STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Acres Center for Nursing and Rehabilitation	279 Brian Center Drive Lexington, NC 27292

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #64 was admitted to the facility 3/8/23 with the most recent readmission date of 4/26/25. Diagnoses for Resident #64 included respiratory failure and diabetes. a. A nursing note dated 2/25/25 documented Resident #64 had a change in condition and was transferred to the hospital. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident. A nursing note dated 3/1/25 documented Resident #64 returned to the facility after hospitalization. b. A nursing note dated 3/2/25 documented Resident #64 was transferred to the hospital after a change in condition. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident. A nursing note dated 3/4/25 documented Resident #64 returned to the facility after hospitalization. c. A nursing note dated 4/15/25 documented Resident #64 was transferred to the hospital after a change in condition. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident. A nursing note dated 4/26/25 documented Resident #64 returned to the facility after hospitalization. A significant change Minimum Data Set assessment dated [DATE] documented Resident #64 was severely cognitively impaired. The Responsible Party was not available for interview. (continued on next page)

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 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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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	An interview was conducted with the Director of Nursing (DON) on 5/20/25 at 9:30 AM. The DON reported the transfer form was sent with the resident when they were transferred to the hospital and the Responsible Party was notified of the transfer by phone. The DON explained that she was unaware the transfer notification was to be mailed to the Responsible Party and given to the resident. Based on record reviews and interviews with Responsible Party (RP) and staff, the facility failed to provide the RP written notification of the reason for a hospital transfer for 2 of 4 residents reviewed for hospitalization (Residents #7 and #64). The facility had no process in place to provide RPs with written notification which had the potential to affect all residents during transfers and discharges. The findings included: 1. Resident #7 was admitted to the facility on [DATE] and was noted to have a guardian for her medical and financial concerns. Resident #7 was transferred to the hospital on 1/7/25 for abdominal pain and on 4/17/25 for warmth and redness to a surgical site. On 5/20/25 at 9:30 AM, an interview occurred with the Director of Nursing (DON) who explained that when a resident was transferred to the hospital the transfer form was sent with the resident when they were transferred to the hospital and the RP was notified of the transfer by phone. The DON stated that Resident #7 had a guardian that the facility communicated with via phone regarding any changes or the need to transfer to the hospital. The DON stated she was unaware a written reason for a hospital transfer needed to be mailed to the RP. A phone interview was conducted with Resident #7's RP on 5/20/25 at 9:41 AM and stated that he was always informed by phone when Resident #7 was sent to the hospital but had not received anything in writing from the facility. The Administrator was interviewed on 5/21/25 at 1:52 PM, who had been employed at the facility since 3/17/25. The Administrator verified he was aware of the regulation regarding the need for written notice of transfer including the reason for the hospital transfer to be sent to the RP. He was unable to explain why this had not been completed for Resident #7 when she transferred to the hospital but stated a plan would be put into place going forward.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Resident #85 was admitted to the facility 7/8/24 with diagnoses including heart failure and pulmonary embolism (a blood clot in the lungs). Review of the physician orders for Resident #85 revealed an order dated 3/13/25 that specified warfarin (a blood thinner used for blood clots) to be administered 5 milligrams (mg) on Tuesday, Thursday, and Saturday at 5:00 PM, and warfarin 6 mg to be administered Monday, Wednesday, Friday, and Sunday at 5:00 PM. Review of the medication administration record for March, April, and May 2025 revealed Resident #85 received warfarin as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #85 was not taking anticoagulant medications and was taking antibiotic medications. Review of the physician orders for Resident #85 did not have antibiotic medications prescribed. MDS Nurse #2 was interviewed on 5/21/25 at 3:03 PM and she reported that coding antibiotics for Resident #85 was a mistake. MDS Nurse #2 reviewed her handwritten worksheet and on the worksheet she had noted Resident #85 was taking anticoagulation medications. The Administrator was interviewed on 5/21/25 at 3:47 PM and he reported MDS Nurse #2 had mis-keyed the information for Resident #85 and he expected the MDS assessments to be accurate. Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of oxygen use (Resident #7), prognosis (Resident #62), diagnoses (Resident #6) and medications (Resident #85). This was for 4 of 25 residents whose MDS assessments were reviewed. The findings included: 1. Resident #7 was originally admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease and dependence on supplemental oxygen. Resident #7 had a hospital stay from 4/17/25 to 4/21/25. Resident #7's physician orders included an order dated 4/21/25 for oxygen continuous at 3 liters per minute via nasal cannula. A review of the April 2025 Medication Administration Record (MAR) revealed that Resident #7 had oxygen at 3 liters per minute via nasal cannula on 4/21/25, 4/22/25 and 4/23/25. A review of a quarterly MDS assessment dated [DATE] indicated that Resident #7 was cognitively intact and was not coded for the use of oxygen. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/25 at 12:29 PM, an interview occurred with MDS Nurse #1. She reviewed Resident #7's quarterly MDS assessment dated [DATE] and verified that oxygen use was not coded. MDS Nurse #1 reviewed Resident #7's current physician orders as well as the April 2025 MAR and confirmed that Resident #7 was ordered oxygen on a continuous basis. She stated that oxygen use should have been coded for on the 4/23/25 MDS assessment and felt it was an oversight. An interview was completed with the Administrator on 5/21/25 at 1:52 PM and stated that he would expect the MDS assessment to be coded accurately. 2. Resident #62 was admitted to the facility on [DATE] with diagnoses that included vascular dementia. Review of a Hospice Certification of Terminal Illness dated 12/24/24 from the Hospice physician read, I recertify that this patient is terminally ill with a life expectancy of six months or less if the disease follows its normal course. The certification period was noted to be 12/26/24 through 3/25/25. A quarterly MDS assessment dated [DATE] indicated that Resident #62 was coded for hospice care but not marked for a condition or chronic disease that may result in a life expectancy of less than six months. On 5/21/25 at 12:29 PM, an interview occurred with MDS Nurse #1. She reviewed Resident #62's quarterly MDS dated [DATE] and indicated that the prognosis section for a condition or chronic disease that may result in a life expectancy of less than six months should have been marked as yes, as Resident #62 received hospice care. She felt this was an oversight. The Administrator was interviewed on 5/21/25 at 1:52 PM and stated that he would expect the MDS to be coded accurately. 3. Resident #6 was admitted to the facility on [DATE] with diagnoses that included dementia and hypertension. A record review indicated Resident #6 had an active diagnosis of hypertension since 07/01/22 and an active diagnosis for dementia since 08/03/23. The Nurse Practitioner note dated 02/04/25 read in part that Resident #6's Dementia with associated depression seems stable, no significant behaviors, on citalopram and hypertension was managed with diet only. Resident #6's blood pressure (BP) was monitored with six BPs documented during the 7 day look back period. The following BPs were obtained: 03/18/25 at 10:40 AM BP 136/88, 03/19/25 at 6:57 AM BP 126/78, 03/19/25 at 11:59 PM BP 118/62, 03/20/25 at 1:55 PM BP 112/64, and 03/24/25 at 4:55 PM BP 123/70. A weekly nursing summary dated 03/24/25 indicated Resident #6 was alert and oriented to person only and had episodic confusion. She also had short and long term memory problems and required total assistance with transfers and toilet use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] did not indicate Resident #6 had an active diagnosis of hypertension in the Heart/Circulation section or dementia in the Neurological section. An interview was conducted on 05/21/25 at 1:00 PM with Minimum Data Set (MDS) Nurse #2. She reviewed Resident #6's quarterly MDS assessment dated [DATE] and verified that hypertension in the Heart/Circulation section and dementia in the Neurological section were not coded. She stated she did not see any documentation of active diagnoses within the last 7 days in Resident #6's electronic medical record. She indicated it was an oversight that she did not see the documentation in the NPs notes or the vital signs area. She verified dementia and hypertension were included in the care plan. An interview was conducted on 05/21/25 at 2:52 PM with the Administrator. He stated he expected the MDS assessments to be coded accurately.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, family, and Physician Assistant (PA) interviews, the facility failed to provide care safely to a dependent resident. Resident #76 had an impaired gait and she was unable to walk without assistance. On 01/11/25 Nursing Assistant (NA) #1 transferred Resident #76 from her bed to the floor for ambulation to the bathroom. The NA turned away from the resident to place the resident's brief in a trash can leaving the resident in a standing position with no staff support resulting in the resident falling. Resident #76 sustained a left wrist fracture and a left hip fracture. This was for 1 of 4 residents reviewed for accidents (Resident #76). Findings included: Resident #76 was admitted to the facility on [DATE] with diagnosis that included osteoporosis, [NAME] Lymphoma, breast cancer, history of humerus (the long bone that extends from the shoulder to the elbow) fracture, and history of falls. The Minimum Data Set (MDS) quarterly assessment dated [DATE] indicated Resident #76's cognition was moderately impaired and she exhibited no behaviors. She required moderate assistance to ambulate 10 feet and maximal assistance for toileting hygiene, dressing, and transfers. Resident #76 was coded for receiving scheduled pain medications but no as needed pain medications. During the pain assessment, Resident #76 denied having pain. Resident #76 was not coded as receiving opioid, anticoagulant, or antiplatelet medications. Resident #76's admission care plan dated 12/19/24, included a focus that indicated the resident had an activities of daily living (ADL) self-care performance deficit related to dementia and limited mobility. She was admitted following a hospitalization for a fall at her assisted living facility sustaining subdural hematoma (a pooling of blood between the brain's outermost protective layer and the brain itself) and right humerus fracture. The interventions included Resident #76 was dependent on two or more staff and the use of mechanical lift for transfers. The date this intervention was created and initiated was 12/19/24. Another focus indicated that Resident #76 was at risk for falls related to history of falls, gait/balance problems, incontinence, and that she was unaware of safety needs. The interventions included for staff to be sure her call light was within reach and encourage her to use it for assistance as needed. Resident #76 needs prompt response to all requests for assistance and to anticipate and meet her needs. A fall risk assessment (used to predict a patient's likelihood of falling) dated 01/06/25 indicated Resident #76 was categorized as a high risk for falling with a score of 55.0. (Fall scoring: high risk 45 and higher). Resident #76's risk factors included a history of falling, multiple diagnoses, she overestimated or forgets her limits, her gait was impaired, she could not walk without assistance, and she did not use ambulatory aids. Resident #76's pain assessments documented on the Medication Administration Record (MAR) from 01/01/25 through 01/10/25 revealed no pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #76's incident report dated 01/11/25 at 12:55 PM, completed by Nurse #1, indicated Resident #76 had a fall while being assisted to the bathroom by NA #1. Resident #76's brief was falling so NA #1 stopped the resident to remove the brief. NA #1 then turned around to throw the brief in the trash and when she turned back around to face Resident #76 she was falling to the floor. Nurse #1 entered the room and observed Resident #76 lying on her left side by the bed. Resident #76 complained of pain but stated she felt comfortable to be assisted back to bed. A skin tear was noted to her left elbow and a discolored/darkened area noted to her left forearm/wrist. The physician, Director of Nursing, and family were notified of the fall and complaints of left wrist pain. An interview was conducted on 05/21/25 at 9:27 AM with NA #1. NA #1 verified she was Resident #76's NA on 01/11/25 when she fell. She stated she had worked at the facility as a NA since December 2024. She indicated she did not know Resident #76 could not ambulate without assistance or that she was to be transferred via the mechanical lift. NA #1 stated 01/11/25 was the first time she had worked with Resident #76 and that other staff had told her she could ambulate with assistance. NA # 1 was unable to provide the names of those staff members. She explained she was assisting the resident to the bathroom by ambulating with her. The NA said Resident #76's brief was falling down so she stopped her, removed the brief, she let go of Resident #76 and turned to throw the brief in the trash can which was against the wall, and when she turned back around Resident #76 was observed losing her balance and falling before she could get to her. An interview was conducted on 05/21/25 at 9:10 AM Nurse #1. She verified she was Resident #76's nurse on 01/11/25 when she had a fall. She stated she was called to the room by NA #1 and was told that Resident #76 fell while being assisted to the bathroom by NA #1. She indicated a second staff member was not present. Upon entering the room Resident #76 was lying on the floor on her left side beside the bed. She also stated she completed an assessment of the resident to include vital signs, checked for range of motion to all extremities, deformities, and checked her skin. She then explained that Resident #76 complained of pain in her left wrist, denied any other pain, and showed no signs of pain during the initial assessment. Nurse #1 indicated Resident #76 did not give her a rating of pain and she offered pain medication which the resident refused and said, I'm fine. Resident #76 stated she wanted to get back in bed. Nurse #1 and NA #1 assisted Resident #76 back to bed. She had a skin tear noted to her left elbow and a discolored/darkened area noted to her left forearm/wrist, like a hematoma. She then explained she called the PA and received an order to obtain an x-ray of the left wrist and to apply ice as needed for 20 minutes at a time for 2 days. She stated throughout the morning Resident #76 began to complain of pain in the left hip and this was added to the x-ray order. Nurse #1 applied the ice packs to Resident #76's left hip and Resident #76 voiced that this was effective for her pain. She indicated she assessed her hip again, which did not reflect bruising, deformity, or leg shortening. When she called to place the order for the x-ray the company stated they had a high call volume and they would be there as soon as they could. She explained NA #1 told her she was assisting the resident to the bathroom by ambulating with her. The NA said Resident #76's brief was falling so she stopped her, removed the brief, turned around to throw it in the trash and when she turned back around the resident was observed losing her balance falling before she could get to her. Nurse #1 stated Resident #76 was to be transferred by 2 staff members via the mechanical lift due to her poor balance and unsteady gait. She explained that Resident #76 should not have been ambulating due to the risk of falling and she was non weight bearing on her left lower extremity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 5 whys worksheet (a structured tool for problem-solving that uses a series of why questions to uncover the root cause of a problem) completed by the Director of Nursing (DON) dated 01/11/25 revealed the problem was Resident #76 fell while being assisted to the bathroom. The resident sustained a skin tear to her left elbow and darkened left forearm/wrist. Staff were throwing the resident's brief away and when NA #1 turned back to Resident #76 she was falling. The worksheet provided the following information related to the 01/11/25 fall: 1. Why was it happening? Incontinent; 2. Why was that? Gait imbalance; 3. Why was that? Staff were not touching Resident #76 with assistance. The Whys under numbers 4 and 5 were not answered. The identified root cause was staff transferring. The action/plan to address the problem was neurological checks and reeducation to staff when transferring Resident #76. Review of a Situation, Background, Assessment, and Recommendation (SBAR) form dated 01/11/25 at 6:25 PM completed by Nurse #1 revealed a change of condition related to the resident's fall. Resident #76 was identified with discoloration to her skin, a skin tear, and pain. New orders were received for a left wrist x-ray and an ice pack to left wrist every 2 hours for 20 minutes as needed for 2 days related to a fall. Physician orders dated 01/11/25 for Resident #76 indicated an x-ray for the left forearm and wrist for a hematoma; an x-ray of the left hip for acute pain related to a fall; and an ice pack to the left wrist for 20 minutes every 2 hours as needed for 2 days for a hematoma. A progress note dated 01/12/25 at 6:32 AM by Nurse #8 revealed Resident #76 was alert and oriented to person, place, and situation with intermittent confusion noted. She complained of acute pain in her left wrist; swelling was observed and bruising noted related to her fall. As needed pain medications were given with effective results. Awaiting an X-Ray to be obtained. Multiple unsuccessful attempts were made to contact Nurse #8. Resident #76's pain assessment documented on the MAR for 01/13/25 during the day shift (6:00 AM to 6:00 PM) revealed a pain level of 07 (pain scale of 1-10 with 10 being the worst pain). Record review revealed Resident #76 received an x-ray on 01/13/25 with a report date of 01/13/25. The results for the left wrist and forearm included a fracture at the distal radius metaphysis (a break in the wider, flared end of the bone, located near the wrist joint). The results for the left hip x-ray were positive for intertrochanteric femur fracture (hip fracture). A progress note dated 01/13/25 at 3:50 PM by Unit Manager (UM) #2 revealed Resident #76 had a fall on 01/11/25. An x-ray of her hip and forearm were completed and showed a fractured hip upon assessment. Resident #76 was being sent to hospital via emergency medical services (EMS) for further evaluation. The hospital Discharge summary dated [DATE] revealed Resident #76 presented to emergency room on [DATE] with a left hip fracture and left wrist fracture. Resident #76 did not remember the fall and was not in pain. After discussion, the family ultimately opted for comfort measures only. Resident #76's pain was well controlled with oral agents and given her poor baseline there was felt to be no benefit in surgical repair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A phone interview was conducted on 05/18/25 at 11:22 AM with Resident #76's family member. The family member stated he was notified of the fall on 01/11/25 and that she was sent to the emergency room on [DATE] due to the x-ray results revealing a hip fracture and the wrist fracture. He stated he discussed the options with the hospital physician and decided on no surgical interventions. His main concern was to keep Resident #76 comfortable. He explained he came to the facility often and that during his visits Resident #76 did not complain or show signs of being in pain An interview was conducted on 05/21/25 at 3:20 PM with the Director of Nursing. She stated she expected the care plan to be followed. The DON indicated NA #1 should not have let Resident #76 go during ambulation due to her unsteady gait. She stated she thought this resident was care planned for extensive to total assistance by one plus staff members. She indicated she was not aware of her transfer status being changed to a mechanical lift. A phone interview was conducted on 05/21/25 at 3:34 PM with the Physician's Assistant (PA). He stated he recalled the fall in January with Resident #76. He explained that Resident #76 could stand but she was unsteady and was at a high fall risk. He expected the care plan to be followed and the goal was always to keep the residents safe and free of injuries. He stated Resident #76 was sent to the emergency room however she nor her family wanted to go through surgical interventions because they did not feel she was a good candidate. He further explained Resident #76 was not on a blood thinner and she stayed in bed most of the time.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to label enteral feeding formula for 1 of 2 residents reviewed for enteral feeding (method of supplying nutrition through a feeding tube that goes directly into the stomach or small intestine) (Resident #79) and failed to store a plastic enteral feeding syringe with the plunger separated from the barrel of the syringe for 2 of 2 residents (Resident #79 and Resident #43) reviewed for enteral feeding management. This practice had the potential for bacterial growth and contamination. The findings included: 1. Resident #79 was admitted to the facility 8/23/24 with diagnoses including anoxic brain injury. A physician order dated 4/10/25 specified for enteral feeding to be administered at 55 milliliters per hour via j-port (a tube that delivers enteral feeding directly into the small intestine) by pump. The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #79 to be severely cognitively impaired. The MDS documented Resident #79 received enteral feedings and received 51% or more of calories by enteral feedings. a. Resident #79 was observed on 5/18/25 at 1:54 PM. The enteral tube feeding was infusing by j-port tube at 55 milliliters per hour. The enteral feeding was not labeled with the date or time the enteral feeding was changed. b. During the observation on 5/18/25 at 1:54 PM, the enteral feeding syringe was noted in a plastic bag with the plunger in the barrel of the syringe. Droplets of water were noted in the tip of the syringe and the interior of the plastic bag was noted to have droplets of water. Nurse # 3 was interviewed on 5/18/25 at 1:54 PM during the observation. Nurse #3 explained the enteral feeding was changed by night shift and she did not know why the bag of enteral feeding was not labeled with the date and time the feeding was changed. Nurse #3 reported the enteral feeding was changed when the bag was empty, and she didn't think there was a time limit on the feeding. Nurse #3 explained she was not aware the plunger for the enteral feeding syringe should be removed from the barrel and stored separately from the barrel. Nurse #3 reported she had used the syringe to administer medications by j-port tube to Resident #79 earlier in the day. The Director of Nursing (DON) was interviewed on 5/21/25 at 3:30 PM. The DON reported the enteral feeding came with a bag for the enteral feeding and a bag for the water hydration with one label to apply to the enteral feeding. The DON explained that the enteral feeding could hang for up to 24 hours before it needed to be discarded. The DON reported she did not know why the night shift nurse had not labeled the enteral feeding. The DON explained the plunger for the enteral feeding syringe should be removed from the barrel and stored separately from the barrel because of the potential for bacterial growth in the syringe tip when it was used for medication administration. The DON reported the enteral feeding should be labeled with the date and time it was hung, and the enteral feeding syringe should be stored with the plunger separated from the barrel. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Acres Center for Nursing and Rehabilitation	279 Brian Center Drive Lexington, NC 27292

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #43 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and a history of a stroke. A review of Resident #43's physician orders included an order dated 12/21/23 to flush gastrostomy tube with 60 milliliters (ml) of warm tap water after each medication administration. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #43 was cognitively intact and received 51% or more of her total calories and more than 501 ml of fluids per day by enteral feedings. A review of Resident #43's Medication Administration Record (MAR) for 5/18/25 revealed she received medications and 60 ml of warm tap water after each medication administration at 8:00 AM and 9:30 AM on 5/18/25. During an observation of Resident #43 on 5/18/25 at 1:52 PM, the plastic syringe used to provide medications and flush her gastrostomy tube was noted in a plastic bag hanging from the feeding pump pole with the plunger in the barrel of the syringe. Droplets of a clear liquid were noted in the tip of the syringe and the interior of the plastic bag was noted to have droplets of a clear liquid. Nurse #5 was interviewed on 5/18/25 at 1:55 PM and explained she had provided Resident #43 with her medications and water flush via the gastrostomy tube that morning. She stated she was not aware the plunger should be removed from the barrel of the syringe and stored separately. The Director of Nursing (DON) was interviewed on 5/20/25 at 12:15 PM and stated the plunger for the enteral feeding syringe should be removed from the barrel and stored separately from the barrel because of the potential for bacterial growth in the syringe tip when it was used for medication administration.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #20 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including chronic obstructive lung disease (COPD) and respiratory failure. Physician orders for Resident #20 dated 4/26/25 specified oxygen flow rate to be administered at 3 liters per minute (LPM). The quarterly Minimum Data Set, dated [DATE] documented Resident #20 was cognitively intact and used oxygen. Review of the medication administration record for May 2025 indicated by the nursing initials that the oxygen flow rate of 3 LPM was checked by the nurse twice per day (once on each shift). Resident #20 was observed on 5/19/25 at 8:31 AM. She was in bed and had oxygen nasal cannula in place with the oxygen flow rate set at 5 LPM. Resident #20 reported she did not know the oxygen flow rate, but sometimes she felt like she was not getting enough oxygen. Resident #20 was observed on 5/20/25 at 11:06 AM in bed with an oxygen nasal cannula in place with the oxygen flow rate set at 5 LPM. On 5/21/25 at 8:50 AM, Resident #20 was observed in bed with an oxygen nasal cannula in place with the oxygen flow rate set at 5 LPM. Review of the medication administration record for 5/21/25 day shift revealed Nurse #2 initials that indicated she had checked the oxygen flow rate for Resident #20. Resident #20 was observed with Nurse #2 on 5/21/25 at 11:36 AM in bed with an oxygen nasal cannula in place with the oxygen flow rate set at 5 LPM. Nurse #2 reported the oxygen flow rate was supposed to be 2 LPM and 5 LPM was too much oxygen. Nurse #2 adjusted the oxygen flow rate to 2 LPM and then Nurse #2 checked the physician order and reported that she was wrong, and that Resident #20 should be receiving oxygen at 3 LPM. Nurse #2 returned to the room to correct the oxygen flow rate. When asked why the medication administration record indicated Nurse #2 had checked the flow rate on 5/21/25, Nurse #2 explained that she had checked the oxygen flow rate for residents in the past, but that she may have slacked off. The Unit Manager (UM) was interviewed on 5/21/25 at 11:45 AM and she reported the nurses should check oxygen flow rate for all residents receiving oxygen at least once per shift. The UM did not know why Resident #20's oxygen flow rate was set at 5 LPM. During an interview with the Director of Nursing on 5/21/25 at 3:30 PM, she reported that nurses are supposed to check the oxygen flow rate once per shift and that they documented in the medication administration record that the flow rate was correct. The DON reported she did not know why Resident #20's oxygen flow rate was set at 5 LPM and that the nurses should have corrected the flow rate to what the physician ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record reviews, observations and interviews with resident, Physician Assistant and staff, the facility failed to obtain a Physician's order for a resident's use of oxygen (Resident #8) and failed to administer oxygen at the prescribed rate (Resident #20). In addition, the facility failed to apply signage indicating the use of oxygen outside the residents' rooms with supplemental oxygen (Residents #9 and #82). This deficient practice affected 4 of 6 residents reviewed for respiratory care. The findings included: 1. Resident #8 was originally admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), heart failure and asthma. She was recently hospitalized from [DATE] to 3/22/25 for norovirus and on 4/27/25 to 5/2/25 for cellulitis concerns. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was cognitively intact. She was not coded for the use of oxygen. A review of Resident #8's active care plan, last reviewed 4/1/25, had a focus area for oxygen therapy related to heart failure and COPD. The interventions included oxygen settings via nasal cannula per physician orders. Review of a physician's progress note dated 4/26/25 indicated oxygen was available as needed for shortness of breath for Resident #8. A review of Resident #8's April 2025 and May 2025 physician orders did not reveal any orders for the use of oxygen via nasal cannula. There was an order dated 1/21/25 to 3/21/25 for oxygen as needed at 2 liters per minute via nasal cannula for shortness of breath. On 5/18/25 at 10:15 AM, Resident #8 stated that she used 2 liters of oxygen via nasal cannula all the time. The oxygen concentrator was set at 2 liters flow and was in use by Resident #8. On 5/19/25 at 1:35 PM, Resident #8 was observed lying in bed watching TV. Oxygen was being used at 2 liters flow via a concentrator. Nurse #6 was interviewed on 5/20/25 at 10:05 AM and had been assigned to Resident #8 on 5/18/25. She stated she couldn't recall if Resident #8 had oxygen flowing on 5/18/25, however an oxygen concentrator was always available in her room within reach so she could place it on whenever she felt short of breath. Nurse #6 reviewed Resident #8's current physician orders and confirmed there was not an order for the use of oxygen and felt it had not been transcribed when Resident #8 had returned from one of her recent hospitalizations. Nurse #7 was interviewed on 5/20/25 at 1:11 PM and was assigned to care for Resident #8. She stated that Resident #8 has always had an oxygen concentrator in her room within reach that she would use when she felt short of breath. She verified that an order for the use of oxygen was not present for Resident #8 and felt it was not been reinstated when she had returned from her recent hospitalizations. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Assistant (PA) familiar with Resident #8 was interviewed on 5/20/25 at 11:58 AM. He stated that Resident #8 had utilized oxygen in the past when she felt short of breath. He reviewed her current physician orders and verified an order for oxygen was not present. He stated that if Resident #8 was utilizing oxygen, then an order should have been present. The Director of Nursing (DON) was interviewed on 5/20/25 at 12:00 PM. She stated that Resident #8 had used oxygen as needed prior to her hospitalizations in March 2025 and April 2025. She verified there was no order for the use of oxygen when she was readmitted to the facility on [DATE] or 5/2/25 and felt it was an oversight. 3. Resident # 9 was admitted on [DATE] with diagnosis of chronic obstructive pulmonary disease. A physician's order for Resident # 9 dated 8/21/24 read oxygen continuous at 4 liters per minute via nasal canula. Review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident # 9 was cognitively intact and coded for the use of oxygen. During an observation on 5/18/25 at 10:52 AM of Resident #9's room, there was no signage for oxygen use found anywhere near Resident # 9's room entrance. Resident #9 was observed wearing oxygen via nasal cannula at 4 liters per minute (LPM). The oxygen concentrator was observed in Resident # 9's room. During an observation on 5/19/25 at 12:49 PM there was no signage for oxygen use found anywhere near the entrance of Resident # 9's room. Resident #9 was observed wearing oxygen via nasal cannula at 4 liters per minute (LPM). The oxygen concentrator was observed in Resident # 9's room. During an interview with Nurse #6 on 5/20/25 at 11:27 AM she stated that Resident #9 received oxygen continuously and nursing staff made sure oxygen was applied to Resident #9 and she was monitored. Nurse #6 further revealed that she did not know for sure why Resident #9 was missing the signage, but it should have been posted outside the door. An interview occurred on 5/20/25 at 11:42 AM with the Director of Nursing (DON). She stated it was the nursing staff's responsibility to put up the oxygen in use sign on the resident's door and if the signage is missing the nurse should have it replaced. An interview on 5/21/25 at 3:13 PM occurred with the Administrator. The Administrator indicated that Resident #9 should have had signage posted outside the room to indicate the use of oxygen. 4. Resident # 82 was admitted on [DATE] with diagnosis of chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #82 was cognitively impaired and coded for the use of oxygen. A physician's order for Resident # 82 dated 3/25/25 read oxygen continuous at 3 liters per minute via nasal canula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/18/25 at 11:01 AM of Resident #82's room, there was no signage for oxygen use found anywhere near Resident # 82's room entrance. Resident #82 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 82's room. During an observation on 5/19/25 at 12:52 PM there was no signage for oxygen use found anywhere near the entrance of Resident # 82's room. Resident #82 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 82's room. During an interview with Nurse #6 on 5/20/25 at 11:27 AM she stated that Resident #82 received oxygen continuously and nursing staff made sure oxygen was applied to Resident #82 and she was monitored. Nurse #6 further revealed that she did not know for sure why Resident #82 was missing the signage, but it should have been posted outside the door. An interview occurred on 5/20/25 at 11:42 AM with the Director of Nursing (DON). She stated it was the nursing staff's responsibility to put up the oxygen in use sign on the resident's door and if the signage is missing the nurse should have it replaced. An interview on 5/21/25 at 3:13 PM occurred with the Administrator. The Administrator indicated that Resident #82 should have had signage posted outside the room to indicate the use of oxygen.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and staff interview, the facility failed to ensure a Nursing Assistant (NA) was trained and competent on utilizing the kardex (a concise, quick-reference system for resident care information) to identify the care needs that residents required prior to providing direct care to residents. This was for 1 of 5 staff reviewed for competency (NA #1). The findings included: This tag is cross-referred to: F689: Based on record review, staff, family, and Physician Assistant (PA) interviews, the facility failed to provide care safely to a dependent resident. Resident #76 had an impaired gait, and she was unable to walk without assistance. On 01/11/25 Nursing Assistant (NA) #1 transferred Resident #76 from her bed to the floor for ambulation to the bathroom. The NA turned away from the resident to place the resident's brief in a trash can leaving the resident in a standing position with no staff support resulting in the resident falling. Resident #76 sustained a left wrist fracture and a left hip fracture. This was for 1 of 4 residents reviewed for accidents (Resident #76). NA #1's hire date was 11/07/24. NA #1's orientation packet dated 01/01/25 was reviewed and revealed no evidence she was trained in accessing residents' kardex. During an interview with NA #1 on 05/21/25 at 9:27 AM she stated she began working at the facility in December 2024. She revealed she was not educated on what a kardex was or how to access it when she was hired or while being trained on the floor. She revealed she had no training on the kardex until after she was educated by Nurse #1 on 01/11/25. She indicated she would ask the residents and/or other staff about care needs of residents prior to learning about the kardex. NA #1 stated she has utilized the kardex since education was provided. She further stated she wished she would have known how to utilize it prior to the training because she should know how to safely assist and care for the residents. An interview was conducted on 05/21/25 at 9:10 AM Nurse #1 she verified on 01/11/25 NA #1 informed her she did not know how to access the kardex. She reported that she educated NA #1 immediately. Nurse #1 explained she educated NA #1 on what the kardex was and how it provided guidelines for resident care needs such as assistance required for safe transfers and other activity of daily living tasks. An interview was conducted on 05/21/25 at 3:20 PM with the Director of Nursing. She stated she expected NAs to look at the kardex prior to working with residents so the staff knew how to provide safe care for the resident. She stated she was not aware NA #1 did not know how to access the kardex until after she was trained by Nurse #1 on 1/11/25. She indicated new staff were trained in using the kardex during orientation and she thought NA #1 had been educated during orientation. She added that when staff were working on the floor other NAs trained new hires after orientation and that other NAs trained newly hired NAs on accessing the kardex when training on the floor after classroom/computer training was provided. NA #1's orientation packet was reviewed with the DON, and she verified there was no evidence she was trained on accessing the kardex during orientation. The DON stated they have a new Staff Development Coordinator and this training will be included in orientation.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, record review, and staff interviews, the facility failed to post accurate nurse staffing forms for 5 of 8 posted daily posted nurse staffing forms reviewed (11/28/24, 3/14/25, 5/7/25, 5/17/25, and 5/18/25). The findings included: Posted nurse staffing forms for the following dates were reviewed: 7/20/24, 9/1/24, 11/28/24, 1/5/25, 3/14/25, 5/7/25, 5/17/25, and 5/18/25. a. The facility posted nurse staffing form was observed on 5/18/25 at 9:40 AM. The date on the staffing form was 5/16/25. The Receptionist was interviewed at the time of the observation, and she reported she did not know who was responsible for changing or updating the posted nurse staffing form. b. A posted nurse staffing form dated 11/28/24 was reviewed. The staffing form indicated 5 Licensed Practical Nurses (LPNs) were working 2nd shift (7:00 PM to 7:00 AM). The schedule indicated 4 LPNs were scheduled to work that shift. c. A posted nurse staffing form dated 3/14/25 indicated 9 Nursing Assistants (NA) were working 1st shift (7:00 AM to 7:00 PM). The schedule indicated 1 NA called out sick and 8 NAs were working that shift. d. The posted nurse staffing form dated 5/7/25 indicated no Registered Nurse (RN) worked 1st or 2nd shift, 10 NAs worked 1st shift. Review of timecards and the schedule for that date confirmed 1 RN worked 8 hours on day shift (8:30 AM to 4:30 PM) and 10.5 NAs worked 1st shift. e. The posted nurse staffing form dated 5/17/25 indicated 10 NAs worked 1st shift. Review of the schedule for that date, revealed 8.5 NA were working that date. An interview was conducted with the Scheduler on 5/21/25 at 12:34 PM. The Scheduler reported the RN should have been added to the nurse staffing form on 5/7/25 and she did not know why she was not added. The Director of Nursing was interviewed on 5/21/25 at 12:34 PM. The DON explained that some of the nursing staffing form errors may have been her responsibility, including adding the RN to the 5/7/25 posted nurse staffing form, but she was not certain. The DON explained that the nursing staffing form should be updated with any staffing changes. The Scheduler was interviewed again on 5/21/25 at 2:40 PM. The Scheduler reported she was making corrections to the nurse staffing forms during the week when she was in the building, and on the weekend, the receptionist was responsible, and she did not know why the receptionist had not updated the staffing form on 5/18/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, Pharmacist, and staff interviews, the pharmacy failed to label a medication blister package correctly, which resulted in the facility administering 18 doses of oxycodone (an opioid pain medication) to Resident #75 instead of ordered hydrocodone (an opioid pain medication). This was for 1 of 6 residents reviewed for medication administration. The findings included: Resident #75 was admitted to the facility 11/4/23 with diagnoses including stroke, chronic pain, and ovarian cancer. A physician order dated 2/28/24 specified for hydrocodone/acetaminophen 5/325 milligrams (mg) to be given by mouth every 4 hours as needed for pain. A facility incident report dated 4/5/24 and completed by Unit Manager (UM) #1 documented that on 4/5/24 it was discovered that Resident #75 received 18 doses of oxycodone/acetaminophen 5/325 mg instead of hydrocodone/acetaminophen 5/325 mg as the physician ordered. The incident report documented the tablets in the blister packet were scored, round, white tablets with the number 512 on them, and the labeling on the blister packet indicated the hydrocodone/acetaminophen tablets were oblong with M365 imprinted on the tablets. Resident #75 was notified of the medication error, and she reported that she had no adverse reactions to the oxycodone/acetaminophen. A progress note dated 4/5/24 documented the physician was notified of the medication packaging error. A nursing physical assessment was completed for Resident #75 on 4/5/24 at 1:19 PM and no issues were identified. A physician note dated 4/8/24 documented he was notified of the medication error, and this was not a significant medication error for Resident #75. The physician documented he had assessed Resident #75 who did not experience adverse effects from the medication error, and if she wanted to switch medication from hydrocodone to oxycodone, that would be fine. Review of the March 2024 and April 2024 medication administration record revealed that Resident #75 received oxycodone/acetaminophen 5/325 mg instead of hydrocodone on these dates: -3/27/24 at 5:18 AM, 12:26 PM, and 11:07 PM -3/28/24 at 1:14 PM, and 11:28 PM -3/29/24 at 11:11 AM -3/30/24 at 3:21 AM and 12:25 PM -3/31/24 at 1:08 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/1/24 at 3:00 AM and 12:34 PM -4/2/24 at 12:11 AM and 12:42 PM -4/3/24 at 3:16 AM and 2:15 PM -4/4/24 at 3:32 AM and 12:18 PM 4/5/24 at 4:00 AM The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #75 was cognitively intact. The MDS documented Resident #75 took opioid medications. Resident #75 was interviewed on 5/18/25 at 11:20 AM and she reported that in April 2024, she was given the wrong medication. Resident #75 reported she did not recall the details of the error, but she did remember that she did not have good pain control during that time and felt that she needed medication more frequently. Resident #75 explained that the physician discussed the medication error with her and assessed her. Resident #75 reported that as far as she knew, no further medication errors had been made. UM #1 was interviewed on 5/21/25 at 11:39 AM. UM #1 explained that on 4/5/24 a nurse brought her a blister packet of medications labeled as hydrocodone/acetaminophen 5/325 mg. The nurse pointed out that the pills that were in the blister packet did not match the description of the pills on the pharmacy label and she thought the medications in the package were wrong. UM #1 described observing the medication blister package and calling the pharmacy to notify them the medication package was incorrect. The Director of Nursing (DON) was interviewed on 5/21/25 at 11:55 AM. The DON explained that a nurse discovered the medications packaged as hydrocodone/acetaminophen were incorrect, and the pharmacy was notified of the error. The DON reported a nurse consultant from the pharmacy was sent to the facility to check all narcotic medications and did not find any further mislabeled medications. The DON reported the facility audited all narcotics on all medication carts and did not find any other mislabeled medications. The DON reported the facility educated the nurses to examine the medications in the blister packaged to the description on the label to ensure the correct medications were packaged. The pharmacy Director of Operations was interviewed by phone on 5/22/25 at 1:58 PM. The Director of Operations reported that the pharmacy completed a root cause analysis to determine why the oxycodone/acetaminophen 5/325 mg was labeled with the hydrocodone/acetaminophen 5/325 mg label and they determined that a pharmacy technician grabbed the wrong blister packet, and the pharmacist had not double-checked the medication to ensure it was correct. The Director of Operations explained that the pharmacist was supposed to double-check the medications that the pharmacy technician brought to them for labeling, but this did not happen with this medication. The Director of Operations reported that the pharmacy discovered that they had a surplus of hydrocodone/acetaminophen and a shortage of oxycodone/acetaminophen when they did a weekly inventory check and the pharmacy was unable to determine where the error occurred, until the facility contacted the pharmacy on 4/5/24 and reported the error. The Director of Operations reported the pharmacy nurse consultant went to the facility and checked all narcotics in the building and did not find any other issues. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility submitted the following plan of correction with a compliance date of 4/11/25: How corrective action will be accomplished for those residents found to have been affected by the deficient On 4/5/24 it was identified that Resident #75's hydrocodone did not have the same appearance as the usual pill. After researching the pills characteristics, it was identified that the medication had been packaged wrong at the pharmacy. The pharmacy had packaged Percocet in error. The pharmacy was notified by the Administrator. The Unit Manager completed a check of narcotics in the facility as soon as the issue was identified. In addition, the pharmacy sent a Nurse Consultant to the facility to conduct an audit of the narcotics. Resident #75 still resides in the facility and has had no further issues. Resident #75 had an assessment completed by the physician and no adverse reaction from the medication administered. Address how the facility will identify other residents having the potential to be affected by the same deficient. Residents residing in the facility have the potential to be affected by the deficient practice. The Unit Manager completed an audit of the five narcotic drawers on 4/5/25. The Nurse Consultant with Pharmacy Services completed an audit of the five narcotic drawers on 4/8/25 for residents' narcotics to ensure the dispensed medication matched the physician order. In addition, the medication label was matched to the medication dispensed. There were no issues identified. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not occur. An ad hoc Quality Assurance Performance Improvement (QAPI) meeting was completed on 4/5/25 with the Administrator leading. The Administrator, the Regional Nurse Consultant, the Director of Public Relations, MDS nurse, Social Worker, Medical Records, Housekeeping Director, Activities Director, Admissions Director, Human Resources, the nurse at the time the incident was identified, and Medical Director were present for the meeting. The Director of Clinical Services at Polaris Pharmacy attended via telephone. The Director of Nursing was notified via telephone. The facility team collaborated with the pharmacy on an appropriate plan to avoid the incident happening again. The Team members present as well as the Director of Nursing approved the plan of correction and put it in to place. Education was completed by the Director of Nursing between 4/5/25 and 4/10/25 with the staff nurses regarding reconciliation of narcotics received to the physician order. The nurses were educated to match the paper delivery sheet to the pill, and to the physician order. The nurses were re-educated on using the description on the narcotic card to identify the pill. The nurse will check the label and description to the actual packaged product. Furthermore, the nurses were educated that the electronic health record has an area where they can see a picture of the pill if in question. Nurses that do not receive the education will not be able to start next shift until education is completed. Newly hired nurses will receive the education during orientation by the Director of Nursing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Acres Center for Nursing and Rehabilitation	279 Brian Center Drive Lexington, NC 27292

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pharmacy is using a process as follows: the technician types the order in, pharmacist checks the order and prints a label, technician labels the medication and pharmacist verifies. Pharmacist verifies that the label is correct and the medication being dispensed is what is packaged. A double check system is in place between technicians and pharmacists to check accuracy of label and medication. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The decision was made on 4/5/24 that the Director of Nursing or designee will audit narcotics on medication carts three times a week including weekends for four weeks, then one time a week including weekends for four weeks to ensure narcotics received from the pharmacy matched the physician order. The label is read to compare the packaged medication to the named medication on the label. The DON will read the label for the medication and description then compare to what the medication package looks like visually. On 4/5/24 during the ad hoc QAPI committee meeting it was decided the Director of Nursing or designee will forward the results of the audit to the QAPI committee for 3 months. The QAPI committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator will be responsible for the plan of correction. Date of compliance 4/11/24. The plan of correction was validated on 5/22/25 by reviewing the education provided to the nurses, reviewing the audits conducted by the facility, interviewing the staff nurses about the process of accepting narcotics from the pharmacy and how to identify medications within the blister package, and reviewing the QAPI meeting notes. The compliance date of 4/11/24 was validated on 5/22/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews the facility failed to discard milk stored past the use by date in 1 of 1 reach-in cooler and failed to label, and date opened left food items in 1 of 1 walk-in cooler. This practice had the potential to affect food served to residents. The findings included: Observations during the initial tour of the main kitchen with Dietary Aide #1 on 05/18/25 at 9:56 AM, revealed the following: a. In the reach-in cooler the following leftover beverage was stored past the use by date: -one gallon of whole milk partially consumed with a use by date of 05/15/25. b. In the walk-in cooler the following items were observed on 05/18/25 at 10:02 AM with Dietary Aide #1. -two opened 5 pound bags of leftover shredded cheese with no label or date. An interview was conducted on 05/18/25 at 10:04 AM with Dietary Aide #1. She stated the milk should have been discarded by the use by date. She also stated when staff opened items the date should be written on the item including a use by date. c. In the walk-in cooler the following items were observed on 05/18/25 at 10:06 AM with the Dietary Manager. -One opened bag of hot dogs with no open date. -One 4 quart container of purple jelly like substance in it. Label read jelly with a use by date of 05/15/25. -One 4 pound roll of bologna with no open date. -One 2.5 pounds bag sliced cooked ham with a use by date of 05/15/25. An interview was conducted on 05/18/25 at 10:17 AM with the Dietary Manager. She stated she was responsible for monitoring the freezer and coolers for dated and labeled food items. She stated she had been on vacation since 05/13/25 and returned last night (05/17/25). She explained she checked the coolers and freezers on 05/12/25 prior to leaving the facility. She also explained that the facility Social Worker was making daily rounds in the kitchen using check off sheets that she provided to her while she was out. She then stated she expected Dietary Cooks and Aides to label and date items in the coolers and freezers according to regulations. (continued on next page)

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	345011	A. Building B. Wing	05/22/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 05/19/25 at 9:20 AM with the Social Worker (SW). She verified she made daily rounds in the kitchen from 05/13/25 through 05/16/25 using the check off sheets provided to her by the Dietary Manager. She stated on 05/14/25 she noted undated food in the walk-in-cooler and she notified kitchen staff at that time. She also stated on 05/15/25 she noted food that had not been labeled in the walk-in-cooler and she again notified the kitchen staff. The SW explained she did not see repeated undated, or items not labeled during the rounds. An interview was conducted on 05/20/25 at 11:02 AM with Dietary Aide #1. She verified she was working on 05/14/25 and 05/15/25 when the Social Worker (SW) was covering the kitchen. She stated the SW did tell her on 05/14/25 and 05/15/25 that there was an open food item that had no open date and there was a food item without a label. She stated the items had been opened on those days and she dated and labeled them according to regulation. An interview was conducted on 05/21/25 at 3:02 PM with the Administrator. He indicated he was unaware that dietary staff were not labeling or dating open food items and that they were not discarding opened food items within 7 days. He stated that he expected the Dietary Manager and kitchen staff to properly label, date, and discard prepared food items per regulations.