy Log revealed the prescription date of 09/10/25 for Resident #69 with prescription #1144328 Hydrocodone/Acetaminophen 10mg/325mg had a quantity of 42 tablets recorded as returned on 01/17/26.	F0755		05/21/2026

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F0755 SS = E	Continued from page 11 A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that a total of 42 tablets of Hydrocodone/Acetaminophen 10mg/325mg were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received medications back from the facility, the medications were reviewed to verify contents and quantity returned. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the secured controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Hydrocodone/Acetaminophen 10mg/325mg was discontinued on 11/12/25 and should not have still been in the controlled substance box on the medication cart. The DON stated the system failure was that the controlled medication was not returned back to the pharmacy when the medication was discontinued. 1d.) A physician's order written on 12/05/25 and discontinued on 12/08/25 for Resident #94 revealed Oxycodone 5 mg one tablet by mouth every 4 hours as needed for pain for up to 7 days, and a physician's order written on 12/05/25 for Hydroxyzine (anti-itch medication) 25 mg one tablet every 8 hours for itching for 15 days; which was discontinued on 12/19/25. Resident #94 did not have physician orders in place for Seroquel (a medication to treat psychiatric diagnoses) or Metoprolol (a medication to treat high blood pressure).	F0755		05/21/2026

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F0755 SS = E	Continued from page 12 A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 12/06/25 a total of 30 Oxycodone 5 mg tablets for Resident #94 with prescription #1268757 were delivered to the facility. The delivery receipt was received by Nurse #14 on 12/06/25. The declining count sheet for 30 Oxycodone 5 mg tablets that were delivered on 12/06/25 with prescription #1268757 for Resident #94 revealed the remaining count was recorded as 18 tablets remaining. A total of 12 doses were signed out as removed from the declining count sheet. An undated handwritten note on the declining count sheet indicated 12 pills were returned with 6 pills that did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed she could not recall if the Oxycodone blister pack she identified as being taped up and tampered with on 12/30/25 belonged to Resident #94, but she knew it was Oxycodone and there were other medication pills that were replaced in the blister pack, but she could not recall how many or what the pills were. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25, Resident #94 had 3 pills that had been replaced with Seroquel, 2 pills were replaced with Metoprolol and one pill was replaced with Hydroxyzine. She stated that a total of 12 tablets of Oxycodone 5 mg were returned back to the pharmacy. Review of the Prescriptions Returned To Pharmacy log revealed the prescription date of 12/05/25 for Resident #94 with prescription #1268757 Oxycodone 5 mg had a quantity of 12 tablets returned on 01/17/26. A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that a total of 12 tablets of Oxycodone 5 mg were returned on 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received the medications back from	F0755		05/21/2026

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F0755 SS = E	Continued from page 13 the facility, they were reviewed to verify contents and quantity returned. The Pharmacy Director stated had Resident #94 received the Metoprolol in error it would have had the potential to lower his blood pressure and heartrate and had he received the Seroquel it could have caused Resident #94 to be lethargic (sleepy). An interview with the Nurse Practitioner on 04/24/26 at 1:30 PM confirmed that Resident #94 did not have a physician's order for Seroquel or Metoprolol, but he did have an order for Hydroxyzine which was discontinued on 12/15/25. The Nurse Practitioner stated had Resident #94 received the Metoprolol or Seroquel he could have had syncopal event and increased lethargy as result. The Nurse Practitioner stated there was no allergy listed for either medication for Resident #94. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the box located in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Oxycodone 5mg medication was discontinued on 12/08/25 and should not have still been in the controlled substance box on the medication cart. The DON added that the system failure was not returning the controlled medication back to the pharmacy when it was discontinued. 1e.) A physician's order written on 12/19/25 for Resident #95 revealed Oxycodone 5mg; give 5mg every 6 hours as needed for pain for 3 days. This order was discontinued on 12/22/25. Resident #95 did not have an order in place for Metoprolol.	F0755		05/21/2026

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F0755 SS = E	Continued from page 14 A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 12/19/25 a total of 12 Oxycodone 5mg tablets for Resident #95 with prescription #1294991 were delivered to the facility. The delivery receipt was signed off with an illegible name on 12/20/25. The declining count sheet for Oxycodone 5mg one tablet by mouth every 6 hours as needed for pain for Resident #95 with prescription #1294991 revealed the remaining count was 9 tablets. There were three doses signed out as removed by a nurse. An undated handwritten note on the declining count sheet indicated that 8 pills were returned and one pill did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed she could not recall if the Oxycodone blister pack identified as being taped up and tampered with on 12/30/25 belonged to Resident #95, but she knew it was Oxycodone and there were other medication pills that were replaced in the blister pack. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25, Resident #95 had one pill that had been replaced with Metoprolol. Review of the Prescriptions Returned To Pharmacy log revealed the prescription date of 12/19/25 for Resident #95 with prescription #1294991 Oxycodone 5mg had a quantity of 8 tablets recorded as returned on 01/17/26. A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that a total of 8 tablets of Oxycodone 5mg were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received the medications returned back from the facility, they were reviewed to verify contents and quantity returned. The Pharmacy Director stated had Resident #95 received the Metoprolol in error it would have had the potential to lower his blood pressure and heartrate.	F0755		05/21/2026

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F0755 SS = E	Continued from page 15 An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #95 did not have a physician's order for Metoprolol. The Nurse Practitioner stated if Resident #95 had received the Metoprolol in error due to being replaced in the Oxycodone blister pack it may have lowered his blood pressure and heartrate and could have caused a syncopal event. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance had been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located in the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Oxycodone 5mg medication was discontinued 12/22/25 and should not have still been in the controlled substance box on the medication cart. The DON added that the system failure was not returning the controlled medication back to the pharmacy when it was discontinued. A phone interview was conducted with Nurse #5 on 04/23/26 at 7:38 PM. Nurse #5 stated on the morning of 12/30/25 when she arrived for her shift, she noticed that Nurse #6 was doing the narcotic count with Nurse #7 and Nurse #6 stated she was not taking the keys to cart because there were some narcotic blister packs that were tampered with on the 300 hall medication cart. Nurse #5 stated she worked on the 400 hall medication cart and thought it best to look through her cart to see if there were any tampered narcotic blister packs on her cart. Nurse #5 stated she identified a few (could not recall how many or for which residents) and notified the Nurse Supervisor. Nurse #5 stated some of the blister packs were taped up and some had the tiniest little sliver break noted on the back of the blister pack. She stated the Administrator saw that there were different pills replaced in the blister	F0755		05/21/2026

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F0755 SS = E	Continued from page 16 packs and the previous Director of Nursing did a narcotic count on the 400 hall medication cart and there were no other discrepancies. Nurse #5 stated she had to complete a drug test and it was negative for opioids (narcotic pain medications). A phone interview was conducted with Nurse #7 on 04/24/26 at 11:27 AM. Nurse #7 reported when she arrived for her shift 7:00 PM to 7:00 AM on 12/29/25 she had begun to do her narcotic medication count for 300 hall medication cart with Nurse #1. Nurse #7 stated the narcotic count appeared to be accurate; however, it was noted there were two blister packs for Oxycodone that had tape on the back side of the packs. Nurse #7 stated she did not remember which resident the blister packs belonged to or the dose of the medication. Nurse #7 stated, at that time, she told Nurse #1 that they should waste the medications that were taped up in the blister pack and Nurse #1 stated “no.” Nurse #7 stated the tablets that were taped up were noted to be on the bottom right hand corner of the blister pack. Nurse #7 stated she should have reported this to the supervisor and not taken over the medication cart keys until it was investigated. Nurse #7 stated she did not see tape on any of the other narcotic cards but she knew that having tape on the blister packs was not right and the integrity of the blister pack had been tampered with. Nurse #7 stated when she did the shift change count off on 12/30/25 with Nurse #6 and showed her the taped up Oxycodone blister packs, Nurse #6 stated they needed to call the Director of Nursing immediately and she would not accept the keys to the 300 hall medication cart. Nurse #7 stated she was asked to do a drug screening test and it was negative for opioids. A phone interview was conducted with Nurse #6 on 04/24/26 at 12:07 PM. Nurse #6 reported on the morning of 12/30/25 she arrived for her shift and had begun to do her narcotic medication count with Nurse #7 who worked the night shift. Nurse #6 stated while they were doing the count, Nurse #7 pointed out that there were two narcotic blister packs of Oxycodone that had tape covering the back of the blister pack. Nurse #6 stated when Nurse #7 showed her the blister packs, it looked as though the Oxycodone pills had been “popped” out of the blister pack but there were different pills in place in the blister packs that were taped up. Nurse #6 stated she did not remember which resident the blister packs belonged to or what the dose of the medication was. Nurse #7 stated to Nurse #6 that the	F0755		05/21/2026

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F0755 SS = E	Continued from page 17 pills that were in the blister pack did not match the description of an Oxycodone tablet and both Nurse #7 and Nurse #6 looked up the description of the tablets that were replaced on the internet to check and see what medications were put in place. She stated the medication was Metoprolol which was a blood pressure medication for one of the blister packs and the other blister pack had been replaced with a lower dose of Oxycodone. Nurse #7 stated she reported the concern to the Weekend Supervisor and she called the Administrator and the previous Director of Nursing. Nurse #6 stated she was not asked to do a drug screening test. A phone interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated she was nurse doing the shift change with Nurse #7 on the evening of 12/29/25. She stated she recalled Nurse #7 showing her the taped up narcotic blister packs and asked if they should waste the medications that were taped up. Nurse #1 stated she told Nurse #7 not to waste it. Nurse #1 stated sometimes medications would accidentally pop out and she would tape them back up if she saw them falling out. Nurse #1 stated she did not know that the narcotics were replaced with other medications. Nurse #1 stated the DON asked her to do a drug test and she refused to do a drug test that day because she was not feeling well and then was terminated for not doing the drug test. An interview was conducted with the current Director of Nursing on 04/24/26 at 5:10 PM. The DON stated the system failure was that controlled substances were not being returned to the pharmacy when they were discontinued and that resulted in the misappropriation of the narcotics. The DON stated education was initiated when this occurred to be sure when doing the controlled substance count at shift change, both nurses should be checking for accuracy of the right medication and checking the blister packs for any signs of being tampered with, but she would reinforce that education along with providing education for making sure all discontinued narcotics were returned to the pharmacy according to the procedure. 2a. A physician's order was written on 07/18/25 to discontinue Lorazepam 0.5mg every 8 hours as needed for anxiety for Resident #9. The declining count sheet for 90 Lorazepam 0.5mg tablets with prescription #979977 for Resident #9	F0755		05/21/2026

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F0755 SS = E	Continued from page 18 revealed the Lorazepam 0.5mg was documented as removed on 09/10/25, 09/30/25, 10/03/25, 10/05/25, and 12/03/25 by Nurse #1. On 11/19/25, one (1) tablet was documented as removed by Nurse #20. There was no active physician order for this medication during these dates. Review of the Medication Administration Record for September 2025, October 2025, and December 2025 revealed there was no active order for Lorazepam 0.5mg recorded on the Medication Administration Records for Nurse #1 and Nurse #20 to sign off as administered. An interview was attempted with Nurse #20 via phone on 04/24/26 at 12:33 PM. A voice mail message was left but Nurse #20 but did not return the phone call. A phone interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated “my system was not good” and clarified that she knew which medications her residents’ received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an order before she administered the medication. Nurse #1 stated whenever she removed the Lorazepam for Resident #9, she administered the medication to him. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #9’s Lorazepam order for 0.5mg was discontinued on 07/18/25 and there was no active order to administer this medication after that date in 2025. The Nurse Practitioner stated the medication should not have been removed to be administered if there was no active order for it. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated in 2025, it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the secured controlled substance box in the medication cart and sent back to the dispensing	F0755		05/21/2026

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F0755 SS = E	Continued from page 19 pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the system failure was that the controlled medication was discontinued on 07/18/25 and should have been returned back to the pharmacy when the order was discontinued. The DON added that Nurse #1 and Nurse #20 should not have documented the removal of the Lorazepam tablets since there was not an active order. She stated before nursing staff removed a medication from the blister pack, they should be confirming there was a physician's order, check the order against the controlled substance blister pack, sign and date the declining count sheet with the number of tablets remaining after removal, and then sign off the administration of the medication on the Medication Administration Record. 2b. A physician's order written on 04/23/25 for Resident #41 and discontinued on 07/24/25 for Oxycodone 5mg tablet, one tablet by mouth every 8 hours for pain as needed. There was no active physician order for Oxycodone 5mg to be given from 07/25/25 through 09/10/25. The declining count sheet for 90 Oxycodone 5mg tablets with prescription #909487 for Resident #41 revealed the Oxycodone 5mg was documented as removed on 08/08/25 and 09/06/25 by Nurse #1. There was no active physician order for this medication at this time. Review of the Medication Administration Record for August 2025, revealed there was no order for Oxycodone 5mg recorded on the Medication Administration Records for Nurse #1 to sign off as given on 08/08/25 and 09/06/25. An interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated "my system was not good" and clarified that she knew which medications her residents' received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration	F0755		05/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345549	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Rehabilitation and Healthcare Center	**1070 Old Ocean Highway , Bolivia, North Carolina, 28422**

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F0755 SS = E	Continued from page 20 record (eMAR) to be sure there was an active order before she administered the medication. Nurse #1 stated whenever she removed the Oxycodone for Resident #41, she administered the medication to him. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #41's Oxycodone 5mg order was discontinued on 07/24/25 and there was no active order to administer this medication on 08/08/25 and 09/06/25. The Nurse Practitioner stated the medication should not have been removed to be administered if there was no active order for it. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON in 2025, it was the responsibility of all the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the control substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the system failure was that the controlled medication was discontinued on 07/24/25 and should have been returned back to the pharmacy when the order was discontinued. The DON added that Nurse #1 should not have removed those tablets. She stated before nursing staff removed a medication from the blister pack, they should be confirming there was a physician's order, check the order against the controlled substance blister pack, sign and date the declining count sheet with the number of tablets remaining after removal, and then sign off as administered on the Medication Administration Record. 2c. A physician's order written on 06/18/25 and discontinued on 11/12/25 for Resident #69 revealed Hydrocodone/Acetaminophen (Tylenol) 10mg/325mg one tablet by mouth every 6 hours as needed for pain.	F0755		05/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345549	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

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F0755 SS = E	Continued from page 21 A physician's order written on 11/12/25 and discontinued on 11/19/25 for Resident #69 revealed Hydrocodone/Acetaminophen 5mg/325mg one tablet by mouth every 6 hours as needed for pain. There was no active physician's order for Hydrocodone Acetaminophen 10mg/325 mg or Hydrocodone Acetaminophen 5mg/325mg since 11/19/25. A physician's order was written on 12/01/25 for Hydrocodone Acetaminophen 5mg/325mg give one tablet every 12 hours as needed for pain, but there was no packing slip or declining sheet for Hydrocodone/Acetaminophen 5mg/325 mg every 12 hours from 12/01/25. A phone interview with the Pharmacy Director on 04/24/26 at 3:17 PM was conducted. The Pharmacy Director stated there was no active order for either dosage of Hydrocodone/Acetaminophen from 11/20/25 through 12/25/25. He stated an order was written on 12/01/25 for Hydrocodone/Acetaminophen 5mg/325 mg every 12 hours as needed for pain, but the pharmacy did not receive a prescription for it so it was never filled. A phone interview with the Administrator on 05/04/26 at 3:19 PM confirmed that the pharmacy received the order on 12/01/25 for the Hydrocodone-Acetaminophen 5mg/325mg but they had sent over a form for clarification which was not completed and returned back to the pharmacy from the facility. The Administrator stated the pharmacy confirmed the order was never dispensed so therefore there would be no packing slip or declining count sheet. The Administrator stated there was no active order for Hydrocodone-Acetaminophen 5mg/325mg or Hydrocodone-Acetaminophen 10mg/325mg since 11/19/25. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 07/04/25 a total of 60 Hydrocodone/Acetaminophen 10mg/325mg tablets for Resident #69 with prescription #1065301 were delivered to the facility. The delivery receipt signed off as received by two signatures that were illegible.	F0755		05/21/2026

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F0755 SS = E	Continued from page 22 The declining count sheet for Hydrocodone/Acetaminophen 10mg/325mg tablets for Resident #69 with prescription #1065301 from 11/24/25 through 12/22/25 was reviewed. There was no active order in place to administer 10mg/325mg tablets to Resident #69. On the following days this medication dose was documented as removed. 11/24/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #1 at 9:00 AM 11/25/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #1 at 9:00 AM 11/30/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #1 at 9:00 AM 12/01/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #20 at 9:30 PM 12/03/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #20 at 4:00 AM 12/03/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #23 at 8:00 PM 12/06/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #23 at 9:00 AM 12/07/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #15 at 9:00 AM 12/08/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #1 at 9:00 AM 12/09/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #21 at 5:00 PM 12/11/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #24 at 6:49 AM 12/25/25 one tablet Hydrocodone/Acetaminophen 10mg/325mg removed by Nurse #21 at 10:00 PM An interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated “my system was not good” and clarified that she knew which medications her residents’ received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an active order before she administered the medication. Nurse #1	F0755		05/21/2026

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F0755 SS = E	Continued from page 23 stated whenever she removed the Hydrocodone/Acetaminophen 10mg/325mg tablets (11/24/25, 11/25/25 and 12/08/25) for Resident #69, she administered the medication to the resident. A phone interview was attempted with Nurse #20 on 04/24/26 at 12:30 PM. A voicemail message was left for a return call. Nurse #20 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/07/25 and 12/03/25. Nurse #20 did not return the phone call. A phone interview was attempted with Nurse #15 on 05/04/26 at 4:52 PM. A voicemail message was left for a return call. Nurse #15 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/07/25. Nurse #15 did not return the phone call. A phone interview was attempted with Nurse #21 on 05/04/26 at 4:53 PM. A voicemail message was left for a return call. Nurse #21 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/09/25 and 12/25/25. Nurse #21 did not return the phone call. A phone interview was attempted with Nurse #23 on 05/05/26 at 10:51 AM. A voicemail message was left for a return call. Nurse #23 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/03/25 and 12/06/25. Nurse #23 did not return the phone call. A phone interview was attempted with Nurse #24 on 05/05/26 at 10:51 AM. A voicemail message was left for a return call. Nurse #24 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/11/25. Nurse #24 did not return the phone call. An interview was conducted with the current Director of Nursing on 05/05/25 at 9:20 AM. The DON she was not working at the facility during this time (12/30/25). She stated at this time it was the floor nurse's responsibility to remove the discontinued controlled substances from the medication cart. The DON stated the system failure was that the discontinued controlled substances along with the declining count sheet were not being removed once discontinued.	F0755		05/21/2026

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F0755 SS = E	Continued from page 24 A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 09/10/25 a total of 60 Hydrocodone/Acetaminophen 10mg/325mg tablets for Resident #69 with prescription #1144328 were delivered to the facility. The delivery receipt was not signed off as received by a nurse. The declining count sheet for Hydrocodone/Acetaminophen 10mg/325mg tablets for Resident #69 with prescription #1144328 from 11/20/25 through 12/25/25 was reviewed. There was no active order in place to administer 10mg/325mg tablets to Resident #69. On the following days this medication dose was documented as removed. 11/20/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 2:00 PM 11/21/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 12:00 PM 11/21/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 4:00 PM 11/29/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 9:00 AM 12/06/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #14 at 1:12 PM 12/07/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #18 at 6:00 AM 12/09/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 11:00 AM 12/09/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 4:00 PM 12/12/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 9:00 AM 12/13/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1at 9:00 AM 12/14/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 9:00 AM 12/15/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 11:00 AM	F0755		05/21/2026

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F0755 SS = E	Continued from page 25 12/15/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 11:00 PM 12/17/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #1 at 9:00 AM 12/25/25 one tablet of Hydrocodone/Acetaminophen 10mg/325 mg was removed by Nurse #21 at 5:00 AM An interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated “my system was not good” and clarified that she knew which medications her residents’ received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an active order before she administered the medication. Nurse #1 stated when she removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 11/21/25, 11/29/25, 12/09/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25 and 12/17/25 for Resident #69 she administered the medication to the resident. A phone interview was attempted with Nurse #21 on 05/04/26 at 4:53 PM. A voicemail message was left for a return call. Nurse #21 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/25/25. Nurse #21 did not return the phone call. A phone interview with Nurse #18 on 05/05/26 at 10:21 AM was conducted. Nurse #18 stated he was a temporary agency nurse for the facility and worked there about 3 times. He stated he could not recall Resident #69 but his process before administering a controlled substance was to check the order in the eMAR prior to removing a controlled substance, signing off the removal and documenting the administration of the medication in the Medication Administration Record. He stated he did not recall removing the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/07/25 specifically. Nurse #18 added, that if the unit was busy with a lot of emergencies and falls, etc., he would just “pop” out the controlled substance and sign it off later in the Medication Administration Record. A phone interview was attempted with Nurse #14 on 05/05/26 at 10:50 AM. A voicemail message was left	F0755		05/21/2026

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F0755 SS = E	Continued from page 26 for a return call. Nurse #24 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/06/25. Nurse #14 did not return the phone call. A proof of delivery packing slip was sent to the facility for Resident #69 on 11/13/25 with prescription number #1233864 for 14 tablets of Hydrocodone/Acetaminophen 5mg/325 mg and signed by Nurse #11. The declining count sheet for 14 Hydrocodone/Acetaminophen 5mg/325 mg tablets that were delivered to the facility on 11/13/25 for Resident #69 with prescription #1233884 was reviewed. There was no active order in place to administer 5mg/325mg tablets to Resident #69. On the following days this medication dose was documented as removed: 11/20/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #1 at 12:00 PM. 12/05/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #3 at 10:00 PM 12/09/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #1 at 10:00 AM 12/09/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #21 1t 12:00 PM 12/11/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #3 at 10:00 PM 12/14/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #1 at 11:00 AM 12/14/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #26 at 10:55 PM 12/17/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #27 at 9:00 PM 12/19/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #3 at 3:34 AM 12/20/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #28 at 7:35 PM 12/22/25 one tablet of Hydrocodone/Acetaminophen 5mg/325mg was removed by Nurse #28 at 5:35 AM	F0755		05/21/2026

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F0755 SS = E	Continued from page 27 An interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated “my system was not good” and clarified that she knew which medications her residents’ received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an active order before she administered the medication. Nurse #1 stated when she removed the Hydrocodone/Acetaminophen 10mg/325mg tablets (11/20/25, 12/09/25, and 12/14/25) for Resident #69, she administered the medication to the resident. A phone interview was attempted with Nurse #21 on 05/04/26 at 4:53 PM. A voicemail message was left for a return call. Nurse #21 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/09/25. Nurse #21 did not return the phone call. A phone interview was attempted with Nurse #3 on 05/05/26 at 10:49 AM. A voicemail message was left for a return call. Nurse #3 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/05/25 and 12/11/25. Nurse #3 did not return the phone call. A phone interview was attempted with Nurse #26 on 05/05/26 at 10:55 AM. A voicemail message was left for a return call. Nurse #26 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/14/25. Nurse #26 did not return the phone call. A phone interview was attempted with Nurse #27 on 05/05/25 at 10:53 AM. A voicemail message was left for a return call. Nurse #27 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/17/25. Nurse #27 did not return the phone call. A phone interview was attempted with Nurse #28 on 05/05/26 at 10:42 AM. A voicemail message was left for a return call. Nurse #28 removed the Hydrocodone/Acetaminophen 10mg/325mg tablets on 12/20/25 and 12/22/25. Nurse #27 did not return the phone call.	F0755		05/21/2026

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F0755 SS = E	Continued from page 28 An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated in 2025, it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the controlled substance box on the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Hydrocodone/Acetaminophen 10mg/325mg was discontinued on 11/12/25 and should not have still been in the controlled substance box on the medication cart. The DON stated the system failure was that the controlled medications were not returned back to the pharmacy when the medication was discontinued. A phone interview with the Pharmacy Director on 04/24/26 at 3:17 PM confirmed the Hydrocodone/Acetaminophen 10mg/325 mg was discontinued on 11/12/25 and a new order was written for Hydrocodone/Acetaminophen 5mg/325 mg from 11/12/25 through 11/19/25. The Pharmacy Director stated there was no active order for either dose of Hydrocodone/Acetaminophen from 11/20/25 through 12/25/25. A phone interview with the Administrator on 05/04/26 at 3:19 PM confirmed that the pharmacy received the order on 12/01/25 for the Hydrocodone-Acetaminophen 5mg/325mg but they had sent over a form for clarification that was not completed and returned back to the pharmacy. The Administrator stated the pharmacy confirmed the order was never dispensed so therefore there would be no packing slip or declining count sheet. The Administrator stated there was no active order for Hydrocodone-Acetaminophen 5mg/325mg or Hydrocodone-Acetaminophen 10mg/325mg since 11/19/25. The Administrator stated she this was a medication error. A phone interview was conducted with the	F0755		05/21/2026

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F0755 SS = E	Continued from page 29 Pharmacist Consultant on 05/04/26 at 4:20 PM. The Pharmacy Consultant stated she did not review the controlled substance box or the declining count sheets on the medication cart on a regular basis. She stated she would expect that documentation on the declining medication sheets be clear and legible and if a controlled substance was discontinued it should be removed from the controlled substance box and returned to the pharmacy. The Pharmacy Consultant stated she would also expect the nursing staff to make sure they were reviewing the physician order in the electronic medication administration record prior to administering any medication to be sure they were administering the right medication and that there was an existing order. A follow up phone interview was conducted with the current Director of Nursing on 05/05/25 at 9:20 AM. The DON stated she was not working at the facility in 2025 and that at this time it was the floor nurse's responsibility to remove the discontinued controlled substances from the medication cart. The DON stated the system failure was that the discontinued controlled substances along with the declining count sheets were not being removed once discontinued. 2d. A physician's order written on 12/05/25 and discontinued on 12/08/25 for Resident #94 revealed Oxycodone 5mg one tablet by mouth every 4 hours as needed for pain for up to 7 days. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 12/06/25 a total of 30 Oxycodone 5mg tablets for Resident #94 with prescription #1268757 were delivered to the facility. The delivery receipt was received by Nurse #14 on 12/06/25. The declining count sheet for 30 Oxycodone 5mg tablets that were delivered on 12/06/25 with prescription #1268757 for Resident #94 revealed on 12/09/25 at 9:00 AM, and 12/13/25 at 9:00 AM and 2:00 PM, Nurse #1 documented that she removed one tablet each time. There was no active order to administer this medication on these days. Review of the Medication Administration record for December 2025 revealed there was no active physician order on the Medication Administration Record for Nurse #1 to sign off that it was administered.	F0755		05/21/2026

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F0755 SS = E	Continued from page 30 An interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated “my system was not good” and clarified that she knew which medications her residents’ received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an active order before she administered the medication. Nurse #1 stated when she removed the Oxycodone 5 mg tablet (12/09/25 and 12/13/25) for Resident #94, she administered the medication to the resident. An interview with the Nurse Practitioner on 04/24/26 at 1:30 PM confirmed that Resident #94 did not have an active physician’s order Oxycodone 5mg. The Nurse Practitioner stated she discontinued the Oxycodone 5mg one tablet every 4 hours as needed on 12/08/25 to try and simplify Resident #94’s pain medication orders. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the controlled substance box on the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Oxycodone 5mg medication was discontinued on 12/08/25 and should not have still been in the controlled substance box on the medication cart. The DON added that the system failure was not returning the controlled medication back to the pharmacy when it was discontinued. 2e. A physician’s order written on 12/19/25 for Resident #95 revealed Oxycodone 5mg; give 5mg every 6 hours as needed for pain for 3 days. This order was discontinued on 12/22/25.	F0755		05/21/2026

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F0755 SS = E	Continued from page 31 A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 12/19/25 a total of 12 Oxycodone 5mg tablets for Resident #95 with prescription #1294991 was delivered to the facility. The delivery receipt was signed off with an illegible name on 12/20/25. The declining count sheet for Oxycodone 5mg one tablet by mouth every 6 hours as needed for pain for Resident #95 with prescription #124991 was reviewed. The order of Oxycodone 5mg was discontinued on 12/22/25. On 12/24/25 Nurse #1 documented the removal of one tablet at 12:00 PM. Review of the Medication Administration Record for December 2025 revealed there was no active physician order for Resident #94 on the Medication Administration Record for Nurse #1 to sign off that it was administered on 12/24/25. An interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated “my system was not good” and clarified that she knew which medications her residents’ received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an active order before she administered the medication. Nurse #1 stated when she removed the Oxycodone 5 mg tablet (12/24/25) for Resident #94, she administered the medication to the resident. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #95 did not have a physician’s order on 12/24/25 and Nurse #1 should not have removed the Oxycodone 5mg tablet. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated it was the responsibility of the floor nurses who were on the medication cart to be sure any	F0755		05/21/2026

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F0755 SS = E	Continued from page 32 discontinued controlled substances were removed from the secured narcotic box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Oxycodone medication was discontinued 12/22/25 and should not have still been in the controlled substance box on the medication cart. The DON added that the system failure was not returning the controlled medication back to the pharmacy when it was discontinued. The facility provided a plan of correction, but it was not accepted.	F0755		05/21/2026
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. §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	F0550	Plan of Correction – F550 Resident Rights Deficient Practice The facility failed to ensure resident dignity and respect during transportation when a staff member pulled a resident's wheelchair down the hallway while the resident was positioned facing backward, preventing the resident from being able to see where he was going. The facility also failed to promote dignity during meal service when staff were observed standing over residents at bedside while providing feeding assistance rather than positioning themselves at eye level to support a dignified dining experience. 1. Corrective Action for the Residents Affected Residents # 19 and #33 involved in the cited observations were immediately assessed by ADON for any negative physical or psychosocial outcomes related to the deficient practice. No adverse outcomes were identified. On 5/12/26, the staff involved in the cited observations received immediate counseling and re-education by the Director of Nursing/designee regarding resident dignity, resident rights, appropriate wheelchair transport techniques, and dignified dining assistance practices.	05/21/2026

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F0550 SS = D	Continued from page 33 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 observations, record review and staff interviews the facility failed to treat a resident in a respectful and dignified manner when Resident #19 was seated in his geriatric wheelchair (a special medical recliner with a wheeled base designed for older adults and individuals with mobility issues) and Nurse Aide #1 pulled the wheelchair down the hall with the resident positioned behind her resulting in the resident being unable to see where he was going. A reasonable person would have had the expectation of being treated with dignity and would have wanted to be wheeled facing forward. In addition, the facility failed to promote dignity during meals when Nurse Aide #1 and Nurse Aide #4 were observed standing over the bedside feeding Resident #19 and Resident #33 who required total dependent care with eating. A reasonable person would have the expectation of being treated with dignity while dining. This occurred for 2 of 6 residents reviewed for dignity (Resident #19 and Resident #33). Findings included: 1. Resident #19 was admitted to the facility on 09/13/24 with diagnoses of dementia and anxiety. The Minimum Data Set quarterly assessment dated 03/23/26 revealed Resident #19 had severe cognitive impairment. An observation of Resident #19 on 04/20/26 at 1:30 PM revealed the resident was seated in a geriatric wheelchair, slumped over with his head hanging over the chair and with his eyes opened. Resident #19 was noted to be moaning as Nurse Aide #1 was pulling the geriatric wheelchair down the hall. Resident #19 was facing the opposite direction of	F0550	Continued from page 33 Education included: Ensuring residents are transported facing forward whenever possible Ensuring staff providing feeding assistance position themselves at resident eye level whenever feasible Promoting dignity, comfort, and resident-centered care during transportation and meal assistance On 5/12/26, the Director of Nursing/designee reviewed resident care plans and updated them as appropriate to reflect resident preferences related to transportation and dining assistance. 2. Identification of Other Residents with the Potential to be Affected All residents requiring wheelchair transportation and/or feeding assistance have the potential to be affected by the deficient practice. On 5/12/26, the Director of Nursing/designee completed facility-wide observations on all shifts of resident transportation practices and meal assistance interactions to ensure resident dignity and respect were maintained. The audit included: Observation of wheelchair transportation techniques Observation of meal assistance practices Observation of staff positioning during feeding assistance Review of resident dignity practices during care interactions Any concerns identified during the audit process were immediately addressed by the Director of Nursing/designee through supervisory intervention, staff counseling, and re-education by 5/12/26. No concerns identified.	05/21/2026

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F0550 SS = D	Continued from page 34 travel and was not able to see where he was being taken by NA #1. An interview was conducted with Nurse Aide #1 on 04/20/26 at 1:30 PM. Nurse Aide #1 stated she had been educated and in-serviced on treating residents with dignity and respect and realized that she should not have been pulling the resident from behind her and instead should have pushed him in front of her. NA #1 stated the wheelchair was hard to push and that was why she was pulling it. Nurse Aide #1 stated she was not aware he was slumped over the chair or that he was moaning and if he had been in front of her, she would have visualized and heard Resident #19. At this time, Nurse Aide #1 turned Resident #19's geriatric wheelchair around so that he was being pushed in front of her and repositioned him. An interview with the Director of Nursing (DON) on 04/24/26 at 3:30 PM revealed that the Nurse Aide should have been pushing the resident in front her and not pulling him. The DON stated it was a dignity issue, and staff should be treating all residents with dignity and respect. The Director of Nursing added that had the nurse aide been pushing the resident in front of her she would have seen that he was slumped over and perhaps he was moaning due to his positioning. 2. Resident #33 was admitted to the facility on 6/30/22 with a diagnosis of traumatic brain injury. The Minimum Data Set (MDS) quarterly assessment dated 1/20/26 revealed Resident #33 had severely impaired cognition. He was dependent on staff assistance with eating. During an observation of the lunch meal on 4/22/26 at 1:20 PM. Resident #33 was observed in bed in his room with the head of the bed elevated. Resident #33 was assisted with eating by Nurse Aide #4 who was standing at the bedside over Resident #33 and was not at eye level. A chair was observed in Resident #33's room. During an interview on 4/22/26 at 1:20 PM Nurse Aide #4 stated she was an agency nurse aide and had been a nurse aide for 10 years and had never heard of having to sit down to feed a resident. She	F0550	Continued from page 34 3. Systemic Changes to Prevent Recurrence Beginning 5/12/26, the Director of Nursing/designee revised and reinforced education related to: Resident Rights Resident dignity and respect Appropriate wheelchair transport techniques Appropriate meal assistance techniques Maintaining resident-centered care during transportation and dining assistance On 5/12/26, education was initiated for all licensed nurses, nurse aides, contracted agency staff, and other departmental staff responsible for resident transportation or meal assistance by the Director of Nursing/designee. Education included: Residents should be transported in a manner that allows the resident to safely view their surroundings whenever possible Residents should be positioned safely and comfortably during transportation Staff assisting with meals should sit or position themselves at resident eye level whenever feasible rather than standing over residents during feeding assistance Staff are expected to maintain resident dignity and respect during all resident interactions Facility policy regarding resident dignity and resident rights. Education for all licensed nurses, nurse aides,	05/21/2026

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F0550 SS = D	Continued from page 35 asked if she needed to pull up a chair to continue assisting Resident #33 with eating. Nurse Aide #4 then placed a chair that was in the room at the bedside and sat down at eye level and continued to assist Resident #33 with his meal. During an interview on 4/24/26 at 1:30 PM the Director of Nursing (DON) stated staff should be providing care to residents while promoting and maintaining dignity. She stated staff were to sit down with residents while assisting them with eating to promote dignity. The DON stated Nurse Aide #4 was an agency Nurse Aide and she was uncertain of what type of education on resident rights and promoting dignity that agency staff had received. 3. Resident #19 was admitted to the facility on 09/13/24. Review of an annual Minimum Data Set assessment dated 03/23/26 revealed Resident #19 had severely impaired cognition and was dependent on staff for all activities of daily living. During the lunchtime meal on 04/24/26 at 1:01 PM Nurse Aide #1 was observed standing over Resident #19 while feeding him his meal in the dining room. Resident #19 was positioned in a geriatric chair, semi-reclined, with his eyes closed as he was fed. An empty chair was observed in the dining room that was available for Nurse Aide #1 to use. Nurse Aide #1 was interviewed at the completion of the observation on 04/24/26 and stated she did not have a chair to sit on during the meal but realized as she looked around the room that there was a chair available across the room for her to sit on as she fed the resident. She also stated that she needed to stand as she fed Resident #19 because she had to keep an eye on the other 3 residents seated at another table in the dining room who were feeding themselves. She reported she was the only staff member in the dining area. In an interview with the Director of Nursing on 04/24/26 at 2:20 PM she stated that she expected staff to sit when assisting a resident during a meal.	F0550	Continued from page 35 contracted agency staff, and applicable departmental staff was completed by 5/12/26 prior to staff assuming independent resident care responsibilities. Staff not present during the initial education were educated upon return to duty prior to providing resident care. Beginning 5/12/26, all newly hired licensed nurses, nurse aides, contracted agency staff, and applicable departmental staff responsible for transportation or meal assistance will receive education regarding resident rights, dignity, transportation practices, and dignified meal assistance during orientation prior to providing resident care services. Beginning 5/12/26, unit managers, nursing supervisors, and department heads will conduct ongoing observations during routine rounds to ensure residents are treated with dignity and respect during transportation and meal assistance. 4. Monitoring to Ensure Continued Compliance Beginning 5/12/26, the Director of Nursing/designee will complete observational audits of resident transportation and meal assistance practices as follows: 5 observations weekly for 4 weeks 5 observations monthly for 3 months Audits will include: Residents transported facing forward unless clinically contraindicated Resident dignity and comfort maintained during transportation Residents safely positioned during transport Staff providing meal assistance at resident eye level whenever feasible Resident dignity maintained during transportation and meal assistance interactions	05/21/2026

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F0550 SS = D		F0550	Continued from page 36 Any concerns identified during audits will be immediately addressed by the Director of Nursing/designee through counseling, re-education, and/or corrective action as indicated. Audit findings will be reviewed by the Director of Nursing/designee and the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. Additional interventions and/or education will be implemented as indicated to ensure ongoing compliance. Facility Alleges compliance on 5/21/26.	05/21/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Nurse Practitioner interviews, the facility failed to follow a physician's order when nursing staff administered the wrong dose of a prescription opioid pain medication 5 times for 1 of 6 residents reviewed for medications (Resident #69). Findings included: Resident #69 was admitted to the facility on 06/18/25. Diagnoses included peripheral vascular disease (narrowed or blocked blood vessels, typically affecting legs and feet, that can cause pain and cramping in the leg muscles) and status post above the knee amputation of left leg. The Minimum Data Set quarterly assessment dated 11/21/25 revealed Resident #69 was moderately cognitively impaired. Resident #69 did not receive scheduled pain medication but did receive as needed pain medication for a pain rating of 6 out of 10. Resident #69 was coded as receiving opioids (narcotic pain medication) during this assessment. A physician's order written on 06/18/25 and	F0658	Plan of Correction – F0658 Services Provided Meet Professional Standards Deficient Practice The facility failed to ensure services provided met professional standards of nursing practice when nursing staff administered the incorrect dose of a prescribed opioid pain medication, resulting in failure to follow physician orders. 1. Corrective Action for Resident(s) Found to be Affected by the Deficient Practice Resident #69 identified during the survey process had been discharged from the facility at the time the deficient practice was identified and therefore could not be reassessed by the facility. All licensed nurses involved received immediate counseling and re-education by Director of Nursing (DON)/Designee on 5/12/2026 regarding medication administration standards, physician order verification, opioid safety, the five rights of medication administration, and facility medication administration policies. Documentation related to the medication error, notifications, and interventions was reviewed for completeness and accuracy by the DON/Designee. 2. Identification of Other Residents Who Have the Potential to be Affected	05/21/2026

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F0658 SS = D	Continued from page 37 discontinued on 11/12/25 for Resident #69 revealed Hydrocodone/Acetaminophen (Tylenol) 10mg/325mg one tablet by mouth every 6 hours as needed for pain. A physician's order written on 11/12/25 and discontinued on 11/19/25 for Resident #69 revealed Hydrocodone/Acetaminophen 5mg/325mg one tablet by mouth every 6 hours as needed for pain. Review of the November 2025 Medication Administration Record (MAR) revealed there were two orders on the MAR. One order was for documenting the administration of the Hydrocodone/Acetaminophen 10mg/325mg. This order was in effect until 11/12/25. There was no documentation to support that 10mg/325mg was given from 11/01/25 thru 11/12/25. On the same page of this November 2025 MAR, revealed an order for Hydrocodone/Acetaminophen 5mg/325mg starting on 11/12/25. The following days were noted that the discontinued order of Hydrocodone/Acetaminophen 10mg/325mg were removed from the declining count sheet: On 11/16/25 Nurse #17 documented on the MAR at 10:00 PM she administered Hydrocodone/Acetaminophen 5mg/325mg, but the declining count indicated Nurse #17 removed one tablet of Hydrocodone/Acetaminophen 10mg/325mg. On 11/17/25 Nurse #17 documented on the MAR at 10:00 PM she administered Hydrocodone/Acetaminophen 5mg/325mg, but the declining count indicated Nurse #17 removed one tablet of Hydrocodone/Acetaminophen 10mg/325mg. On 11/18/25 Nurse #17 documented on the declining count sheet at 5:00 AM she removed one tablet Hydrocodone/Acetaminophen 10mg/325mg. There was no documentation on the MAR that the narcotic pain medication was given at this time. On 11/18/25 Nurse #15 documented on the MAR at 2:08 PM she administered Hydrocodone/Acetaminophen 5mg/325mg, but the declining count indicated Nurse #15 removed one tablet of Hydrocodone/Acetaminophen 10mg/325mg.	F0658	Continued from page 37 On 5/12/2026 DON/Designee conducted an audit of physician orders, medication administration records and narcotic documentation to identify any additional residents potentially affected by similar deficient practices related to incorrect medication dosing, failure to follow physician orders, accurate transcription of physician orders, and compliance with medication administration procedures. Any concerns identified through the audit process were immediately addressed through physician notification, resident assessment, corrective action, and staff re-education as appropriate. No concerns identified. 3. Systemic Changes Made to Ensure the Deficient Practice Does Not Recur All licensed nurses and contract agency nurses received mandatory re-education by DON/Designee on 5/12/2026 to include following physician orders accurately, the five rights of medication administration, medication administration documentation requirements, Medication administration policy, narcotic accountability procedures, and professional nursing standards related to medication administration. All new licensed nurses hired after 5/12/2026 will receive education upon orientation. On 5/12/2026 the Director of Nursing/designee audited discontinued controlled medication orders and ensured removal of discontinued medication cards from cart and returned to pharmacy. On 5/12/2026 the DON/Designee educated licensed nurses on expectations regarding immediate reporting and investigation of medication variances. 4. Monitoring to Ensure Continued Compliance Beginning 5/12/26 The Director of Nursing and/or Assistant Director of Nursing/designee will conduct medication administration observation audits focused on	05/21/2026

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F0658 SS = D	Continued from page 38 On 11/18/25 Nurse #20 documented on the declining count sheet at 9:00 PM she removed one tablet Hydrocodone/Acetaminophen 10mg/325mg. There was no documentation on the MAR that the narcotic pain medication was given at this time. An interview was attempted via phone with Nurse#20 on 04/24/26 at 12:30 PM. Nurse #20 did not return the call. An interview was attempted via phone with Nurse #17 on 05/04/26 at 4:22 PM. Nurse #17 did not return the call. An interview was attempted via phone with Nurse #15 on 05/04/26 at 4:23 PM. Nurse #7 did not return the call. An interview with the Nurse Practitioner on 04/24/26 at 1:30 PM confirmed that from 11/12/25 through 11/19/25 Resident #69 had an order for Hydrocodone/Acetaminophen 5mg/325mg. The Nurse Practitioner stated the nurses removed the 10mg/325mg tablet instead of 5mg/325mg resulting in Resident #69 receiving the wrong dose. The Nurse Practitioner reviewed her progress notes during this time frame and reported there was no negative outcome as a result of Resident #69 receiving the wrong dose. An interview was conducted with the Director of Nursing on 04/24/26 at 4:00 PM. The Director of Nursing stated that the order for the Hydrocodone/Acetaminophen 10mg/325mg was discontinued on 11/12/25 and the declining count sheet and the blister pack for that dose should have been removed from the controlled substance box on the medication cart when it was discontinued. The DON stated had the nurses removed the discontinued Hydrocodone/Acetaminophen 10mg/325mg it could have prevented Resident #69 from getting the wrong dose.	F0658	Continued from page 38 compliance with physician orders and accurate opioid administration. The Director of Nursing and/or Assistant Director of Nursing/designee will review order listing report during daily clinical meeting for any discontinued opioid medications and remove immediately. ADON/designees will review physician orders against the electronic medication administration record (eMAR) to ensure accuracy of transcription and administration. Audits will include controlled substance cards in medication carts match active physician orders Audit frequency will be five medication pass observations weekly for four weeks and three medication pass observations monthly for three months thereafter. Findings from the audits will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 4 months. Identified concerns will be addressed promptly with additional education, counseling, and corrective action as indicated. The facility alleges compliance on 5/21/2026.	05/21/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F0677	Plan of Correction – F0677 Activities of Daily Living Care Provided for Dependent Residents Deficient Practice The facility failed to ensure staff provided necessary feeding assistance to a resident who was dependent	05/21/2026

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F0677 SS = D	Continued from page 39 This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to assist a resident who was dependent on staff for feeding assistance with a meal. This resulted in Resident #2, who was cognitively impaired, waiting for assistance with eating after the meal tray was placed within view at the bedside. This occurred for 1 of 3 residents reviewed for assistance with activities of daily living (Resident #2). Findings included: Resident #2 was admitted to the facility on 5/2/25 with diagnoses including traumatic brain injury and diabetes. A care plan dated 2/28/26 revealed Resident #2 had activities of daily living (ADL) self-care deficit related in part to; failure to thrive, lack of coordination, and muscle weakness. Interventions included to assist with ADL's including eating. Resident #2 was totally dependent on staff with eating her meals. The Minimum Data Set (MDS) comprehensive assessment dated 3/8/26 revealed Resident #2 had moderately impaired cognition. She was dependent on staff for feeding assistance. Resident #2 received Hospice services. During an observation on 4/22/26 at 9:20 AM Resident #2 was observed in her room seated upright in bed. The breakfast tray was on the bedside table in view of Resident #2. During an interview on 4/22/26 at 9:20 AM Nurse Aide #5 stated she was an agency nurse aide and today was her third day in the facility. She stated she had 16 residents on her assignment, and she had two residents that needed assistance with eating. She stated the assignment was busy since she was not familiar with the residents, but she was getting ready to start assisting the residents that needed assistance with eating. Nurse Aide #5 stated she was assisting other residents and had not had time to sit and assist Resident #2 with eating yet. Nurse Aide #5 stated the cart with the breakfast trays came out on the hallway around 9:00 AM.	F0677	Continued from page 39 on staff for eating assistance when a meal tray was placed in front of the resident without assistance being provided. 1. Corrective Action for Resident(s) Found to be Affected by the Deficient Practice Resident #2 identified during the survey was immediately assisted with feeding by designated staff. The resident's care plan, Kardex, and meal assistance status were reviewed and updated as necessary to clearly reflect the required level of assistance during meals by Director of Nursing (DON)/designee on 4/22/26. On 4/22/26 Staff assigned to the resident received immediate re-education by Assistant Director of Nursing (ADON) regarding provision of meal assistance and supervision requirements for dependent residents. 2. Identification of Other Residents Who have the Potential to be Affected All residents requiring extensive or total assistance with meals have the potential to be affected by the alleged deficient practice. An audit of all residents requiring feeding assistance was completed by the Director of Nursing/designee on 5/12/26 to verify: • Appropriate identification of feeding assistance needs in the care plan and Kardex • Appropriate meal tray set-up and feeding assistance • Staff awareness of residents requiring assistance • Timely assistance during meal service Any concerns identified during the audit were addressed immediately. No additional concerns identified. 3. Systemic Changes Made to Ensure the Deficient Practice Does Not Recur Licensed nurses, nursing assistants, and contracted agency staff were educated by the Director of Nursing/designee beginning 5/12/26 regarding: - Resident dignity and person-centered care during meals	05/21/2026

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F0677 SS = D	Continued from page 40 During an interview on 4/22/26 at 9:25 AM Nurse #8 stated she was the assigned nurse for the 200 hall. She stated there were two residents including Resident #2 on the 200 hall that needed assistance with eating. She stated Resident #2 was dependent on staff with eating. A continuous observation conducted on 4/22/26 from 9:20 AM until 9:45 AM revealed no staff member entered Resident #2's room to assist her with eating breakfast. During an observation on 4/22/26 at 9:45AM Nurse #8 was observed sitting at the nurses' station. When asked if she knew Resident #2 still had not been fed her breakfast meal, she stated that Nurse Aide (#5) had not asked her for help. Nurse #8 stated she was not aware Resident #2 had not been fed her breakfast yet. Nurse #8 stated she would go assist Resident #2. During an observation on 4/22/26 at 9:50 AM Nurse #8 was observed in Resident #2's room assisting her with eating her breakfast meal. During an interview on 4/22/26 at 9:50 AM Resident #2 was asked by the Surveyor if her food was warm enough to eat. Resident #2 stated yes. During an interview on 4/22/26 at 10:30 AM the Unit Manager stated Resident #2 was dependent on staff assistance with ADL care including eating. She stated Resident #2's appetite varied, she has had weight loss and was currently on Hospice services. During an interview on 4/22/26 at 11:00 AM the Director of Nursing (DON) stated she was new to the facility and had been the DON for three weeks. She stated Resident #2 should not have waited 45 minutes to be assisted with eating her breakfast meal. The DON stated the Nurse on the hallway should assist the Nurse Aides during meals to ensure that the residents that needed assistance with eating didn't have to wait for that length of time to be assisted by staff.	F0677	Continued from page 40 - Requirements for timely feeding assistance - Identification of residents requiring extensive or total assistance with eating - Monitoring of meal service to ensure dependent residents are not left unattended with trays Staff not present during the initial education were educated upon return to duty prior to providing resident care. A meal assistance assignment process was reviewed and reinforced by the DON/designee on 5/12/26 to ensure accountability for residents requiring feeding assistance during each meal service. The charge nurse/designee will complete rounds during meal service to verify residents requiring feeding assistance are receiving timely assistance. Residents requiring feeding assistance will be identified on the dining assistance list/Kardex to ensure consistency of care. 4. Monitoring to Ensure Continued Compliance Beginning 5/12/26 The Director of Nursing/designee will conduct meal assistance audits for residents requiring extensive or total assistance with eating: • Five residents observed during meal service, 5 times weekly for 4 weeks • Then weekly for 4 additional weeks • Then monthly for 3 months Audits will include verification that: • Staff provide timely feeding assistance • Residents are not left unattended with meal trays when dependent on staff	05/21/2026

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F0677 SS = D		F0677	Continued from page 41 • Care plans and Kardexes accurately reflect feeding assistance needs Results of the audits will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings monthly times 5 months for continued monitoring and recommendations as indicated. The facility alleges compliance on 5/21/26.	05/21/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and Nurse Practitioner interviews, the facility failed to obtain weights as ordered by the physician and failed to verify the accuracy of weights after significant weight changes for 1 of 3 residents reviewed for weight monitoring (Resident #32). Findings included: Resident #32 was admitted to the facility on 1/28/26 with diagnoses including end stage renal disease with dependence on hemodialysis, and congestive heart failure (CHF). A physician's order dated 1/29/26 for Resident #32 revealed to obtain daily weights for CHF. Record review revealed the following documented weights for Resident #32 for February 2026: 02/01/26 – 190.6 lbs. (pounds) 02/03/26 – 193.6 lbs.	F0684	Plan of Correction – F0684 Quality of Care Deficient Practice: The facility failed to ensure quality of care by failing to obtain resident weights as ordered by the physician and failed to verify the accuracy of weights following significant weight changes. 1. Corrective Action for Residents Found to Be Affected Resident #32 identified as having missed, inaccurate, or questionable weights were immediately reviewed by the interdisciplinary team, including nursing and dietary services on 5/12/2026. Care plans, nutritional interventions, and physician orders were reviewed and updated by the DON/designee based on verified weight findings and clinical status. 2. Identification of Other Residents Who May Be Affected All residents have the potential to be affected by this deficient practice. On 5/12/26 the Director of Nursing/designee completed an audit of resident weights for the previous 30 days to identify any additional residents who may have been affected by the deficient practice. The audit included review of: • Physician orders related to weights • Significant weight changes • Re-weigh documentation following variances • Accuracy and consistency of weight documentation • Appropriate clinical follow-up and notification	05/21/2026

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F0684 SS = D	Continued from page 42 02/09/26 – 194.0 lbs. 02/10/26 – 194.4 lbs. 02/11/26 – 194.6 lbs. 02/16/26 – 194.1 lbs. 02/17/26 – 194.8 lbs. 02/18/26 – 194.0 lbs. 02/19/26 – 195.4 lbs. 02/20/26 – 195.4 lbs. 02/21/26 – 203.2 lbs. Review of Resident #32's progress notes from 2/1/26 through 2/21/26 revealed no documentation explaining why weights were not obtained on days when no weight was recorded. There was no notation of Resident #32's refusal. Record review revealed Resident #32 was hospitalized from late February through 03/04/2026. A care plan dated 3/9/26 revealed Resident #32 was at risk for nutritional compromise due to end stage renal disease and dependence on hemodialysis, chronic obstructive pulmonary disease (COPD) and chronic respiratory failure. Resident #32 was at risk for weight fluctuations secondary to hemodialysis. The care plan included an intervention to obtain weights per the physician's order. Record review revealed the following documented weights for Resident #32 for March 2026: The weight was scheduled to be obtained daily at 6:00 AM: 03/05/26 – Refused 03/07/26 – Refused 03/08/26 – 197 lbs. 03/09/26 – 222 lbs., documented by Nurse #24 03/10/26 – 221 lbs.	F0684	Continued from page 42 Residents identified with concerns received immediate assessment, re-weigh as indicated, physician notification, and updated interventions as appropriate. 3. Measures Put Into Place to Prevent Recurrence Beginning 5/12/26 the DON/designee • Re-educated Licensed nurses, certified nursing assistants, contracted agency regarding: - Obtaining weights as ordered - Proper weight techniques and equipment usage - Consistent weighing practices (same scale, similar clothing, same time of day when possible) - Identification and reporting of significant weight variances - Requirement to obtain and document re-weighs when significant weight changes occur - Timely physician and dietary notification of significant changes Staff not present during the initial education will be educated upon return to duty prior to assuming resident care responsibilities • Scales will continue to be calibrated routinely per facility policy and manufacturer recommendations. • A standardized weight review process was implemented to ensure: - Ordered weights are completed timely - Significant variances are identified promptly - Re-weighs are completed and documented - Clinical follow-up occurs timely • The interdisciplinary team, including nursing, dietary, and administration, will review significant weight changes during weekly weight meetings beginning 5/21/26 to ensure appropriate interventions are implemented.	05/21/2026

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F0684 SS = D	Continued from page 43 03/13/26 – 223.4 lbs. 03/14/26 – 222 lbs. 03/19/26 – Refused 03/22/26 – 218.8 lbs. 03/23/26 – 220.2 lbs. 03/24/26 – 245 lbs., documented by Nurse #25 03/24/26 – 187.2 lbs., documented by Nurse #16 Review of Resident #32's progress notes from 3/5/26 through 3/24/26 revealed no documentation explaining why weights were not obtained on days when no weight was recorded. There was no documentation indicating a reweigh was completed on 3/9/26 that showed a 25 pound weight gain. There was no documentation on 3/24/26 that the Unit Manager or Director of Nursing were notified of the weight difference. Record review revealed Resident #32 was hospitalized 3/24/26 through 4/2/26 for evaluation of shortness of breath with coughing and wheezing. A physician's order dated 4/2/26 for Resident #32 revealed to obtain weekly weights for CHF. Record review revealed the following documented weights for Resident #32 for April 2026: 04/06/26 – 193.0 lbs. 04/10/26 – 189.9 lbs. 04/17/26 – 185.6 lbs. 04/20/26 – 183.3 lbs. 04/21/26 – 193.2 lbs., documented by Nurse #26 Review of Resident #32's progress note dated 4/21/26 revealed no documentation indicating a reweigh was completed or any follow up to verify accuracy for the 10 lb. weight increase in 24 hours. There were no further weights recorded after 4/21/26.	F0684	Continued from page 43 4. Monitoring Process to Ensure Continued Compliance Beginning on 5/12/26 The Director of Nursing/designee will conduct audits to monitor compliance with physician-ordered weights and weight accuracy procedures. Audits will include: • Verification that ordered weights are obtained timely • Review of residents with significant weight changes • Confirmation that re-weighs are completed when indicated • Verification of physician, dietary, and responsible party notification as appropriate • Review of documentation accuracy and follow-up interventions Audit frequency: • Weekly audits x4 weeks • Monthly audits x3 months thereafter Results of audits will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meetings for 4 months. Additional education and corrective action will be implemented as indicated to ensure continued compliance. Facility alleges compliance on 5/21/26.	05/21/2026

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F0684 SS = D	Continued from page 44 The Minimum Data Set (MDS) quarterly assessment dated 4/9/26 revealed Resident #32 had moderately impaired cognition. Resident #32 received diuretics, oxygen, and dialysis. She had no rejection of care. During an interview on 4/24/26 at 10:00 AM the Administrator indicated that nursing staff should obtain weights according to the physician's order and document accurate weights. She stated Nurse #24 (who documented the 3/9/26 weight of 222 lbs.) was no longer employed at the facility. Attempts were made on 4/24/26 to contact Nurse #25 who documented the 3/24/26 weight of 245 lbs. which was a 25 lb. weight gain. There was no response. During a phone interview on 4/24/26 at 5:10 PM Nurse #16 who documented the 3/24/26 weight of 187.2 lbs., a 57.8 lb. weight difference stated she was most likely told by another Nurse or the Unit Manager to get a reweigh on Resident #32 and entered the weight without reviewing the previous weight. Nurse #16 had no further comment. Attempts were made on 4/24/26 to contact Nurse #26 who documented the 4/21/26 weight of 193.2 lbs. which was a 10-pound weight gain in a 24-hour period. There was no response. During an interview on 04/23/26 at 10:53 AM Nurse Aide #6 stated nurse aides obtained weights and recorded them on a weight list posted at the nurses' station. She stated the Unit Manager, or nurse would notify them if a reweigh was needed. During an interview on 4/24/26 at 10:00 AM the Unit Manager indicated Resident #32 had orders for daily weights that was changed to weekly weights. She stated the assigned nurse aide obtained the weights and she or the assigned nurse would enter the weights into the resident's record. The Unit Manager stated weights should be obtained as ordered and residents should be reweighed the same day if there was a significant change. She stated she was not aware that daily weights were missed or that significant weight discrepancies occurred for Resident #32.	F0684		05/21/2026

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F0684 SS = D	Continued from page 45 During an interview on 4/24/26 at 1:00 PM, the Nurse Practitioner (NP) stated Resident #32 had multiple comorbidities, including end-stage renal failure and end-stage congestive heart failure, and required accurate weights. She stated a 20 to 25 lb. weight gain in 24 hours was unlikely and may indicate failure to subtract wheelchair weight or scale variance, and the 57 lb. weight loss was inaccurate. The NP indicated nursing staff should also compare facility weights with dialysis center weights. She stated she should be notified only after a significant weight change was verified. During an interview on 4/24/26 at 2:00 PM the Director of Nursing (DON) stated she expected weights to be obtained according to the physician's order, and residents reweighed the same day if significantly different from the previous weight and reported to her or the Unit Manager so accuracy could be verified and communicated to the Physician.	F0684		05/21/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff, and the Nurse Practitioner's interviews the facility failed to administer an as needed antihypertensive medication (Clonidine 0.2 milligrams) according to the physician's order and withhold the medication Isosorbide Mononitrate (a vasodilator that relaxes and dilates blood vessels and can lower blood pressure) according to the physicians order when blood pressure parameters were met. This occurred for 1 of 6 residents reviewed for medication administration (Resident #60). Findings included: Resident #60 was admitted to the facility on 10/23/25 with diagnoses including hypertension, congestive heart failure, and coronary artery disease. a. A physician's order dated 12/13/25 for Resident #60 revealed to administer Clonidine 0.2 milligrams	F0760	Plan of Correction – F0760 Residents are Free of Significant Medication Errors Deficient Practice The facility failed to administer an as needed medication according to the physician's order and withhold the medication according to the physician's order when blood pressure parameters were met. 1. Corrective Action for Resident(s) Found to Have Been Affected by the Deficient Practice Resident #60 identified during survey review had the physician order and medication administration record (MAR) reviewed by the Director of Nursing/designee on 5/12/26 to ensure the as needed medication parameters were accurately transcribed and clearly reflected on the MAR. The licensed nurses #15 and #8 involved received counseling and re-education on 5/12/26 by the Director of Nursing/designee regarding: Following physician orders as written;	05/21/2026

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F0760 SS = D	Continued from page 46 (mgs) every 12 hours as needed for systolic blood pressure greater than 180 or diastolic blood pressure greater than 90. Review of Resident #60's Medication Administration Record (MAR) dated December 2025 revealed the following blood pressure recorded: 12/21/25 at 9:00 AM blood pressure 248/100 documented by Nurse #15 Review of Resident #60's Medication Administration Record (MAR) dated 12/21/25 revealed no documentation that Clonidine 0.2 mgs was administered to Resident #60. Review of Resident #60's nursing progress notes on 12/21/25 revealed no documentation that Clonidine 0.2 mgs was administered, and no documented clinical rationale for withholding the medication. Review of Resident #60's Medication Administration Record dated January 2026 revealed the following blood pressures recorded: 1/07/26 at 9:00 AM blood pressure 210/87 documented by Nurse #16 1/08/26 at 9:00 AM blood pressure 235/101 documented by Nurse #15 1/13/26 at 9:00 AM blood pressure 231/90 documented by Nurse #15 1/17/26 at 9:00 AM blood pressure 187/88 documented by Nurse #15 1/21/26 at 9:00 AM blood pressure 212/87 documented by Nurse #15 Review of Resident #60's Medication Administration Record dated January 2026 revealed no documentation that Clonidine 0.2 mgs was administered to Resident #60 from 1/7/26 through 1/21/26.	F0760	Continued from page 46 Reviewing blood pressure parameters prior to administration of medications; Appropriate withholding of medications when ordered parameters are met Accurate documentation of medication administration and clinical decision making. The attending physician and responsible party were notified as appropriate, and the resident was assessed for any adverse effects with no negative outcome identified. 2. Identification of Other Residents Who Have the Potential to Be Affected All residents with physician orders containing blood pressure parameters and/or hold parameters for medications have the potential to be affected by the alleged deficient practice. An audit of current physician orders for medications with blood pressure or pulse parameters was completed by the Director of Nursing/designee on 5/12/26 to verify: Orders were accurately transcribed to the MAR; Parameters were clearly visible and complete Appropriate hold instructions were present Nurses were documenting administration or withholding appropriately Any identified concerns were corrected immediately 3. Measures Put Into Place or Systemic Changes Made to Ensure the Deficient Practice Does Not Recur Licensed nurses and contracted agency were	05/21/2026

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F0760 SS = D	Continued from page 47 Review of Resident #60's nursing progress notes from 1/7/26 through 1/21/26 revealed no documentation that Clonidine 0.2 mgs was administered, and no documented clinical rationale for withholding the medication. During a phone interview on 4/24/26 at 9:30 AM Nurse #15 stated that she had not been assigned to Resident #60 for a while prior to the times she recorded the elevated blood pressures. Nurse #16 stated she was not aware during that time that Resident #60 had an order for Clonidine as needed if her blood pressure was elevated. During a phone interview on 4/24/26 at 5:10 PM Nurse #16 stated she could not speak on a medication issue that occurred in January. She had no further comment. b. A physician's order dated 4/6/26 for Resident #60 revealed Isosorbide Mononitrate extended release 60 milligrams (mg). Give 1 tablet by mouth once a day for angina (chest pain or discomfort that occurred when the heart muscle does not receive enough oxygen-rich blood). Hold for systolic blood pressure less than 120. Review of Resident #60's Medication Administration Record (MAR) dated April 2026 revealed Isosorbide Mononitrate extended release 60 mg tablets were administered on the following dates and time as evidence by the nurses signature with the following blood pressures recorded: 4/09/26 at 8:30 AM Nurse #8 signed as administered with blood pressure 112/76. 4/22/26 at 8:30 AM Nurse #8 signed as administered with blood pressure 118/70. 4/23/26 at 8:30 AM Nurse #8 signed as administered with blood pressure 118/75. Review of Resident #60's nursing progress notes on 4/9/26, 4/22/26, and 4/23/26 revealed no documentation or clinical justification for	F0760	Continued from page 47 re-educated by the Director of Nursing/designee on: Medication administration standards Compliance with physician orders Reviewing and following medication parameters prior to administration Appropriate withholding of medications when parameters are met Documentation requirements for medications held or administered The clinical management team will review newly written physician orders involving medication parameters during the clinical review process to ensure accuracy of transcription onto the MAR Medication pass observations will be conducted to validate compliance with physician orders and medication administration standards Nurses identified as needing additional support will receive follow-up observation and competency validation Staff not present during the initial education were educated upon return to duty prior to providing resident care. Beginning 5/12/26, all newly hired licensed nurses, nurse aides, contracted agency staff, will receive education during orientation. 4. How the Facility Will Monitor to Ensure Ongoing Compliance Beginning 5/12/26 The Director of Nursing/designee will conduct medication administration audits for residents with blood pressure or pulse parameter medications:	05/21/2026

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F0760 SS = D	Continued from page 48 administering the medication. During an interview on 4/23/26 at 3:30 PM Nurse #8 stated she has not had to hold Resident #60's Isosorbide Mononitrate any time including today. She stated she didn't realize the medication had hold parameters. Nurse #8 stated when she viewed the electronic Medication Administration Record (eMAR) the hold parameters weren't noticeable which was why it was overlooked. Nurse #8 stated she would go check Resident #60's blood pressure to ensure her blood pressure was not too low. Nurse #8 stated Resident #60 had been resting quietly this afternoon with no complaints. The Minimum Data Set (MDS) quarterly assessment dated 3/15/26 revealed Resident #60 had moderately impaired cognition. During an interview on 4/24/26 at 9:00 AM Resident #60 who was alert and oriented to person, and place stated she was on blood pressure medications, but she did not know what medications or when they were to be given. She stated she would get headaches and felt dizzy at times but otherwise felt okay at this time. During an interview on 4/24/26 at 1:00 PM the Nurse Practitioner stated Resident #60 had elevated blood pressures and received scheduled antihypertensive medications and had the Clonidine order in place for increased blood pressure. She stated Resident #60's blood pressure continued to run high at times and then would run low at times, and she has had to adjust her medications. The Nurse Practitioner indicated that the as needed Clonidine was ordered for a reason and the blood pressure parameters should be followed and as needed medications administered when indicated. She stated nitrates dilated blood vessels, and can lower blood pressure, which is why the hold parameters were ordered for the Isosorbide Mononitrate. She stated the ordered parameters should be followed and the medication held if the systolic blood pressure was less than 120. The Nurse Practitioner stated she would only need to be notified of Resident #60's blood pressure if the Clonidine had been administered and the blood pressure had remained significantly elevated. The Nurse Practitioner indicated Resident #60 has had no significant outcome related to the medication errors.	F0760	Continued from page 48 Five medication pass observations weekly for four weeks Then five medication pass observations monthly for three months. Audits will include verification that: Ordered parameters are present on the MAR Vital signs are obtained prior to administration when indicated Medications are withheld appropriately according to physician orders Documentation is completed accurately Results of the audits will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process. Additional education and corrective action will be implemented as indicated based on audit findings. Facility Alleges compliance 5/21/26.	05/21/2026

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F0760 SS = D	Continued from page 49 During an interview on 4/24/26 at 2:30 PM the Director of Nursing (DON) stated the nurses were expected to read the medication orders and follow the ordered parameters and administer or withhold medications when it was indicated when the parameters were met. .	F0760		05/21/2026
F0842 SS = D	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 (iv) Systematically organized §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- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F0842	Plan of Correction – F842 Resident Records – Identifiable Information Deficient Practice: The facility failed to accurately document the administration of controlled substances, resulting in inaccurate medical records. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 5/12/26 The Director of Nursing (DON)/designee conducted a review of Resident #41, #69, #94, #95 controlled substance documentation, including the electronic medication administration record (eMAR), narcotic count sheets, physician orders, and medication availability records to ensure accuracy and reconciliation of administered medications. Any identified discrepancies were investigated by the DON/designee and corrected in the medical record in accordance with facility policy and professional documentation standards. The attending physician and pharmacy consultant were notified by the DON/designee as indicated regarding identified discrepancies. Residents were assessed for any adverse outcomes related to the inaccurate documentation of controlled substances, and appropriate follow-up was completed as necessary. On 5/12/26 all licensed nurses and contract agency received re-education by the DON/designee regarding five rights of medication administration and narcotic count reconciliation.	05/21/2026

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F0842 SS = D	Continued from page 50 operations, as permitted by and in compliance with 45 CFR 164.506; (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. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Nurse Practitioner and staff, the facility failed to accurately document the administration of controlled substances for 4 of 6 residents reviewed for accurate medical records (Residents #41, #69, #94 and #95).	F0842	Continued from page 50 2. How the facility will identify other residents having the potential to be affected by the same deficient practice An audit of all current controlled substance documentation records was completed for the previous 30 days by the DON/Designee on 5/12/26, including eMAR documentation, narcotic count sheets, shift-to-shift narcotic reconciliation records, and pharmacy dispensing records, as applicable. The audit was conducted by the Director of Nursing, Assistant Director of Nursing, and/or designee to identify missing signatures or initials, inaccurate documentation, discrepancies between medication administration records and narcotic counts, and documentation completed inconsistent with physician orders. Any identified discrepancies were immediately investigated and corrected as appropriate. All residents receiving controlled substances have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur Licensed nursing and contracted agency staff were re-educated by DON/designee on 5/12/26 regarding accurate and timely documentation requirements for controlled substances. Education included proper completion of eMAR documentation, controlled substance administration procedures, shift-to-shift narcotic reconciliation, documentation of refused, held, wasted, or unavailable medications. Licensed nurses completing medication administration will be required to perform and document narcotic reconciliation at shift change in accordance with facility policy. Beginning 5/12/26 the Director of Nursing/designee will conduct random medication pass observations	05/21/2026

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F0842 SS = D	Continued from page 51 Findings included: a.) Resident #41 was admitted to the facility 03/23/23. A physician's order written on 09/11/25 for Resident #41 and discontinued on 11/19/25 for Oxycodone (opioid pain medication) 5 milligrams (mg) tablet, one tablet by mouth every 8 hours as needed for pain. Review of Resident #41's declining count sheet (an inventory log used to record a running total for each controlled medication) revealed Nurse #1 documented the removal of Oxycodone 5 mg on 09/11/25 at 4:00 PM, 09/12/25 at 2:00 PM and 6:00 PM, 09/19/25 at 9:00 AM and 4:00 PM, 09/20/25 at 9:00 AM and 4:00 PM, and 09/21/25 at 1:00 PM. The Medication Administration Record (MAR) for September 2025 for Resident #41 revealed on 09/11/25 at 4:00 PM, 09/12/25 at 2:00 PM and 6:00 PM, 09/19/25 at 9:00 AM and 4:00 PM, 09/20/25 at 9:00 and 4:00 PM, and 09/21/25 at 1:00 PM, Nurse #1 did not document that she administered the Oxycodone 5 mg on the MAR. b.) Resident #69 was admitted to the facility on 06/18/25. A physician's order written on 11/12/25 and discontinued on 11/19/25 for Resident #69 revealed Hydrocodone/Acetaminophen (opioid pain medication) 5 mg / 325 mg one tablet by mouth every 6 hours as needed for pain. Review of Resident #69's declining count sheet revealed on 11/14/25 at 9:00 AM and 11/15/25 at 4:00 PM, Nurse #1 documented the removal of Hydrocodone/Acetaminophen 5 mg/325 mg. The MAR for November 2025 for Resident #69 revealed on 11/14/25 at 9:00 AM and 11/15/25 at 4:00 PM, Nurse #1 did not document that she administered Hydrocodone/Acetaminophen 5 mg / 325 mg on the MAR.	F0842	Continued from page 51 focusing on controlled substance documentation accuracy. The DON/designee reinforced expectations for immediate reporting and investigation of any controlled substance discrepancy. Pharmacy consultant services will continue to review medication documentation and controlled substance practices during routine monthly pharmacy reviews. 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur Beginning 5/12/26 The Director of Nursing, Assistant Director of Nursing, Unit Manager, and/or designee will complete audits of controlled substance documentation and narcotic reconciliation records as follows: 5 controlled substance records audited weekly for 4 weeks. 5 controlled substance records audited monthly for 3 months. Audits will include review of accuracy of eMAR documentation, corresponding physician orders, narcotic count reconciliation, documentation of held/refused medications, and resolution of discrepancies. Any identified concerns will be immediately addressed through corrective action and additional staff education as indicated. Results of the audits will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program monthly for 4 months for continued monitoring and recommendations for sustained compliance.	05/21/2026

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F0842 SS = D	Continued from page 52 c.) Resident #94 was admitted to the facility on 12/05/25. A physician's order written on 12/05/25 and discontinued on 12/08/25 for Resident #94 revealed Oxycodone 5 mg one tablet by mouth every 4 hours as needed for pain for up to 7 days. A physician's order written on 12/14/25 for Resident #94 revealed Oxycodone 5 mg one tablet by mouth every 6 hours as needed for pain until 12/16/25. Review of Resident #94's declining count sheet for Oxycodone 5 mg revealed on 12/08/25 at 8:00 AM and 12:00 PM, and 12/14/25 at 8:00 AM and 12:00 PM, Nurse #1 documented the removal of Oxycodone 5 mg. The MAR for December 2025 for Resident #94 revealed on 12/08/25 and 12/14/25 at 8:00 AM and 12:00 PM, Nurse #1 did not document that she administered Oxycodone 5 mg on the MAR. d.) Resident #95 was admitted to the facility on 12/12/25. A physician's order written on 12/19/25 for Resident #95 revealed Oxycodone 5 mg; give 5 mg every 6 hours as needed for pain for 3 days. Review of Resident #95's declining count sheet for Oxycodone 5 mg revealed on 12/22/25 at 8:00 AM, Nurse #1 documented the removal of Oxycodone 5 mg. The MAR for December 2025 for Resident #94 revealed on 12/22/25 Nurse #1 did not document that she administered Oxycodone 5 mg on the MAR. A phone interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated "my system was not good" and clarified that she knew which medications her residents' received and she would administer them without looking at the order. Nurse #1 added that she did not sign off the medication as	F0842	Continued from page 52 Facility alleges compliance on 5/21/26.	05/21/2026

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F0842 SS = D	Continued from page 53 given on the MAR because she was too busy at the time and she forgot to go back and sign the MAR. A phone interview with the previous Director of Nursing (DON) on 04/24/26 at 12:37 PM revealed that she would expect the nursing staff to sign off on the MAR whenever administering pain medications and added it was important to document on the MAR to determine if the pain was being managed for the resident. An interview with the Nurse Practitioner on 04/24/26 at 1:30 PM revealed she utilized the MAR to determine how residents were responding to their as needed pain medication, so it was important for the nursing staff to accurately document the administration of the medication. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM stated she expected her nursing staff to be accurately documenting the administration of pain medications on the MAR. She stated the system failure was that this nurse did not follow the process of medication administration which included the documentation of administration.	F0842		05/21/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	Plan of Correction – F0880 Infection Prevention & Control Deficient Practice: The facility failed to implement the facility's Infection Prevention and Control Program policies and procedures related to Contact Precautions during environmental cleaning of a resident room for a resident on Contact Precautions for suspected norovirus. 1. Corrective Action for Those Residents Found to Have Been Affected by the Deficient Practice The staff members involved received immediate re-education by the Assistant Director of Nursing (ADON) on 4/22/26 regarding Infection Prevention and Control procedures, including appropriate use of Personal Protective Equipment (PPE), hand hygiene, proper donning and doffing procedures, and cleaning/disinfection requirements for residents on Contact Precautions for suspected norovirus. The Infection Preventionist and/or designee	05/21/2026

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F0880 SS = D	Continued from page 54 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 54 conducted observation rounds on 4/22/26 to verify compliance with infection control procedures for the affected resident area. No additional concerns were identified at the time of review. 2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice All residents residing on Contact Precautions and/or enhanced infection control precautions have the potential to be affected by the alleged deficient practice. The Infection Preventionist and/or designee completed an audit on 5/12/26 of residents currently on Contact Precautions to ensure: Appropriate signage was in place; Required PPE was available outside resident rooms; Staff were properly implementing Contact Precautions; Environmental cleaning procedures were being followed according to facility policy and CDC/CMS guidance. Any identified concerns were addressed immediately through corrective intervention and staff re-education. No additional concerns were identified. 3. Measures Put Into Place or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur On 5/12/26 the Director of Nursing (DON)/designee reinforced and re-educated licensed nurses, nursing assistants, housekeeping staff, ancillary staff, and contracted agency on the facility Infection Prevention and Control Program policies and procedures including: Contact Precautions	05/21/2026

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F0880 SS = D	Continued from page 55 Based on observations, record review, and staff interviews, the facility failed to implement their infection control policy and procedures for Contact Precautions when cleaning a resident's room (Resident #37) who was on Contact Precautions for suspicion of Norovirus (a highly contagious group of viruses that cause inflammation of the stomach and intestines and can survive on surfaces for weeks) and Rotavirus (a highly contagious virus that causes gastrointestinal symptoms). This occurred with 2 of 5 staff members who were observed for infection control practices (Housekeeping Aide #1 and Housekeeping Aide #2). Findings included: The Infection Control Policy dated January 2026 revealed "Contact Precautions" were implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the residents environment. Staff and visitors are to wear gloves and a gown when entering the room and remove before leaving the room when a resident is on Contact Precautions. During an observation on 4/22/26 at 9:35 AM Resident #37 was observed lying in bed. A "Contact Precautions" sign was observed on the door of Resident #37's room. A PPE (personal protective equipment) supply bag with supplies including gloves and gowns were hanging on the door of Resident #37's room. Housekeeping Aide #1 was observed in Resident #37's room, cleaning the room including wiping down the bedside table and handling trash. Housekeeping Aide #1 was wearing gloves but no gown. She removed her gloves and performed hand hygiene before leaving the room. During an interview on 4/22/26 at 9:35 AM Housekeeping Aide #1 stated she did not see the sign on Resident #37's door because the door was open. She stated she saw the gloves and gowns hanging on Resident #37's door but did not see the Contact Precautions sign. Housekeeping Aide #1 then read the sign and stated she should have put on a gown and gloves before going into Resident #37's room. She stated she had received infection control training on Contact Precautions. During an observation on 4/23/26 at 11:05 AM Resident #37 was observed lying in bed. A "Contact	F0880	Continued from page 55 Transmission-Based Precautions Proper PPE use Hand hygiene The facility Infection Preventionist and/or designee will conduct routine infection control rounds to monitor compliance with: Proper implementation of Contact Precautions Appropriate PPE usage Hand hygiene compliance 4. How the Facility Will Monitor Its Corrective Actions to Ensure the Deficient Practice Is Being Corrected and Will Not Recur Beginning 5/12/26 The Infection Preventionist, DON, and/or designee will conduct audits of staff adherence to Contact Precautions for residents on transmission-based precautions: 5 times weekly for 4 weeks Then weekly for 8 week Then monthly thereafter as indicated by compliance findings Audits will include: Appropriate PPE use Hand hygiene compliance	05/21/2026

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Brunswick Rehabilitation and Healthcare Center	**1070 Old Ocean Highway , Bolivia, North Carolina, 28422**

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F0880 SS = D	Continued from page 56 Precautions" sign was observed on the door of Resident #37's room. A PPE supply bag with supplies including gloves and gowns were hanging on the door of Resident #37's room. Housekeeping Aide #2 was observed in Resident #37's room cleaning the room including the bathroom, and handling trash. Housekeeping Aide #2 was wearing gloves but no gown. He removed his gloves and performed hand hygiene before leaving the room. During interview on 4/23/26 at 11:05 AM Housekeeping Aide #2 stated he wasn't sure what it meant to be on Contact Precautions. Housekeeping Aide #2 stated he had received infection control training. During an interview on 4/23/26 at 11:20 AM the Housekeeping Manager stated Housekeeping Aide #1 and Housekeeping Aide #2 had received infection control training. She stated housekeeping staff had been instructed to read the precaution signs on the door of the residents' room before entering and wear the appropriate PPE. During an interview on 4/24/26 at 3:50 PM the Assistant Director of Nursing (ADON) stated she was also the Infection Preventionist, but she was new to the facility and had only worked here for three weeks. She indicated that all staff should have received infection control training and should wear the appropriate PPE when going into resident rooms that are on transmission-based precautions. During an interview on 4/24/26 at 4:00 PM the Director of Nursing (DON) stated she was new to the facility and had worked here for three weeks. She stated staff were to follow the guidelines and wear the appropriate PPE when entering resident rooms that were on any type of precautions. She stated Resident #37 was on Contact Precautions and the Housekeeping Aides (#1 and #2) should have had on gloves and a gown before entering Resident #37's room.	F0880	Continued from page 56 Availability of precaution signage and supplies Results of the audits will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meetings for 3 months. Any identified concerns will be addressed promptly with additional education and corrective action as needed. Facility alleges compliance on 5/21/26.	05/21/2026