STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. Building B. Wing	01/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Place Center for Nursing and Rehabilitation	1201 Carolina Street Greensboro, NC 27401

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review, staff and resident interviews, the facility failed to act upon group grievances, resolve repeat grievances, and/or communicate the facility's efforts to address grievances voiced during Resident Council meetings for 2 of 3 months reviewed (November 2025 and December 2025).The findings included:Resident Council minutes completed on 10/14/25 by the previous Activities Director, Activities Director #1, revealed the following grievances were expressed: staff had poor attitudes and used foul language, medications were dropped off and left in resident rooms, call lights not in reach, staff observed voicing confidential resident information in public areas, unsanitary shower rooms and bathrooms, and lack of communication regarding room changes. A review of the grievances for October 2025 revealed one grievance form completed by the Administrator on 10/14/25 that corresponded to the Resident Council minutes dated 10/14/25. This form revealed no mention of the grievances voiced by the Resident Council related to staff voicing confidential resident information in public areas, unsanitary shower rooms and bathrooms, and lack of communication regarding room changes. Multiple attempts were made to interview Activities Director #1, but attempts were not successful.Resident Council minutes completed on 11/18/25 by the current Activities Director, Activities Director #2, indicated a review of old business and follow up on grievances/concerns were read and approved as corrected. However, there was no evidence the specific grievances voiced during the 10/14/25 meeting related to staff voicing confidential resident information in public areas, unsanitary shower rooms and bathrooms, and lack of communication regarding room changes were discussed, addressed, and/or resolved. The 11/18/25 minutes noted a repeat grievance from the October 2025 Resident Council meeting related to staff being rude (previously voiced as staff having poor attitudes and using foul language). Additionally, the following new grievances were expressed: call lights not answered on 2nd and 3rd shift, bugs observed, staff turning off call lights and leaving the room without returning, residents not being told who their assigned nursing assistant was for that shift, and noise levels (staff) being too loud on the hallways. A review of the grievances for November 2025 revealed one grievance form completed by the Administrator on 11/18/25 that corresponded to the Resident Council minutes dated 11/18/25. This form revealed documentation of the concerns related to staff turning off call lights and leaving the room without returning, residents not being told who their assigned nursing assistant was for that shift, and noise levels being too loud on the hallways. However, there was no indication of an investigation, interventions, and/or a resolution to these specific grievances expressed by the Resident Council. Resident Council minutes completed on 12/16/25 by Activities Director #2 indicated a review of old business and follow up on grievances/concerns were read and approved as corrected. However, there was no evidence of the specific grievances voiced during the 12/16/25 Resident Council meeting related to staff turning off call lights and leaving the room without returning, residents not being told who their assigned nursing assistant was for that shift, and noise levels being too loud on the hallways. The 12/16/25 minutes included a repeat grievance from the (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 2025 Resident Council meeting related to leaving medications in residents' rooms (previously voiced as medications being dropped off and left in resident rooms). Additionally, the following new grievances were expressed: staff not responding to residents in a timely manner, staff using personal phones while in resident rooms and on the hall, and staff rushing residents when eating. A Resident Council meeting was held on 1/7/26 at 11:00 AM with Resident #20 (the Resident Council President), Resident #5, Resident #55, Resident #11 and Resident #12. During the meeting, all residents voiced that the Resident Council had made repeated grievances month after month which had not been fully addressed or resolved. An interview with Activities Director #2 on 1/9/26 at 1:07 PM revealed that she completed the Resident Council minutes and then provided a copy of the minutes to the Administrator after each Resident Council meeting. She further indicated that the follow-up process for grievances voiced during the Resident Council meetings was for the Administrator to address all Resident Council concerns and then provide her with the follow-up so that she could review it with the Resident Council members at the next meeting. Activities Director #2 further revealed that she was not aware that the grievance follow-up that she provided to the Resident Council during the November 2025 and December 2025 Resident Council meetings did not address all the grievances that were voiced during the previous month's meeting. Activities Director #2 did not know why this had not been completed and that this was an oversight. An interview with the Administrator on 1/10/26 at 9:39 AM revealed that the Resident Council grievance process was for the Activities Director to document any Resident Council members' concerns in the minutes, and then the Administrator would initiate a grievance form. The Administrator further explained that the Resident Council grievances were discussed at the next morning meeting with all department heads and the department heads were responsible for addressing any Resident Council concerns in their areas and report the resolution to him (the Administrator). The Administrator indicated he would document the resolution on the grievance form or attach documentation to the form so that the Activities Director could follow up with the Resident Council members at their next meeting. The Administrator indicated that these actions should have been taken to address all the Resident Council members' concerns. He indicated he felt this was an oversight.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and record review, the facility failed to maintain accurate and consistent advance directive information throughout both the electronic medical record and paper record kept at the nursing station for 1 of 32 residents reviewed for advance directives (Resident #96). The findings included:Resident #96 was admitted to the facility on [DATE] with cumulative diagnoses which included cancer and generalized muscle weakness.On [DATE] at 10:15 AM, a 3-ring binder containing paper copies of the residents' advance directives was observed at the nursing station. A review of Resident 96's record kept in this binder revealed it included a signed Do Not Resuscitate (DNR) form dated [DATE] and printed on bright yellow/orange-colored paper indicating the resident had a DNR status with No Expiration Date. Further review of the 3-ring advance directive binder revealed it also contained a Medical Order for Scope of Treatment (MOST) form dated [DATE] and signed by the resident's Nurse Practitioner. This MOST form indicated cardiopulmonary resuscitation (CPR) was to be attempted if the resident had no pulse and was not breathing. Resident #96's most recent Minimum Data Set (MDS) was an admission assessment dated [DATE]. A review of the MDS assessment revealed Resident #96 had moderately impaired cognition. A review of Resident #96's physician's orders in her electronic medical record (EMR) revealed an order was received on [DATE] for the resident to have a code status of CPR. The resident's care plan included an area of focus initiated on [DATE] which read, Advance Directive-Resident is a full code. An interview was conducted on [DATE] at 4:00 PM with the facility's Director of Nursing (DON) in the presence of the Administrator. During the interview, inquiry was made as to who was responsible to obtain information on advance directives for newly admitted and current residents. The DON and Administrator reported that the facility's Social Worker (SW) assumed this responsibility. An interview was conducted on [DATE] at 4:23 PM with the SW. When asked what the process involved for obtaining an advance directive for a newly admitted resident, the SW stated she would typically try to address the advance directive either on the day of or the day after the resident's admission to the facility. If the resident had intact cognition, she would go over the form with the resident. If the resident did not have intact cognition, she would involve the family as well. Once the resident or designated family member signed the advance directive, the form would be put in a physician's box kept within the Nursing Supervisor's office so the provider could review it the next day he/she was in the office. The SW stated that to her knowledge, the nursing staff completed the process of documenting and retaining the orders for a resident's advance directive.On [DATE] at 4:27 PM and upon request, the SW was accompanied as she reviewed Resident #96's DNR and MOST forms stored in the advance directive binder stored at the Nursing Station. When asked, the SW acknowledged there was potential for confusion with both forms kept in this binder. She reported she would need to follow the facility's protocol to clarify the resident's and family's wishes for her advance directive. An interview was conducted on [DATE] at 3:58 PM with Nurse #3. Nurse #3 was identified as the nurse assigned to care for Resident #96. When asked where she would look to find a resident's advance directive in the case of an emergency, she reported she would go to the first resource she could access. Nurse #3 reported she could find information on a resident's advance directive either in the 3-ring binder stored at the Nursing Station or in the resident's electronic medical record. An interview was conducted on [DATE] at 3:15 PM with the facility's Director of Nursing (DON) in the presence of the Administrator and Regional Nurse Consultant to follow up with the concern identified for Resident #96's advance directive. At that time, the DON and Regional Consultant reported the Do Not Resuscitate (DNR) form (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	printed on bright yellow/orange-colored paper should not have been in the advance directive binder kept at the nursing station. They reported the facility did not use that form and surmised it must have come from the hospital. When asked, it was agreed that storing the two contradictory advance directives (DNR and MOST forms) in the binder containing the advance directives would be potentially confusing in the event of an emergency.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to maintain in good repair a resident's room door and bathroom sink in 1 of 11 resident rooms and 1 of 11 resident bathrooms on 1 of 2 halls whose room and/or bathroom was observed to have environmental concerns (Resident #48).The findings included:1) An initial observation of Resident #48's room was conducted on 1/5/26 at 1:10 PM. This observation revealed the door latch on the door to the resident's room did not secure the door so that it would remain closed. Accompanied by the facility's Maintenance Director, an observation of the door to Resident #48's room was conducted on 1/8/26 at 4:00 PM. When the Maintenance Director was shown the door latch and strike plate on the resident's door, he reported having worked on the door in the past. However, he acknowledged the repair did not appear to have fixed the problem. The Maintenance Director was observed as he attempted several times to close the door, but the door would not latch so that it would remain closed. The Director stated the door would likely need to be replaced. An interview was conducted on 1/9/26 at 3:15 PM with the facility's Administrator, Director of Nursing (DON), and Regional Nurse Consultant to discuss the environmental concerns that had been identified. When asked about the concern related to Resident #48's door not latching, the Administrator and Regional Nurse Consultant agreed that they would expect residents to be able to close the door to their room. 2) An initial observation of Resident #48's bathroom was conducted on 1/5/26 at 1:10 PM. This observation of the bathroom revealed the sink had approximately one to two inches of standing water (not draining) in the sink. Accompanied by the facility's Maintenance Director, an observation of Resident #48's bathroom sink was conducted on 1/8/26 at 4:00 PM. At that time, one to two inches of standing water (not draining) was observed at the bottom of the sink. When the Director was informed a similar observation was made of the bathroom sink on 1/5/26, he responded by stating the sink would need to be fixed to ensure it drained properly.An interview was conducted on 1/9/26 at 3:15 PM with the facility's Administrator, Director of Nursing (DON), and Regional Nurse Consultant to discuss the environmental concerns that had been identified. When asked about the concern related to Resident #48's bathroom sink, the Administrator reported that he and the Maintenance Director fixed that sink drain on the evening of 1/8/26. Upon further inquiry, the Administrator acknowledged failure of the sink to drain water did not create a homelike atmosphere.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on record review, and Ombudsman and staff interviews, the facility failed to notify the Ombudsman in writing of residents transfer to the hospital for 2 of 2 emergency hospitalization transfers reviewed for hospitalization (Resident #99 and Resident #88). The findings included:1. Resident #99 was admitted to the facility on [DATE].The nursing progress note dated 12/10/25 revealed Resident #99's was out of the facility at an appointment and was transferred to the hospital for further evaluation due to chest pain.The medical record indicated Resident #99 was discharged from the facility on 12/10/25 and did not return to the facility.The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #99's transfer to the hospital.An interview was conducted with the Social Worker on 1/9/26 at 10:37 AM and revealed she was hired in October of 2025, and she had not sent the Ombudsman office any notifications regarding emergency transfers as it was not her responsibility. The Social Worker stated she did not know who was supposed to complete the notification for emergency transfers to the Ombudsman.An interview was conducted with the interim Ombudsman on 1/9/26 at 4:42PM and she indicated the facility had not notified the ombudsman office of any resident emergency transfers to the hospital since September of 2025.An interview was conducted with the Administrator on 1/9/26 at 2:01 PM who revealed he was not aware the facility had not notified the Ombudsman office of emergency transfers since September of 2025 and it was the Social Worker's responsibly to notify the Ombudsman of any emergency transfers to the hospital.2.a. Resident # 88 was admitted to the facility on [DATE].The nursing progress note dated 11/13/25 revealed Resident #88 was transferred to the hospital per family member's request for seizures.The medical record indicated Resident #88 was discharged from the facility on 11/13/25 and returned to the facility on [DATE],The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #88s transfer to the hospital.b. The nursing progress note dated 12/7/25 revealed Resident #88 was transferred to the hospital for further evaluation of seizure-like activity.The medical record indicated Resident #88 was discharged from the facility on 12/7/25 and returned to the facility on [DATE].The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #88s transfer to the hospital.An interview was conducted with the Social Worker on 1/9/26 at 10:37 AM and revealed she was hired in October of 2025, and she had not sent the Ombudsman office any notifications regarding emergency transfers as it was not her responsibility. The Social Worker stated she did not know who was supposed to complete the notification for emergency transfers to the Ombudsman.An interview was conducted with the interim Ombudsman on 1/9/26 at 4:42PM and she indicated the facility had not notified the ombudsman office of any resident emergency transfers to the hospital since September of 2025.An interview was conducted with the Administrator on 1/9/26 at 2:01 PM who revealed he was not aware that the facility had not notified the Ombudsman office of emergency transfers since September of 2025 and it was the Social Worker's responsibly to notify the Ombudsman of any emergency transfers to the hospital.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to transmit Minimum Data Set (MDS) assessments within the regulated timeframe for 2 of 32 residents reviewed for MDS assessments (Resident # 1 and # 30).Findings included: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes and hypertension. Resident #1's quarterly MDS with an assessment reference date (ARD, the last day of the look back period) of 11/14/25 was completed on 11/26/25 and had not been transmitted. The MDS coordinator was not available for interview. An interview was conducted on 01/10/26 at 11:34 a.m. with the Director of Nursing (DON). She verified Resident #1's MDS quarterly MDS dated [DATE] had not been transmitted. The DON indicated there was a glitch in the system and it should have automatically transmitted when the assessment was completed. On 01/10/26 at 11:40 a.m. an interview was conducted with the Administrator. He indicated it was his expectation for all MDS assessments to be transmitted on time. 2. Resident #30's electronic medical record (EMR) indicated the resident was admitted to the facility on [DATE] and was discharged on 9/18/25. Review of Resident #30's EMR revealed a discharge MDS with an assessment reference date (ARD, the last day of the look back period) of 9/18/25 was signed as completed by the facility's MDS nurse on 10/3/25. However, the Discharge MDS was not reported as having been transmitted or accepted by the Centers for Medicare and Medicaid Services (CMS) System. An interview was conducted on 1/6/26 at 4:00 PM with the facility's Director of Nursing (DON) in the presence of the Administrator. At that time, the DON and Administrator reported the MDS nurse was unavailable. The DON reviewed Resident #30's records and acknowledged the 9/18/25 Discharge MDS had not been transmitted to CMS. An interview was conducted on 1/9/26 at 3:15 PM with the facility's Administrator, Director of Nursing (DON), and Regional Nurse Consultant to discuss the concerns that had been identified to date. When asked about the failure to transmit Resident #30's 9/18/25 Discharge MDS, the DON reported that the MDS nurse should have been monitoring a print-out which would have shown whether the MDS assessments were successfully transmitted and accepted. Upon further inquiry, the DON reported Resident #30's Discharge MDS should have been transmitted within 14 days of the Assessment Reference Date (ARD) of 9/18/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Preadmission Screening and Resident Review (PASRR, a review to determine if the resident needs specialized services and nursing home care) Level II status (Resident #2) and Hospice services (Resident #17). This occurred for 2 of 32 residents whose MDS assessments were reviewed (Resident #2 and Resident #17).The findings included: 1. Resident #2's electronic medical record (EMR) included a PASRR Level II Determination Notification letter issued 11/22/23 which had no expiration date. Resident #2 was admitted to the facility on [DATE] with a cumulative diagnosis which included schizophrenia and major depressive disorder. The resident's care plan included an area of focus which reported the resident had a Level II PASRR status related to a serious mental illness and related condition due to schizophrenia (Initiated 3/25/25). Resident #2's most recent annual Minimum Data Set (MDS) dated [DATE] reported Resident #2 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. An interview was conducted on 1/9/26 at 3:15 PM with the facility's Director of Nursing (DON), Administrator, and Regional Nurse Consultant to discuss concerns that had been identified to date. When asked about the failure to identify Resident #2 as having a PASRR Level II status on his 11/15/25 annual MDS assessment, the DON reported she thought it may have been a corporate MDS nurse who completed this assessment. This MDS nurse was not available for an interview. An interview was conducted on 1/10/26 at 12:45 PM with the facility's Social Worker (SW). Upon inquiry, the SW reviewed Resident #2's PASRR status and confirmed he had a PASRR Level II status. 2. Resident #17 was admitted to the facility on [DATE] with a diagnosis of cerebrovascular disease (CVA). A review of Resident #17's care plan, last updated on 06/14/2024, noted a terminal prognosis related to CVA and enrollment in hospice services. Resident # 17's physician orders dated 06/12/2024 confirmed hospice admission, and a hospice recertification (continued dates of coverage for hospice services) dated 10/27/2025 covered the period from 11/25/2025 to 01/23/2026. A review of Resident #17's hospice physician order dated 10/27/25 read in part the hospice certification period was 11/25/25 to 01/23/26. A review of Resident #17's quarterly MDS assessment dated [DATE] did not reflect hospice services. The MDS Coordinator was unavailable for interview. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/2026 at 11:25 AM, during an interview with the Director of Nursing (DON) she verified that Resident #17 was receiving hospice care and the 11/02/2025 MDS should have been coded accordingly.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident interviews and staff interviews, the facility failed to develop a comprehensive care plan in the areas of use of a colostomy bag and urinary catheter (Resident #52), dialysis treatment (Resident #14), and discharge goal (Resident #65) for 3 of 32 residents whose care plans were reviewed. The findings included: 1.Resident #52 was admitted to the facility on [DATE] with diagnoses that included necrotizing fasciitis, other specified soft tissue disorders, and rectal hemorrhage. The resident was admitted with a colostomy bag and a urinary catheter. A review of Resident #52's physician orders dated 10/27/2025 revealed orders for catheter care, including checking the placement of the catheter strap every shift and monitoring urinary catheter output every shift. Physician orders dated 10/29/2025 directed staff to check and empty the resident's colostomy bag every shift and replace it as needed. A review of Resident #52's care plan dated 10/28/2025 revealed that no care plan had been developed for colostomy bag care or indwelling urinary catheter care. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #52 was cognitively intact and that she had both an indwelling urinary catheter and an ostomy bag in place. A review of Resident #52's Care Area Assessment (CAA) summary revealed it was completed on 01/10/2026 by the MDS Coordinator on 11/4/2025. Further review indicated Urinary Incontinence and Indwelling Catheter was a triggered care area. It was indicated in the CAA summary that urinary incontinence and indwelling catheter would be addressed in the care plan to minimize risks. The MDS Coordinator, who was responsible for the care plan, was not available for interview during the survey. An interview with the Director of Nursing (DON) and the Administrator was conducted on 1/10/2026 at 12:10 PM. The interview was conducted with the DON and Administrator because the Minimum Data Set (MDS) nurse was out on leave and not available for interview. During the review of Resident #52's care plan, the DON stated that a care plan should have been developed for both the colostomy bag and the indwelling urinary catheter by the MDS Coordinator and was unsure why these areas were omitted. The Administrator agreed that both the colostomy and indwelling urinary catheter should have been included in Resident #52's care plan and could not provide a reason for the omission. 2. Resident #14 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease. Review of Resident #14's Physician orders showed the following orders in place: 9/29/25 Dialysis Arteriovenous (AV) shunt-Monitor Every Shift for thrill and bruit. 9/29/25 Dialysis AV shunt-Monitor Every Shift for signs and symptoms of bleeding. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/29/25 Kidney Center Monday-Wednesday-Friday chair time at 7:05 AM. The comprehensive care plan last reviewed on 10/1/25 revealed no interventions or goals related to dialysis treatment. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact and received dialysis treatment. An interview with Resident #14 on 1/6/26 at 12:45 PM revealed he received dialysis treatment 3 times a week since his admission to the facility. An attempt was made to interview the MDS Nurse, however she was unavailable for interview. On 1/9/26 at 9:33 AM an interview was conducted with the Director of Nursing. She indicated Resident #14 went to dialysis as ordered and that the MDS Nurse was responsible for the development of care plans. She said a dialysis care plan should have been added to Resident #14's care plan and that the MDS Nurse normally created a dialysis care plan for any resident who received dialysis treatment and that this must have been an oversight. The Administrator stated on 1/9/26 at 9:40 AM that Resident #14 should have a care plan developed which included dialysis treatment. 3. Resident #65 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy. An admission MDS assessment dated [DATE] revealed Resident #65 was moderately cognitively impaired and participated in discharge planning with a goal to return to the community. A social work progress note dated 12/2/25 revealed the Social Worker and Resident #65's emergency contact discussed a plan to seek placement at an assisted living facility. The comprehensive care plan dated 12/4/25 revealed no interventions or goals related to discharge planning. An interview was conducted with Resident #65 on 1/5/26 at 12:26 PM and he indicated that he requested assistance from the facility Social Worker and his emergency contact with placement in an assisted living facility or back to his home. Multiple attempts were made to interview Resident #65's emergency contact but attempts were not successful. An interview was conducted with the Social Worker on 1/7/26 at 1:30 PM. She indicated she was responsible for discharge planning and developing discharge planning care plans. The Social Worker indicated she was aware of Resident #65's request to discharge back to the community and that his emergency contact was in support of transitioning Resident #65 to an assisted living facility. The Social Worker further revealed she did not know why she did not include a discharge focus area on Resident #65's care plan and that it must have been an oversight. On 1/9/26 at 9:34 AM during an interview with the Director of Nursing, she stated the Social Worker (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was responsible for the development of discharge care plans. The DON further revealed that a discharge care plan should have been added to Resident #65's comprehensive care plan and that it must have been an oversight. An interview was conducted with the Administrator on 1/8/26 at 1:56 PM. The Administrator indicated that the Social Worker was responsible for discharge planning and should have had a discharge planning focus area included in Resident #65's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, resident interview and staff interviews, the facility failed to shave facial hair for 1 of 4 residents reviewed for activities of daily living (ADL) (Resident #65). The findings included:Resident #65 was admitted to the facility 11/18/25 with diagnoses that included metabolic encephalopathy, needs assistance with personal care and muscle weakness.The admission Minimum Data Set (MDS) assessment completed on 11/24/25 documented Resident #65 was moderately cognitively impaired and required supervision or touching assistance with personal hygiene needs.A care plan developed on 12/4/25 documented Resident #65 required staff supervision/touching assistance with personal hygiene and included the goal that Resident #65 would improve current level of function in ADL through the next review. Interventions included Resident #65 required assistance by staff with personal hygiene. Resident #65 was observed on 1/5/26 at 12:26 PM. Resident #65 had a full beard that was approximately an inch in length and a mustache approximately 1/2 inch in length, which covered the full top lip and curled toward the inside of his lip toward his mouth. An interview was conducted with Resident #65 on 1/5/26 at 12:27 PM and he indicated he had made several requests to the nursing assistants that he would like to have his mustache trimmed. He indicated that he was not concerned about the length of his beard only the length of the mustache as it was so long it was growing toward his mouth which bothered him and he was frustrated that nobody had assisted him with his requests. Resident #65 further revealed the nursing assistants told him that someone would come to trim his mustache, but it had been several weeks, and his mustache still had not been trimmed.An observation of Resident #65 was conducted on 1/7/26 at 10:20 AM. Resident #65 had a full beard approximately an inch in length and a mustache approximately 1/2 inch in length, which covered the full top lip and curled toward the inside of his lip toward his mouth. Nursing Assistant (NA) #1 was interviewed on 1/7/26 at 10:20 AM and she reported she had worked with Resident #65 regularly and was his assigned nursing assistant. She further revealed that Resident #65 required staff assistance for facial hair trimming and he had requested to have his mustache trimmed for a while and that it had not been done. NA #1 explained it was her understanding that because Resident #65's mustache and beard was so long it required the use of clippers and not a razor, therefore the Transportation Aide was responsible for trimming his facial hair. NA #1indicated she had reported this request to the Transportation Aide but did not recall when and did not know why it had not been done.An interview was conducted with Nurse #2 on 1/7/26 at 10:26 AM. Nurse #2 reported that she was not aware of Resident #65's requests to have his mustache trimmed but the nursing assistants normally shaved men's facial hair per the resident's preference. Nurse #2 further revealed if nursing staff felt a resident's facial hair was too long then the staff notified the Transportation Aide to come and use the clippers to trim the long facial hair. Nurse #2 reported she was not aware why Resident #65's facial had not been trimmed.An interview was conducted with the Transportation Aide on 1/7/26 at 11:51 AM and she indicated that she helped at times with trimming men's facial hair, but it was the responsibility of the nursing assistants to trim all facial hair or to notify her if her assistance was needed. The Transportation Aide revealed she was never made aware by any staff member that Resident #65 had requested to have his facial hair trimmed.The Director of Nursing (DON) was interviewed on 1/7/26 at 1:08 PM and she reported nursing assistants were responsible for providing facial hair trimming and clippers were available to all nursing staff. The DON further revealed that if the nursing assistants did not have access to the clippers for any reason or felt uncomfortable providing the assistance they were expected to notify the DON or the Transportation Aide that assistance with facial hair trimming was needed.The Administrator was interviewed by phone on 1/7/26 at 2:00 PM. The Administrator reported he (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not know why Resident #65's facial hair had not been trimmed, and he expected the staff to complete all ADL care for all residents.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Nurse Practitioner interviews, the facility failed to obtain a physician order for the treatment of a stage 3 pressure ulcer and failed to set a pressure relieving air mattress to the correct setting for 1 of 3 residents reviewed for pressure ulcers (Resident #17). The findings included:Resident #17 was admitted to the facility on [DATE] with diagnosis that included cerebral vascular disease, type 2 diabetes, hypertension, pressure ulcer of sacral region, and peripheral vascular disease.The care plan revised on 08/29/25 revealed Resident #17 had a pressure ulcer on her coccyx and was at risk for further breakdown related to failure to thrive and disease process. The goal was Resident #17's pressure ulcer would show signs of healing and remain free from infection. Interventions included assessing resident for risk of skin breakdown, keeping skin clean and dry as possible, and skin assessments as indicated. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, administer treatments as ordered and monitor for effectiveness,The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #17 had severe cognitive impairment and was dependent for activities of daily living. Further review of the MDS indicated Resident had no rejection of care and no pressure ulcers during the assessment period. a. A review of Resident #17's weekly skin review dated 12/23/25 indicated Resident had pressure ulcers to her left buttock and sacrum.A review of the wound measurements, documented by the Wound Care Nurse on 12/23/25 were for a stage 3 pressure ulcer that measured 6.5 cm (centimeters) long, 5.0 cm wide and 0.1 cm depth on the sacrum and a stage 3 pressure ulcer that measured 2.5 cm long, 3.0 cm wide, and 0.1cm depth on the left buttock.A review of the physician orders for Resident #17 revealed and order dated 12/24/25 to cleanse the left buttock with Dakin's/normal saline, apply honey fiber to the wound bed, cover with a silicone super absorbent pad, daily and PRN (as needed) and an order dated 12/24/25 to cleanse the sacrum with Dakin's/normal saline, apply honey fiber to the wound bed, cover with a silicone super absorbent pad daily and PRN. There was no treatment order for the right buttock.A review of Resident #17's weekly pressure wound observation tool dated 12/29/25 revealed Resident had a stage 3 pressure ulcer to her left buttock, and a stage 3 to her sacrum.A review of the wound measurements, documented by the Wound Care Nurse on 12/29/25 were for a stage 3 pressure ulcer that measured 2.5 cm long, 3.0 cm wide and 0.1cm depth on the left buttock and a stage 3 pressure ulcer that measured 6.5 cm long, 5.0 cm wide, and 0.1cm depth on the sacrum.A review of Resident #17's weekly skin review dated 01/05/26 indicated Resident had a stage 3 pressure ulcer to sacrum and stage 3 pressure ulcer to left gluteal fold.A review of the wound measurements, documented by the Wound Care Nurse on 01/05/26 were for a stage 3 pressure ulcer that measured 2.0 cm long, 2.5 cm wide and 0.1cm depth on the left buttock and a stage 3 pressure ulcer that measured 6.0 cm long, 4.0 cm wide, and 0.1 cm depth on the sacrum.A review of Resident #17's weekly skin review dated 01/07/26 indicated Resident had a stage 3 pressure ulcer to right buttock. A review of the wound measurements, documented by the Wound Care Nurse on 01/07/26 were for a stage 3 pressure ulcer that measured 5.0 cm long, 4.0 cm wide and 0.1 cm depth on the right buttock. A review of Treatment Administration Record (TAR) for December 2025 and January 2026 reflected the Wound Care Nurse provided wound care to Resident #17's sacral area and left buttock beginning on 12/23/25. There was no documentation for a treatment order in December 2025 for the pressure ulcer on the right buttock.During an observation on 01/07/26 at 9:53 AM of wound care provided by the Wound Care Nurse an observation was made of pressure ulcers to Resident #17's left buttock, right buttock and sacral area. No concerns were identified with the wound care provided.During an interview with the Wound Care Nurse on 01/07/26 at (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:00 AM she indicated Resident #17 had wounds to her left buttock, right buttock and sacrum. She stated the wounds were identified on12/23/25 during a skin check. Wound Care Nurse indicated she had been providing wound care to the left buttock, right buttock and the sacrum and did not realize there was not an order in place for the right buttock. She stated, all the wounds were identified on 12/23/25 and I have been treating them all since then, I don't know what happened, just forget to put the order in, I will get an order now.A further review of the physician orders revealed an order dated 01/07/26 to cleanse the right buttock with Dakin's/normal saline, apply Santyl to slough areas, then sprinkle collagen particles on the granulated tissue, next, cover with a silicone super absorbent pad, daily and PRN (as needed).Review of Resident #17's January 2026 TAR revealed an order dated 01/07/26 to cleanse the right buttock with Dakin's/normal saline, apply Santyl to slough areas, then sprinkle collagen particles on the granulated tissue, next, cover with a silicone super absorbent pad, daily and PRN. The treatment to the pressure ulcer on Resident #17's was first documented as completed on 01/08/26.01/07/26 at 11:05 AM an interview was conducted with the Director of Nursing (DON), and she indicated she was not aware there was not an order or documentation of Resident #17's pressure ulcer to the right buttock.An interview was conducted with the Nurse Practitioner (NP) on 01/10/26 at 2:15 PM and she indicated she was aware of Resident #17's pressure ulcers to her right buttock, left buttock and sacrum, however she was not aware that there was no order in place for the treatment of the right buttock. The NP stated, I will write the order now.b. On 01/05/26 an observation was conducted of Resident #17 in bed, and the pressure-relieving air mattress was set at 350 pounds (lbs.).A review of Resident #17's medical record revealed Resident's weight on 12/04/25 was 133.5 lbs.On 01/06/26 at 8:58 AM an observation was made of Resident #17 in bed and the pressure relieving air mattress was set at 350 lbs.An interview was conducted on 01/07/26 at 10:29 AM with Nurse #2 and she indicated she was the Nurse assigned to Resident #17 on 01/07/24 and was not aware that she was responsible for checking the weight setting on the pressure-relieving mattress, but she would find out.An interview was conducted with the Wound Care Nurse on 01/07/26 at 9:57 AM and she indicated it was the Nurse on the hall's responsibility to ensure the weight set on the pressure relieving mattress was at the correct weight. Nurse #1 stated she would check Resident's weight and get the setting corrected on the pressure relieving mattress.01/07/26 at 11:07 AM during an interview the DON indicated she would provide training to the Nurses to ensure they were aware of their responsibility in making sure the setting on the pressure relieving mattresses was accurate.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, the facility failed to post cautionary signage outside the resident's room to indicate supplemental oxygen was in use for 1 of 1 resident reviewed for respiratory care (Resident #88).The findings included:Resident #88 was admitted to the facility on [DATE] with a diagnosis of systolic (congestive) heart failure.The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS reported Resident #88 had severely impaired cognition. Review of the resident's electronic medical record (EMR) census revealed the resident was sent out to the hospital on [DATE] with re-entry to the facility on [DATE].Resident #88's Physician's Orders included an order received on 12/11/25 for supplemental oxygen to be provided via nasal cannula at 2 liters per minute as needed for shortness of breath to maintain an oxygen saturation rate greater than 90%. During an observation conducted on 1/5/26 at 10:15 AM of Resident #88, the resident was observed lying in bed with supplemental oxygen provided to her via a nasal cannula. There was no signage to indicate oxygen was in use on or near the entrance to the resident's room. Additional observations were made on 1/5/26 at 11:42 AM, 12:26 PM and 1:54 PM as the resident remained in her bed with supplemental oxygen provided via nasal cannula. These observations also revealed there was no signage to indicate oxygen was in use on or near the entrance to the resident's room. On 1/5/26 at 3:55 PM, a No Smoking sign was observed to be posted on the right side of the main entrance door to the facility. The sign did not specifically indicate that supplemental oxygen was in use within the facility. Resident #88's EMR included a nursing progress note dated 1/6/26 at 8:58 AM which indicated the resident was sent out to the hospital for evaluation. A Nursing Note dated 1/8/26 at 6:08 PM reported Resident #88 returned to the facility from the hospital.Resident #88's Physician's Orders included an order received on 1/8/26 for supplemental oxygen to be provided via nasal cannula at 2 liters per minute as needed for shortness of breath to maintain an oxygen saturation rate greater than 90%. An observation was conducted on 1/9/26 at 9:47 AM as Resident #88 was lying in her bed with the head of bed raised. She had supplemental oxygen provided to her via a nasal cannula. There was no oxygen signage on the door or near the entrance to the resident's room to indicate oxygen was in use.An interview was conducted on 1/9/26 at 3:15 PM with the facility's Director of Nursing (DON), Administrator, and Regional Nurse Consultant to discuss concerns identified to date, including the failure to post oxygen signage at the entrance to Resident #88's room. When asked, the DON and Administrator reported the staff member responsible for ensuring oxygen signage was posted by a resident's door was the Medical Records/Central Supply clerk. The DON confirmed the resident had returned to the facility the previous day (1/8/26) and added that being on the supplemental oxygen was fairly new for this resident.On 1/9/26 at 3:52 PM, an interview was conducted with the facility's Medical Records/Central Supply clerk. Upon inquiry, the clerk reported she has worked at the facility since 2017, but only in this position since February of 2025. When asked who was responsible to ensure oxygen signage was posted near the entrance to the room for a resident receiving supplemental oxygen, the clerk stated she thought the nursing staff was responsible for this. The clerk reported the nurses would alert her if a resident was on supplemental oxygen so she could make sure that all the necessary supplies were available on the floor to meet his/her needs. An interview was conducted on 1/9/26 at 3:58 PM with Nurse #3. Nurse #3 was identified as the hall nurse assigned to care for Resident #88's on first shift (7:00 AM - 7:00 PM). When asked who would be responsible for posting oxygen signage near the entrance to a resident's room if he/she was receiving supplemental oxygen, the nurse stated she thought it would be the hall charge nurse on each shift. When asked, Nurse #3 stated she was the hall charge nurse on this (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date. An interview was conducted on 1/10/26 at 11:05 AM with Unit Manager #1. When asked, Unit Manager #1 reported that if she knew in advance that a resident was being admitted with orders for the use of supplemental oxygen, she would prep the room for the resident and put up the oxygen signage. Upon further inquiry, the manager reported it was unclear to her as to who would be responsible to ensure oxygen signage was posted for a resident if the facility was not informed in advance that he/she required supplemental oxygen or for a resident who had new orders for supplemental oxygen.An interview was conducted on 1/10/26 at 9:25 AM with the facility's Nurse Practitioner (NP). During the interview, the NP confirmed that Resident #88 was using the supplemental more often than she initially did. When the NP was informed of the facility's failure to provide oxygen signage at the entrance of the resident's room, the NP stated, I do think it's important.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 2 of 6 residents observed during the medication administration observations (Resident #11 and Resident #33).The findings included:1. Breo Ellipta is an aerosol powder for inhalation used for the management of chronic obstructive pulmonary disease (COPD) and/or asthma. The manufacturer's Full Prescribing Information for the Breo Ellipta inhaled medication included Administration Information. These instructions read, in part: After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis [a superficial yeast infection of the mouth, also known as oral thrush].On 1/7/26 at 8:33 AM, Medication Aide (Med Aide) #2 was observed as she prepared and administered ten (10) medications to Resident #11. The medications administered to the resident included 200 - 25 micrograms (mcg) per actuation of Breo Ellipta aerosol powder given as one puff by mouth. After Resident #11 inhaled one puff of the Breo Ellipta, Med Aide #2 offered him water to drink. The resident accepted it and was observed as he drank and swallowed the water immediately after the Breo Ellipta inhaler was administered. Med Aide #2 did not prompt the resident to rinse his mouth with water and then spit the water out after using this inhaled medication.A review of Resident #11's current orders revealed a medication order was initiated on 12/24/25 for 200 - 25 micrograms (mcg) per actuation of Breo Ellipta aerosol powder to be given as one puff by mouth one time a day for reactive airway disease. A notation was included in the order to rinse mouth and spit after use. An interview was conducted on 1/7/26 at 11:08 AM with Med Aide #2 in the presence of Nurse #2. Nurse #2 was the hall nurse assigned to care for Resident #11. During the interview, Nurse #2 pulled up Resident #11's January 2026 Medication Administration Record (MAR) and reviewed his physician's order for the Breo Ellipta. The nurse confirmed Resident #11's orders included a notation for the resident to rinse and spit after using the Breo Ellipta. When asked, Med Aide #2 recalled the resident drank and swallowed water after the Breo Ellipta was administered. She acknowledged she did not prompt him to rinse and spit the water out. Nurse #2 explained to the med aide why this was important, stating that failure of a resident to rinse/spit after using Breo Ellipta could cause thrush.An interview was conducted on 1/9/26 at 3:15 PM with the facility's Director of Nursing (DON), Administrator, and Regional Nurse Consultant to discuss the concerns that had been identified to date. When asked, the DON reported she would expect the nursing staff administering a steroid inhaler to remind the resident to rinse and spit water out after the inhaler's administration.2. On 1/7/26 at 8:28 AM, Medication Aide (Med Aide) #2 was observed as she prepared and administered four (4) medications to Resident #33. The medications administered to the resident included one tablet of a combination medication containing a multivitamin with minerals taken from a stock medication bottle stored on the medication cart. A review of Resident #33's current physician's orders revealed a medication order was initiated on 7/17/24 for a multivitamin to be given as one tablet by mouth one time a day for vitamin deficiency. An interview was conducted on 1/7/26 at 11:08 AM with Med Aide #2 in the presence of Nurse #2. Nurse #2 was the hall nurse assigned to care for Resident #33. During the interview, Nurse #2 pulled up Resident #33's January 2026 Medication Administration Record (MAR) and reviewed his physician's order for the multivitamin. At that time, Nurse #2 confirmed the order indicated Resident #33 was supposed to receive a multivitamin without the minerals added. When the med aide stated she wasn't sure there was a stock bottle on the medication cart that contained only multivitamins (without minerals), Nurse #2 stated there was. The nurse cautioned Med Aide #2, stating that she would need to look at the bottle more carefully to ensure she was pulling the right stock (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bottle from the medication cart prior to administering a medication.An interview was conducted on 1/9/26 at 3:15 PM with the facility's Director of Nursing (DON), Administrator, and Regional Nurse Consultant to discuss the concerns that had been identified to date. When the medication errors were discussed, the DON stated she would need to be sure the nursing staff was educated on these concerns.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to: 1) Label a medication with the minimum required information (including the resident's name) stored on 1 of 2 medication (med) carts (North Hall Med Cart #2); 2) Discard expired medications stored in 1 of 1 medication storeroom (North Hall Medication Storeroom) and on 1 of 2 medication carts observed (North Hall Med Cart #2); and 3) Date medications as to when they were opened to allow for the determination of the shortened expiration date for medications stored in 1 of 1 medication storeroom (North Hall Medication Storeroom).The findings included:1. An observation was conducted on 1/5/25 at 2:45 PM with Medication (Med) Aide #1 of the North Hall Medication Storeroom. The observation revealed the following medications were stored in the Medication Storeroom:a. One (1) unopened, single-use vial of Arexy for injection (a vaccine for Respiratory Syncytial Virus or RSV) dispensed by the pharmacy on 4/4/25 for Resident #48 was stored in the medication storeroom refrigerator. The manufacturer's expiration date was 10/15/25, indicating the medication was kept past its expiration date.b. The manufacturer's storage instructions for a multi-dose vial of Tuberculin PPD (Purified Protein Derivative) injectable solution (used for skin testing in the diagnosis of tuberculosis) indicated that once opened, the product should be discarded after 30 days. One (1) opened, multi-dose vial of Tuberculin PPD injectable solution dispensed from the pharmacy on 10/10/25 was stored in the med room refrigerator. Neither the vial nor the manufacturer box it was stored in were labeled as to when the vial had been opened to allow for the determination of its shortened expiration date. A second opened, multi-dose vial of Tuberculin PPD injectable solution dispensed from the pharmacy on 11/3/25 was stored in the med room refrigerator. A pharmacy auxiliary sticker placed on the vial indicated the PPD injectable solution was opened on 11/19/25 (indicative of a shortened expiration date of 12/19/25).c. An intravenous (IV) solution of 100 milliliters (ml) of 0.9% sodium chloride (normal saline) solution compounded with 2 grams (g) of cefazolin (an IV antibiotic) was dispensed from the pharmacy on 12/22/25 for Resident #83. The pharmacy labeling placed on the IV bag indicated the stop date for this medication was 12/24/25. The pharmacy labeling also read, Discard After 12/31/25. The labeling on the IV solution revealed the medication was kept past its expiration date.d. A stock box containing 11 expired hemorrhoidal suppositories was stored on the shelf of the medication storeroom. The manufacturer's expiration date of July 2025 was printed on both the box and packaging of the individual suppositories.e. A stock box containing seven 21 milligram (mg) Nicotine Transdermal System Patches was stored on the shelf of the medication storeroom. The manufacturer's expiration date of August 2025 was printed on both the box and packaging of the individual patches, indicating the patches were expired.f. Two opened stock bottles of 500 mg Vitamin C tablets were stored on the shelf of the medication storeroom. Each of the opened bottles appeared to contain approximately 200 tablets. Both stock bottles of the Vitamin C tablets were identified as being expired. One bottle had a manufacturer expiration date of August 2025. The second bottle of Vitamin C tablets had a manufacturer expiration date of November 2025. g. One unopened, 6-ounce stock bottle of a Sore Throat Spray was observed to be stored on a shelf in the medication storeroom. The manufacturer's expiration date of the spray bottle was November 2025 (indicative of the medication being expired).On 1/5/26 at 3:12 PM, Unit Manager #2 reviewed the storeroom medications identified as having a med storage concern and confirmed the labeled information (including expiration dates) noted for the medications was accurate. Unit Manager #2 was observed as she collected these medications for removal from the medication storeroom. 2. An observation was conducted of the North Hall Medication Cart #2 on 1/5/25 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. Building B. Wing	01/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Place Center for Nursing and Rehabilitation	1201 Carolina Street Greensboro, NC 27401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 3:20 PM with Med Aide #3. The observation revealed the following medications were stored on the medication cart:a. One - 6-ounce bottle of a Sore Throat Spray was observed to be stored on the medication cart. The spray bottle was opened and appeared to have 5.5 ounces of solution remaining in the bottle. However, the spray bottle was not labeled with a resident's name. When Med Aide #3 was asked who the bottle of Sore Throat Spray belonged to, the med aide stated that she did not know. It was also noted at that time that the spray bottle was expired with a manufacturer's expiration of December 2025.b. One - 60 milliliter (ml) bottle of 10 grams (g) per 15 milliliters (ml) lactulose dispensed from the pharmacy on 5/29/25 for Resident #6 was stored on the medication cart. The pharmacy labeling indicated this medication had a stop date of 5/30/25 and a notation made on the labeling to Discard after 11/28/25. This medication was identified as having expired.During the medication cart observation conducted on 1/5/26 at 3:20 PM, Med Aide #3 showed the expired throat spray (without the resident information on its label) and the lactulose identified as being expired. The med aide reported she did not have any questions and was observed as she pulled the medications from the med cart to share with her supervisor and/or the Director of Nursing (DON).An interview was conducted on 1/9/26 at 3:15 PM with the facility's Director of Nursing (DON), Administrator, and Regional Nurse Consultant to discuss the concerns that were identified to date. The DON acknowledged the concern about medication storage had been previously discussed and the Central Supply Clerk was identified as assuming responsibility for monitoring the expiration dates of medications stored in the medication storeroom. The nurses and medication aides on night shift were typically responsible for checking the expiration dates for medications stored on the med carts with the Unit Managers and DON herself monitoring the med carts on a weekly basis. The DON indicated that after she became aware of the issues identified in the medication storeroom and first medication cart checked during the survey, the remaining storage areas were audited to ensure there were no further concerns with the storage of medications.