STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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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 0583 Level of Harm - Actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to maintain personal privacy and dignity for 3 of 5 residents reviewed for resident rights. The facility failed to ensure privacy when a Resident #17 was left naked with his genitals exposed and visible to the public. Resident #17 stated he felt angry, embarrassed, and as though he was on display as a result of the incident. The facility also failed to treat Resident #57 in a dignified manner when staff did not provide privacy during activities of daily living, exposing Resident #57's buttocks and private areas during bathing and wound care. Additionally, the facility failed to protect the dignity and privacy of Resident #80 by failing to provide a privacy cover while Resident #80 was dressed only in an adult incontinence brief and visible to the public. These failures resulted in residents experiencing embarrassment, loss of dignity, and compromised privacy. Findings Included: 1. Resident #17 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the bladder (Bladder Cancer), muscle weakness, epilepsy, cerebral palsy, neurogenic bowel, colostomy status, and a Stage 4 pressure ulcer located on the left ischium (the lower portion of the pelvis commonly referred to as the sit bone). The admission Minimum Data Set (MDS) assessment for Resident #17 dated 4/26/26 revealed Resident #17 was cognitively intact, had no documented behavioral symptoms and was dependent upon staff for toileting hygiene. On 06/08/2026 at 12:27 PM, while standing in the hallway outside Resident #17's room, Resident #17 was observed lying in bed near the window with the right side of the bed facing the doorway. Resident #17 was fully naked with his genital area exposed and visible from the hallway through the open doorway. The room door was fully open. The bed was positioned at its highest level. At the time of the observation, no staff member was present in the room. At 12:38 PM, the Wound Nurse returned to Resident #17's room to resume care. On 06/08/2026 at 1:30 PM, an interview was conducted with the Wound Nurse. The Wound Nurse stated that during her afternoon rounds on 06/08/2026 she discovered Resident #17's colostomy bag had burst and observed a large amount of feces on Resident #17 and his clothing. The Wound Nurse stated she removed Resident #17's clothing and intended to place the soiled items in a soiled linen bag. The Wound Nurse stated she left Resident #17's room to obtain disposable trash bags and soiled linen bags. The Wound Nurse stated she forgot to return to Resident #17's room because she had been pulled away by a nurse on a different hall to assist another resident. The Wound Nurse acknowledged that Resident #17 was left naked while she was out of the room. The Wound Nurse did not offer an explanation why she did not provide privacy to the resident prior to leaving the room. When asked why (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 0583 Level of Harm - Actual harm Residents Affected - Few	she did not cover the resident with a sheet or blanket before leaving the room, the Wound Nurse stated she did not know. The Wound Nurse stated she should have closed the door to provide privacy for Resident #17. On 06/08/2026 at 2:00 PM, an interview was conducted with Resident #17. Resident #17 stated he was receiving wound care and assistance with bathing and dressing from the Wound Nurse. Resident #17 stated the Wound Nurse completed the dressing change for the wound and informed him she would return to get him dressed. Resident #17 stated he was unsure why the Wound Nurse left and stated she was gone for a while. Resident #17 reported he was angry that he had been left naked in bed with the room door open. Resident #17 stated he felt embarrassed because he was unclothed and was concerned that someone might see him. Resident #17 reported feeling further embarrassed when surveyor staff observed him in that condition. Resident #17 stated he attempted to use the edge of his bed sheet to cover his genital area but was unsuccessful. Resident #17 expressed concern that staff of family passing by his room may have been able to see him while he was unclothed. On 06/12/2026 at 4:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the expectation when providing personal care is to maintain the resident's privacy. The DON stated the resident's room door should be closed during personal care and should remain closed to protect the resident's privacy. The DON stated staff should obtain all necessary supplies prior to beginning care to avoid leaving a resident unattended during the care process. The DON stated it was disappointing that Resident #17 had been left unclothed with the room door open and indicated this was not consistent with facility expectations. On 06/12/2026 at 4:45PM, an interview was conducted with the Administrator. The Administrator stated that when providing personal care, resident privacy should be maintained by closing the room door or privacy curtain. The Administrator stated that these measures were necessary to protect the resident's privacy during personal care. 2. Resident #80 was admitted to the facility on [DATE] with diagnoses of muscle weakness, reduced mobility, unspecified pain, and rash with other nonspecific skin eruptions. The quarterly Minimum Data Set (MDS), dated [DATE], showed that Resident #80 was cognitively intact and did not exhibit behaviors or reject care. On 6/9/26 from 2:40 PM to 2:52 PM, an observation from the hallway revealed Resident #80 sitting upright in the bed that was closest to the door wearing only an adult incontinence brief. The bedroom door was wide open to the public hallway, where housekeeping staff were cleaning rooms. Resident #80 was clearly visible from the hallway and had no sheet, clothing, or cover on his body. He repeatedly called out loudly for staff to get him a sheet or blanket for about 10 minutes. A housekeeping staff member passed his room multiple times while cleaning surrounding rooms. NA #3 walked past his open doorway as he called out and entered a room three doors down. When NA #3 later returned to the hallway, she stood approximately 20 feet from his open door while he continued calling out. On 06/09/26 at 2:48 PM, NA #3 was interviewed in the hallway while Resident #80 continued loudly calling out that he needed assistance. NA #3 stated that Resident #80 did not want to be covered by a sheet or blanket and preferred to lie completely uncovered. She reported that it was common for Resident #80 to refuse to have the privacy curtain drawn or the door closed, so she did not pull the privacy curtain or shut the door when she left his room after she provided him with incontinence care. (continued on next page)

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F 0583 Level of Harm - Actual harm Residents Affected - Few	NA #3 stated Resident #80 liked to sit in his bed that way. On 06/09/26 at 2:52 NA #3 entered Resident #80's room and asked what he needed. Resident #80 replied that he wanted a sheet or a blanket to cover up with. NA #3 provided a top sheet and laid it across his lap, and the resident adjusted it, leaving his legs and chest uncovered. During an interview in Resident #80's room on 06/09/26 at 2:52 PM, Resident #80 stated that NA #3 had changed his bedding and adult incontinence brief 30 to 40 minutes earlier, then left the room with the soiled linens and told him she would return with clean linen. He explained that he frequently felt hot and preferred not to wear clothing because it irritated his skin, but he explicitly wanted a sheet or blanket to cover himself so people passing by the open hallway door could not see him exposed. He stated that he preferred the door and privacy curtain to remain open only after care was completed and he had a sheet to cover himself. He stated he felt like he was on display for anyone to see. On 06/06/10/26 at 3:54 PM, an interview with the Director of Nursing (DON) revealed that staff were aware of Resident #80's preference to avoid wearing shirts or pants due to feeling hot. However, she stated she had no prior knowledge or observation of the resident being left to lie in bed without a sheet or blanket covering his lap. It was her expectation that staff were to utilize privacy curtains or provide linens to cover Resident #80 and it was her expectation that all residents receive care consistent with their individual preferences. 3. Resident #57 was admitted to the facility on [DATE] with diagnoses of muscle weakness and cognitive communication deficit. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #57 was cognitively intact. She was assessed as needing partial to moderate assistance with bathing. On 6/11/26 at 10:33 AM an observation was conducted for activities of daily living (ADL) care for Resident #57. Resident #57's bed was closest to the door of the room. NA #2 was providing Resident #57 a bed bath with the door closed and privacy curtain pulled between Resident #57 and her roommate who was resting in bed. This surveyor was standing at the foot of Resident #57's bed during the observation when Nurse #1 simultaneously knocked on and opened the door to the resident's room. Resident #57's bare bottom was exposed to the hallway while being washed. No other staff or visitors were observed in the hallway. Nurse #1informed NA #2 that the hospice NA needed to visit Resident #57's roommate then told hospice NA #1 she could enter and shut the door. NA #2 attempted to close the privacy curtain next to the door, but it failed to move due to multiple missing hooks, approximately a 2-foot span, that connected the privacy curtain to the ceiling. However, hospice NA #1 proceeded to enter the room and walked past Resident #57 whose bottom remained exposed and visible to the hospice NA as she walked past the resident. NA #2 was interviewed on 6/11/26 at 10:55 AM. NA #2 explained in this job you do what the nurse tells you to do when asked why she did not inform Nurse #1 that patient care was being done and the privacy curtain did not work. NA #2 continued to explain Nurse #1 allowed hospice NA #1 to enter. The privacy curtain would not pull all the way around so we could not give Resident #57 privacy. On 6/11/26 at 11:12 AM Nurse #1 was interviewed. Nurse #1 stated she was unaware the privacy curtain was broken before she allowed hospice NA #1 to enter Resident #57's room. Nurse #1 explained hospice NA #1 was on a set schedule, and if she was not allowed to go in to take care of Resident #57's roommate when she asked to go in then hospice NA #1 would have left. According to (continued on next page)

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F 0583 Level of Harm - Actual harm Residents Affected - Few	Nurse #1, she should have waited for a response and then she should have spoken with Resident #57's nurse to discuss the care both residents needed before sending the hospice NA in the room. The Unit Manager (UM) was interviewed on 6/11/26 at 11:14 AM who stated Nurse #1 should have knocked and spoken with the staff helping Resident #57 before allowing hospice NA #1 to enter the room. The UM further stated hospice NA #1 should have been asked to wait outside the room until Resident #57's care was completed. Hospice NA #1 was interviewed on 6/11/24 at 11:24 AM and stated she had been working with Resident #57's roommate for approximately two months and during that time Resident #57's privacy curtain had always been messed up. Hospice NA #1 stated she would have remained in the hallway if she had been informed Resident #57 was receiving patient care. Hospice NA #1 further stated she had multiple residents in the building she worked with, and she would have returned to complete the roommate's care later that day if she had been informed she could not enter the room. The Director of Nursing (DON) was interviewed on 6/12/26 at 2:02 PM and stated staff should have provided privacy for Resident #57 even if it meant using a blanket or towel to cover her so she maintained her privacy. On 6/12/26 at 2:55 PM the Administrator was interviewed and stated the privacy curtain should have been maintained in a functional order, and that Resident #57 should not have had an issue related to lack of privacy.

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F 0686 Level of Harm - 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 record review, observations, staff and provider interviews, the facility failed to ensure 1 of 5 residents (Resident # 17) received ongoing assessments of a stage 4 pressure ulcer. The facility failed to recognize the pressure ulcer was not improving and involve a wound provider. On admission, 4/20/26, the wound measurements were 2.5 centimeters (cm) in length, 1.5 cm in width, and 0.5 cm in depth. When the wound provider assessed the pressure ulcer on 5/21/26 the wound measured 10 cm in length, 2.5 cm in width, and 1 cm in depth.Findings Included: Review of the hospital Discharge summary dated [DATE] revealed Resident #17 was discharged to the facility with multiple wound care needs, including a former enterocutaneous fistula site (an abnormal opening connecting the intestine to the skin) requiring daily wound care, wounds to the groin, perineum, and thighs requiring treatment, a left ischial wound requiring ongoing dressing changes, and pressure injury prevention interventions.Review of the hospital physician orders dated 4/20/26 revealed Resident #17 had wound care orders for the left ischium (the lower portion of the pelvis commonly referred to as the sit bone). The orders directed staff to change the dressing every three days and as needed if soiled, cleanse the wound with Vashe (a wound cleansing solution used to clean wounds and reduce bacteria), apply a silver-containing antimicrobial dressing to the wound to help prevent infection, and cover the wound with a protective foam dressing.Resident #17 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the bladder (bladder cancer), muscle weakness, epilepsy, cerebral palsy, and a stage 4 pressure ulcer located on the left ischium (the lower portion of the pelvis commonly referred to as the sit bone). A stage 4 pressure ulcer is the most severe stage of pressure injury and involves full-thickness tissue loss with damage extending into muscle, tendon, or bone.Review of the facility admission skin assessment dated [DATE] revealed Resident #17 was identified as being at risk for pressure ulcers. The skin assessment documented a pressure ulcer to the left ischium (the lower portion of the pelvis commonly referred to as the sit bone) measuring 2.5 centimeters (cm) in length, 1.5 cm in width, and 0.5 cm in depth.Review of Resident #17's care plan dated 4/21/26 revealed Resident #17 was care planned for impaired skin integrity related to a Stage 4 pressure ulcer of the left ischium. Interventions included treatment as ordered, wound consultation as needed, reporting signs of infection, failure to improve or decline in the wound to the provider, providing ADL assistance to maintain clean and dry skin, reporting signs of skin breakdown, and utilizing a specialty mattress as indicated. Review of the care plan did not reveal refusal of wound treatment.The admission Minimum Data Set (MDS) assessment for Resident #17 dated 4/26/26 revealed Resident #17 was cognitively intact, had no documented behavioral symptoms, was dependent upon staff for toileting hygiene, required staff assistance with bathing, dressing, transfers, and wheelchair mobility, and utilized a manual wheelchair. The MDS further documented Resident #17 had a Stage 4 pressure ulcer located at the left ischium and was coded for pressure ulcer-related interventions, including a pressure-reducing device for the bed, a pressure-reducing device for the chair, a turning and repositioning program, wound care, and nutrition/hydration interventions.Review of the Nurse Practitioner (NP) progress note dated 4/27/26 revealed Resident #17's diagnoses included a Stage 4 pressure ulcer of the left buttock. Under the physical examination, the NP documented the exposed skin appeared clean, dry, and intact and indicated no open wounds were noted.Review of the medical record revealed a weekly wound assessment and pressure ulcer assessment were not documented as completed on 4/27/26 for Resident #17's Stage 4 pressure ulcer.Review of the medical record revealed there was no documented weekly wound assessment or pressure ulcer assessment completed on 5/4/26 for Resident #17's Stage 4 pressure ulcer.Review of the NP progress note dated 5/4/26 revealed Resident #17 had an enterocutaneous fistula with stool drainage and documented dressing changes were being performed by the Wound Nurse. Under the physical examination, the NP documented the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	exposed skin appeared clean, dry, and intact and indicated no open wounds were noted. Review of the medical record revealed there was no documented weekly wound assessment or pressure ulcer assessment completed on 5/11/26 for Resident #17's Stage 4 pressure ulcer.Review of the medical record revealed there was no documented weekly wound assessment or pressure ulcer assessment completed on 5/18/26 for Resident #17's Stage 4 pressure ulcer to the left ischium.Review of the NP progress note dated 5/18/26 revealed Resident #17 had a diagnosis of a Stage 4 pressure ulcer of the left ischium and was being followed by the wound provider. Under the physical examination, the NP documented the exposed skin appeared clean, dry, and intact and indicated no open wounds were noted. Review of the Wound Provider initial assessment dated [DATE] revealed Resident #17 was evaluated for a Stage 4 pressure ulcer to the left ischium that was present on admission. The wound measured 10 cm in length, 2.5 cm in width, and 1 cm in depth. The wound assessment documented 40% granulation tissue, which is healthy new tissue that forms during the wound healing process; 30% necrotic tissue, which is dead or nonviable tissue that can delay healing and increase the risk of infection; and moderate serous drainage, which is a moderate amount of clear to pale yellow fluid commonly produced by wounds. The assessment documented no signs of local or systemic infection. The Wound Provider documented the wound was pressure-related and recommended daily wound treatment.Review of the wound assessment dated [DATE] revealed Resident #17 was assessed as having a stage 4 pressure ulcer to the left ischium that was documented as present on admission. The wound assessment documented the wound measured 10 centimeters (cm) in length, 2.5 cm in width, and 1 cm in depth with moderate serous drainage. Review of the Wound Provider progress note dated 5/28/26 revealed Resident #17 was unavailable for evaluation, and no wound assessment was completed.Review of the medical record revealed there was no documented weekly wound assessment or pressure ulcer assessment completed on 6/01/26 for Resident #17's Stage 4 pressure ulcer to the left ischium.Review of the Wound Provider progress note dated 6/4/26 revealed Resident #17 refused treatment, and no wound assessment was completed.Review of the medical record revealed there was no documented weekly wound assessment or pressure ulcer assessment completed on 6/08/26 for Resident #17's Stage 4 pressure ulcer to the left ischium.Review of the Wound Provider progress note dated 6/11/26 revealed Resident #17's Stage 4 pressure ulcer to the left ischium measured 8.9 cm in length, 2.7 cm in width, and 0.7 cm in depth. The wound assessment documented 70% granulation tissue, moderate serous drainage, and no signs of local or systemic infection. The Wound Provider documented the wound was improving and recommended continuation of the current treatment regimen.On 06/11/2026 at 12:15 PM, an observation was conducted of the Wound Care Physician and Wound Care Nurse providing wound care to Resident #17. The Wound Care Physician assessed and measured the resident's wound while the Wound Care Nurse completed the wound treatment. The Wound Care Physician measured the left ischial wound as 8.9 cm in length, 2.7 cm in width, and 0.7 cm in depth. No undermining, which is tissue destruction extending under the wound edges, or tunneling, which is a channel extending from the wound into surrounding tissue, was identified. The wound bed consisted of beefy red granulation tissue, and the periwound area was intact.On 06/11/2026 at 5:15 PM, an observation was conducted of Resident #17. Resident #17 was observed seated in a wheelchair. A foam pressure-relieving cushion was observed in place on the wheelchair seat.On 06/09/2026 at 1:00 PM, an interview was conducted with Resident #17. Resident #17 stated he was aware of the wound on his left ischium and reported staff routinely provided wound care. Resident #17 stated he did not recall staff measuring the wound and reported he had not been informed of the wound measurements or whether the wound was improving or worsening. Resident #17 further stated he did not refuse wound care; however, he reported he frequently attended outside medical appointments and believed he may have missed visits from the wound provider as a result. Resident #17 further stated it was difficult for him to see the wound and know what was occurring with it because the wound was located behind him.On 06/09/2026 at 2:25 PM, an interview was conducted with the Wound Nurse. The Wound Nurse stated she was responsible for providing wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	care to Resident #17 in accordance with the wound physician's orders and reported she routinely cleaned and treated the wound. The Wound Nurse stated she was expected to complete weekly wound assessments, including obtaining wound measurements; however, she acknowledged she had not completed any weekly wound assessments for Resident #17. The Wound Nurse stated she was frequently reassigned from her duties as the Wound Nurse to work as a floor nurse, which affected her ability to complete her wound care responsibilities. The Wound Nurse stated she often did not have sufficient time to complete the weekly wound assessments and would forget to complete the assessments and wound measurements. The Wound Nurse stated the weekly wound measurements were important because they were used to track the progression or deterioration of the wound and to determine whether notification of the wound provider was necessary. When asked whether she was aware if Resident #17's wound had deteriorated, the Wound Nurse stated she was unaware because she had not completed the wound measurements. When asked when she first notified the facility physician or wound provider regarding Resident #17's wound, the Wound Nurse stated the first notification occurred when she completed the initial wound assessment on 5/25/26. The Wound Nurse stated she did not notify the physician or wound provider of any changes in the wound prior to that time because she had not completed the weekly wound assessments or obtained wound measurements to monitor the wound's progression.On 06/12/2026 at 3:45 PM, a phone interview was conducted with Nurse #14 regarding Resident #17's Stage 4 pressure ulcer. Nurse #14 stated he worked every weekend as a Registered Nurse and Weekend Supervisor and had routinely worked on Resident #17's unit during the past three months. Nurse #14 stated he frequently provided wound care to residents when the Wound Nurse was unavailable on weekends and documented wound treatments in the medical record and on the MAR. Nurse #14 stated he was aware Resident #17 had a Stage 4 pressure ulcer and routinely observed the wound while providing care. Nurse #14 stated he recognized the pressure ulcer had deteriorated because the wound had increased in size over time, contained slough tissue, and had drainage. Nurse #14 stated he did not notify the Wound Nurse, NP, wound provider, or nursing management regarding the wound's deterioration because he believed the increase in the wound's size represented normal wound deterioration. Nurse #14 stated if a wound was deteriorating, staff should take action and notify the appropriate clinical staff. Nurse #14 acknowledged he did not report the observed increase in the wound's size or deterioration. Nurse #14 stated he would typically notify a physician or provider only if a wound was bleeding or had an odor. Nurse #14 stated he was aware wound assessments were expected to be completed; however, he did not complete wound assessments or obtain wound measurements because he did not have access to the Wound Nurse's wound documentation system. Nurse #14 stated that when he provided wound care to Resident #17, he should have also measured the wound to monitor for changes in the wound's condition. On 06/12/2026 at 9:00 AM, a phone interview was conducted with the NP regarding Resident #17's Stage 4 pressure ulcer. The NP stated she became aware of the pressure ulcer upon Resident #17's admission to the facility on 4/20/26 after reviewing the hospital discharge summary. The NP stated she assessed Resident #17 on 4/21/26, 5/4/26, and 5/18/26 and believed Resident #17's Stage 4 pressure ulcer was being followed by the wound doctor. The NP stated she did not actively follow the wound because she believed the wound doctor was managing the wound and reported that when a resident is admitted with a wound, the wound doctor is routinely consulted. The NP stated monitoring a resident's wound is a shared responsibility between the Wound Nurse and the NP. The NP acknowledged she was expected to assess wounds in person even when a resident is being followed by a wound doctor. The NP stated the Wound Nurse did not communicate concerns regarding the wound's progression to her. The NP further stated she should have provided additional follow-up regarding the wound and should have recognized that the wound had increased in size. The NP acknowledged she failed to identify the wound's deterioration because she was not actively following the wound and believed the wound doctor was managing it. The NP stated she was concerned that weekly wound measurements had not been completed because wound measurements (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	are used to track the progression or deterioration of a wound. The NP stated the wound measurements would have assisted her in identifying changes in the wound's condition and determining whether additional interventions or notification of the wound provider were necessary. When asked whether she was aware the wound had deteriorated, the NP stated she was unaware of the wound's progression. The NP stated that if the wound had been followed more closely, earlier interventions could have been implemented. On 06/10/2026 at 3:17 PM, an interview was conducted with the Wound Doctor and Regional Clinical Manager regarding Resident #17's Stage 4 pressure ulcer. The Wound Doctor stated the initial wound evaluation was completed on 5/21/26 after the Wound Nurse made them aware of the chronic wound. The Wound Doctor stated Resident #17 refused the wound evaluation on 6/4/26 because he preferred to remain in his wheelchair rather than return to bed. The Wound Doctor stated alternative options were offered; however, Resident #17 continued to refuse the assessment. The Wound Doctor stated the expectation would be for the Wound Nurse to follow up later that day and continue the resident's daily wound treatment plan. The Wound Doctor stated the wound care company had not received any reports from the Wound Nurse regarding concerns with the wound, changes in the wound, or repeated refusals of wound assessments. The Wound Doctor stated wounds are measured during each weekly wound evaluation in accordance with company policy. The Wound Doctor stated wound measurements are important because they allow providers to monitor the progression or deterioration of a wound and determine whether additional interventions are necessary. The Wound Doctor further stated delays in wound care or failure to identify changes in a wound could increase the risk of infection, sepsis, and progression to a bone infection. The Wound Doctor stated the facility should have initiated and obtained routine wound measurements and was responsible for ongoing monitoring and follow-up of the wound. The Wound Doctor stated the role of the wound care company was to evaluate and treat the wound, while the facility remained responsible for daily monitoring and notification of changes in the resident's condition. The Wound Doctor stated if wound care was provided, the care should have been documented. The Wound Doctor further stated that earlier identification of wound deterioration could have resulted in earlier interventions to address the wound and potentially slow the progression of the wound. On 06/12/2026 at 2:02 PM, an interview was conducted with the Facility Provider regarding Resident #17's Stage 4 pressure ulcer. The Facility Provider stated that when a resident is admitted with a Stage 4 pressure ulcer, he would expect wound care orders to be initiated upon admission and the wound to be followed in accordance with physician orders. The Facility Provider stated wound progression is determined through direct assessment of the wound and measurement of the wound's size. The Facility Provider stated he relies on wound measurements provided by facility staff when making treatment decisions regarding wounds. When asked what nursing staff should do if a wound is observed to be increasing in size, the Facility Provider stated nursing staff should immediately notify the provider. The Facility Provider stated the nursing staff should have completed wound assessments and documented wound measurements. The Facility Provider further stated that if wound assessments had been completed as expected, the wound measurements would have reflected any changes in the wound's size and condition. The Facility Provider stated the wound nurse did not do their best documenting the wound and indicated wound documentation should be completed during each assessment. The Facility Provider further stated that because Resident #17 had multiple underlying health conditions, including cancer, ongoing wound monitoring and measurements were especially important. The Facility Provider stated wound measurements are necessary to track the wound's progression, identify deterioration, evaluate the effectiveness of treatment interventions.On 06/12/2026 at 4:00 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #17's Stage 4 pressure ulcer. The DON stated the admission nurse is expected to complete a head-to-toe skin assessment upon admission and document all wounds identified. The DON stated the Wound Nurse is also expected to complete an assessment to ensure all wounds are identified and documented. The DON confirmed Resident #17 was admitted with a pressure ulcer. The DON stated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	staff should be made aware of wounds through admission documentation, hospital records, and communication from nursing staff. The DON stated weekly wound assessments and wound measurements are expected to be completed by the Wound Nurse and wound provider. The DON stated any changes in the wound should be documented, communicated to the provider, and reported to the resident and resident's family. The DON stated if a wound is observed to be increasing in size or deteriorating, staff are expected to complete an assessment and immediately notify the provider and wound provider. The DON stated the provider is expected to assess wounds during routine visits, particularly when there has been a change in the wound's condition. The DON stated that based on her review of the medical record, the weekly wound assessments were not completed by the Wound Nurse. The DON stated the facility normally relies on wound reports and wound measurements to determine whether a wound is improving or worsening; however, there was no wound report documenting ongoing weekly measurements for Resident #17. The DON stated the last documented wound measurements were obtained on 5/21/26. The DON stated wound measurements and assessments are important because without documentation the facility cannot accurately determine how a wound is progressing. The DON further stated that if wound measurements had been obtained sooner, staff could have more closely monitored the wound's progression and implemented interventions sooner. The DON stated she was not satisfied with the care and monitoring provided for Resident #17's wound and acknowledged the wound worsened. The DON stated the wound nurse being reassigned to floor nursing duties was not an acceptable reason for failing to complete wound assessments, measurements, documentation, and follow-up responsibilities.On 06/12/2026 at 5:45 PM, an interview was conducted with the Administrator regarding Resident #17's Stage 4 pressure ulcer. The Administrator stated he was not aware of concerns related to the progression of Resident #17's pressure ulcer. The Administrator stated residents with pressure ulcers are expected to be followed by nursing staff, the Wound Nurse, and the wound provider to ensure wounds are monitored and treated appropriately. The Administrator stated the facility conducts clinical meetings Monday through Friday during which staff discuss residents with clinical concerns, including residents at risk for decline. The Administrator stated he does not routinely attend the wound meetings but expects concerns regarding worsening wounds to be communicated through the facility's clinical process. The Administrator stated he was not aware Resident #17's pressure ulcer had increased in size. The Administrator stated the Wound Nurse did not meet facility expectations because the required wound assessments were not documented. The Administrator stated the facility relies on wound assessments, wound measurements, and documentation to monitor residents with wounds and determine whether additional follow-up or interventions are needed. The Administrator stated that if wound assessments and measurements are not completed and documented, the facility cannot accurately determine whether a wound is improving or worsening. The Administrator further stated failure to complete and document weekly wound assessments was not consistent with facility expectations and negatively impacted the facility's ability to monitor Resident #17's wound progression and identify changes in the wound's condition.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, observations, staff and provider interviews, the facility failed to ensure adequate staffing to ensure 1 of 5 residents (Resident # 17) received ongoing assessments of a stage 4 pressure ulcer and were able to recognize the pressure ulcer was not improving and involve a wound provider. On admission, 4/20/26, the wound measurements were 2.5 centimeters (cm) in length, 1.5 cm in width, and 0.5 cm in depth. When the wound provider assessed the pressure ulcer on 5/21/26 the wound measured 10 cm in length, 2.5 cm in width, and 1 cm in depth.Cross refer to F686 Based on record review, observations, staff and provider interviews, the facility failed to ensure 1 of 5 residents (Resident # 17) received ongoing assessments of a stage 4 pressure ulcer. The facility failed to recognize the pressure ulcer was not improving and involve a wound provider. On admission, 4/20/26, the wound measurements were 2.5 centimeters (cm) in length, 1.5 cm in width, and 0.5 cm in depth. When the wound provider assessed the pressure ulcer on 5/21/26 the wound measured 10 cm in length, 2.5 cm in width, and 1 cm in depth.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interviews, the facility failed to employ a qualified food and nutrition services manager with the competencies and skills required to carry out food and nutrition services for 115 of 116 residents who received meal trays. Finding included:During an interview on 6/11/26 at 3:00 PM, the Registered Dietitian stated she was hired a month prior to the start of survey. She further stated she worked part-time and came to the facility once a month and was available to staff if needed on the phone.During an interview on 6/11/126 at 3:10 PM, Dietary Supervisor stated he was supervising the kitchen for the past month. The Dietary Supervisor indicated that the Dietary Manager had quit her job without notice and he was asked to supervise the kitchen. The Dietary Supervisor stated he did not have Certified Dietary Manager (CDM) certification and was going to start a ServSafe (food and beverage safety training and certificate program administered by the US National Restaurant Association) course on 6/25/26. He indicated he did not have any certification or dietary education.During a telephone interview on 6/11/26 at 1:30 PM, the Executive Director of Nutrition and Dining (Corporate staff) stated that if the facility did not have a Certified Dietary Manager or a full-time dietitian then the facility could reach out to their sister facilities for a Registered Dietitian. She further stated that there was also a consultant dietitian who could be reached for assistance and guidance if the facility did not have certified staff to assist with the kitchen. During an interview on 6/12/26 at 9:10 AM, the Housekeeping Manager indicated she had a ServSafe certification and was helping the Dietary Supervisor with printing the meal tickets, production sheets, ordering food and taking resident's food preferences. Review of the ServSafe certification revealed she had acquired it in 2025 and the certification expired on 5/14/30. When asked if she was assigned to the kitchen, overlooking and monitoring the staff, she indicated she only helped as needed.During an interview on 6/11/26 at 4:30 PM, the Administrator, he stated the facility had a Certified Dietary Manager who quit without notice a month ago. The facility was actively trying to hire a new Dietary manager with CDM certification.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with residents, resident representative and staff, the facility failed to ensure residents' menus and/or individual food plans met their nutritional needs, prescribed diet consistencies, and documented food preferences for 2 of 9 residents reviewed for food plans (Residents #89 and #116). The facility failed to follow standard recipes and failed to serve the indicated serving size during the lunch meal for 1 of 1 tray line observation. This practice had the potential to affect food served to residents. Findings included: 1. Review of the hospital discharge summary for Resident #89 dated 1/19/26 documented no known allergies and a regular diet. Resident #89 was admitted to the facility on [DATE] with diagnoses including hepatic encephalopathy, mild protein^calorie malnutrition, dietary zinc deficiency, and unspecified vitamin deficiency. The admission Minimum Data Set (MDS) dated [DATE] showed Resident #89 was cognitively intact and his oral/dental status was normal. Review of the allergy documentation showed on 1/19/26 no known allergies was entered by the Associate Director of Nursing (ADON). On 1/20/26 multiple drug allergies and a food allergy to shellfish were entered by the Director of Nursing. Review of the care plan indicated on 1/29/26 a long-term goal for Resident #89 was to be free from significant weight changes and signs of dehydration through multiple interventions. Interventions included providing adaptive equipment for meals as ordered including built-up utensils; Clearly label tray cards with food allergy to avoid allergic reactions; Clearly label tray cards with food allergy to avoid allergic reactions; assess resident's food preferences as needed; provide diet as ordered. Resident #89 had a physician order dated 1/31/26 for regular diet, double portions for breakfast and lunch, and required built-up utensils. Review of the allergy documentation showed on 3/23/26 the Nurse Practitioner deleted the shellfish allergy. On 3/30/26 the Nurse Practitioner deleted all drug allergies and entered No Known Allergies. On 6/8/26 at 12:10 PM, during an interview, Resident #89 stated the facility was not serving meals according to the posted menu and that he was receiving single portions instead of ordered double portions. Resident #89 reported he had no known allergies, but his meal ticket stated he was allergic to shellfish and shrimp. Resident #89 reported his favorite meal included fish and shellfish. He stated that he reported these concerns to ADON in early February 2026 and again to the Director of Nursing in March 2026. He further stated that the allergy list was corrected in March 2026, but the incorrect allergy information still appeared on his meal ticket, so he was never served meals with fish. He stated this made him feel frustrated because his concerns had not been resolved and he had reported it to facility leadership 5 months ago. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 6/8/26 at 1:08 PM, Resident #89's lunch meal ticket listed allergies to seafood and shrimp and documented double portions and built-up utensils. The meal tray contained food that was not on the menu provided to Resident #89. The meal tray contained standard metal utensils, single portions of beef stir fry instead of double portions, and white rice instead of tricolor pasta. The medical record documented no known allergies. Resident #89 stated he had been served no fish due to the listed allergies and that he found this upsetting because fish was one of his preferred foods. On 6/9/26 at 1:14 PM, a second meal observation for Resident #89 showed the lunch meal ticket again listed seafood and shrimp allergies and the food served was not the same as the menu provided. The meal tray contained single portions of tuna salad, threeˆbean salad, a dinner roll, beets, one cookie, tea, and water. The printed tray ticket listed green bean casserole, tuna noodle casserole, a snickerdoodle cookie, beverages, builtˆup utensils, double portions, and dietary restrictions of no shellfish and no shrimp. On 6/9/26 at 1:20 PM, Resident #89 stated it was frustrating to receive meals that were not what he ordered, small portions, and not what was listed on the ticket. He stated he often lost his appetite when this occurred and felt exhausted having to repeatedly request correct foods, preferences, or builtˆup utensils. He declined to eat his meal. At 1:20 PM on 6/9/26, a Speech Therapist entered the room and encouraged the resident to attempt eating. Resident #89 stated the meal was not what he had requested. The Speech Therapist described her role in coaching him to eat safely using modified utensils and posture. Resident #89 declined Speech Therapy services and declined the lunch tray. No alternate meal was requested. On 6/10/26 at 1:45 PM, the Dietary Manager stated that resident dietary preferences were collected on the day of admission using the corporate form, which included diet history, appetite, portion preferences, allergies, intolerances, cultural and religious needs, beverage preferences, and food dislikes. The Dietary Manager stated nursing entered diet orders into the electronic record, and those orders automatically populated Meal Tracker. The Dietary Manager stated he added resident dislikes and preferences to the bottom portion of each tray ticket; however, he was not yet trained on how to modify the clinical diet information at the top of the ticket, including texture or allergy fields. He stated that he relied on nursing to notify him of any preference updates and he updated the tickets daily. The Dietary Manager described the tray line as a twoˆcheck process in which the cook checked diet consistency and the servers checked preferences and the accuracy of the ticket. He stated errors occurred when staff failed to read the meal ticket. The Dietary Manager stated that if residents received items they disliked, staff replaced the tray, although he believed this occurred infrequently. The Dietary Manager stated that when the kitchen ran out of a menu item, a substitution notice was posted at the nursing station, and nursing staff were responsible for informing residents of the change. He stated his expectation was that dietary staff read and follow the information printed on the tray tickets. When asked about residents receiving trays with outdated allergies or incorrect textures, the Dietary Manager stated he had not been notified of changes and could not modify the top section of the ticket. He stated he updated only the preference information printed at the bottom. On 6/10/26 at 3:54 PM, the Director of Nursing reported she expected trays to match the ordered diets and that incorrect trays should not be served. She stated she had previously entered allergy information for Resident #89 based on a prior medical record and later updated it in March 2026 when provider records confirmed no known allergies. She also stated dietary staff controlled the Meal Tracker system and nursing had no access to make changes. The Director of Nursing sated she was (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not aware that nursing was expected to notify residents when Dietary provided the daily menu and it was an alternate. 2. Resident #116 was admitted on [DATE] with diagnoses traumatic brain injury, gingivitis, dysphagia of the oropharyngeal phase, and feeding difficulties. The annual Minimum Data Set, dated [DATE] indicated Resident #116 was cognitively intact. At 11:00 AM on 6/8/26, Resident #116 reported that meals often did not match the meal ticket and that he received foods he could not chew due to poor dentition. He stated both he and his Responsible Party had reported this to nursing and leadership. On 6/8/26 at 1:04 PM, during an observational interview, the Associate Director of Nursing (ADON) provided feeding assistance for Resident #116. The meal ticket documented mechanical ground meat and a mechanical soft diet. The ADON stated the beef on the tray was served in large chunks and did not meet the mechanically ground requirement. She stated she intended to cut the beef into smaller pieces. The ADON attempted to feed green beans cut into approximately oneˆinch pieces. Resident #116 refused, stating they were too tough. After further cutting with a spoon, Resident #116 again refused the ADON's spoonful of green beans. She then combined two pieces of green bean with a piece of beef and attempted to feed it to Resident #116. Resident #116 stated he could not chew it. When reminded of the resident's ordered diet, the ADON removed the tray and ordered the correct diet from the dietary services. During an interview on 6/8/26 at 1:08 PM, the [NAME] Health Clinical Competency Coordinator stated staff were trained during orientation and as needed to compare meal tickets to the items served. Incorrect trays were to be returned and replaced by contacting the kitchen. The Clinical Competency Coordinator asked the ADON where the meal try was that the ADON had attempted to feed Resident #116 and asked to review the meal ticket and tray together. During an interview with the Administrator at 1:45 PM on 6/8/26, he stated the facility had a Speech Therapist and Registered Dietitian who provided oversight for diet orders. He stated diet changes by therapy or the Registered Dietitian were expected to be communicated to nursing and dietary services. He reported that nursing staff entered diet and allergy orders into the medical record, updated the Meal Tracker software application, and dietary staff followed the information printed on the meal ticket. On 6/8/26 at 2:06 PM, the Physical Therapy Director reported the Speech Therapist screened all admissions for swallowing and cognition and completed evaluations upon request of nursing, the provider, the resident, or family. At 2:06 PM on 6/8/26, the Speech Therapist (ST) stated she completed swallowing and cognitive screenings at admission and determined the safest diet texture. She stated she notified nursing and dietary of diet changes and provided education as needed. The ST stated mechanical soft diets must include minced and moist textures and that items inconsistent with prescribed diets increased aspiration risk for those residents. ST stated she had not provided recent education to staff about Resident #116's diet modifications. She reported that Speech Therapy had created feeding safety instructions for staff and family and it was posted above Resident #116's bed. ST stated the meal ticket should reflect the ordered consistency and the residents' preferences and limitations due to allergies. ST stated it was unsafe to serve a resident food that was not consistent with the ordered (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diet, modifications, and limitations. On 6/8/26 at 4:30 PM, Resident #116's Responsible Party stated that she observed foods such as rice and corn on 6/3/26, which she stated the resident could not chew and were listed as restricted on his meal ticket. The RP also reported that approximately two weeks earlier, around 6/5/26, she observed his tray containing two boneˆin chicken legs with steamed vegetables. She stated the chicken was not chopped or ground. She stated no alternate meals were offered when he could not safely eat the food served. The RP stated she reported the incidents on 6/3/26 and 6/5/26 to the Director of Nursing. On 6/10/26 at 1:45 PM, the Dietary Manager stated that Speech Therapy or Nursing services entered modified diet orders into the electronic record, and those orders automatically populated in the Meal Tracker software. The Dietary Manager described the tray line as a twoˆcheck process in which the cook checked diet consistency and the servers checked preferences and the accuracy of the ticket. He recalled the 6/8/26 incident in which he ground food himself after Resident #116 received the wrong diet texture. He stated errors occurred when staff failed to read the meal ticket. He reported that staff were trained on reviewing meal tickets and remembering to ask questions when unsure, and notify him when errors occurred. He stated his expectation was that dietary staff read and follow the information printed on the tray tickets. On 6/10/26 at 2:56 PM, the Administrator stated he had been unaware of ongoing meal ticket and dietary accuracy concerns. He stated the previous Dietary Manager left two months earlier and the new manager had been in the role for three weeks. He stated nursing entered diet orders into the medical record, and dietary staff updated Meal Tracker. The Administrator was not aware the Dietary Manager had not been trained in how to edit the clinical diet information at the top of the ticket. He reported the Dietary Manager was expected to be trained in that task. He confirmed dietary staff were expected to follow the diet orders, allergies, preferences, and consistencies listed on the meal ticket. On 6/10/26 at 3:54 PM, the Director of Nursing reported she expected trays to match the ordered diets and that incorrect trays should not be served. She stated nursing could downgrade a diet for preference or safety but could not upgrade a diet without a provider order. She also stated dietary staff controlled the Meal Tracker system and nursing had no access to make changes. She reported that Resident #116's RP had made multiple complaints about meals. The Director of Nursing could not recall details of the 6/3/26 and 6/5/26 food complaints and reported she was working with Dietary services to address them. 3a. The menu for 6/10/25 read as follows, Shepard's pie, Eggplant Parmesan (vegetarian), macaroni and cheese, seasoned green peas, Italian Blend vegetables and peach cobbler. The menus did not indicate the serving size. A continuous tray line observation was conducted on 6/10/25 from 11:55 AM to 12:15 PM. At 12:00 PM, the Dietary Supervisor began plating meals. The scoop size used for the menu item Shepherd Pie was 3 ounces. He was observed placing one 3ˆounce scoop of [NAME] Pie onto each plate. After three meal trays were plated, the tray line was stopped, and the Dietary Supervisor was asked to review the residents' lunch meal ticket. The lunch meal ticket indicated a required serving size of 6 ounces for [NAME] Pie. The Dietary Supervisor had been serving 3 ounces instead of the 6ˆounce portion indicated on the meal ticket. A continuous observation of the tray line was conducted on 6/10/26 from 12:35 PM to 1:20 PM. During (continued on next page)

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Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/11/26 at 4:15 PM, the Administrator stated the Dietary [NAME] might have a different way of making food more appetizing for residents. He stated he did not know whether standard recipes were needed to be followed or whether items could be altered to improve taste. He stated the kitchen should follow scoop sizes based on the daily menu, and production sheets should be printed daily

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and staff interviews, the facility failed to keep the floors and walls behind the deep fryer and stove clean and free of dirt and oil. Staff failed to keep the oven, stove, deep fryer, and steam table backsplash clean and free of burnt food and food stains. Staff failed to label food stored for use in 1 of 1 reachˆin refrigerator and ensured that dry food with a scoop inside it was covered and labeled with the correct name. In addition, the facility failed to keep trash containers in the kitchen covered, failed to store cleaning equipment away from clean dishes, and failed to discard chipped plates and remove cups with dried food on them from the tray line. Dietary staff with facial hair failed to use facialˆhair covers to cover their facial hair for 2 of 2 staff observed. The facility also failed to maintain the ceiling to prevent peeling paint. These failures had the potential to affect food served to residents.Findings included:1a. Observation on 6/10/26 at 11:13 AM revealed that the kitchen floor had a wet appearance and had pieces of paper and food particles scattered across it. The floor near the stove and preparation area was very greasy and slippery. The floor between the stove and the deep fryer and the wall behind the deep fryer had a thick layer of oil and dried food, and the area appeared greasy and sticky.During an interview on 6/10/26 at 11:15 AM, the Dietary [NAME] stated that the dietary staff were in the process of cleaning the kitchen because the breakfast meal had just been completed and the lunch meal had been prepared. The Dietary [NAME] stated he had tried to clean the area between the fryer and the stove, but it had been greasy for so long that it was very difficult to remove.1b. Observation on 6/10/25 at 11:30 AM revealed that the oven had dark brown burnt stains on the inside of the door and on the shelves. The base of the oven had dark brown burnt food on it. Three racks placed over the oven were dark brown and had burnt food stains. Burnt food particles were also on top of the oven. Observation of the gas stove revealed that the front panel, stove knobs, and side splash guard had oil and food stains. The splash guard had brown stains on it. Observation of the deep fryer revealed burnt food in the oil and on the fryer. Observation of the steam table revealed a clear plastic backsplash placed on one side of the steam table with white stains.During an interview on 6/10/26 at 11:45 AM, the Dietary [NAME] stated he cleaned the oven and deep fryer every Friday and that the last cleaning was done on 6/5/26. He indicated there was no cleaning schedule for the dietary staff to follow and stated he was usually responsible for cleaning the oven, stove, and deep fryer.During an interview on 6/11/26 at 2:20 PM, the Dietary Supervisor stated there was no cleaning schedule and that all staff were responsible for cleaning after cooking. The Dietary Supervisor stated the dietary cook cleaned the oven and fryer every Thursday and that the oil was changed on that day. He also stated that staff should clean the backsplash after each meal.2a. Observation of the reachˆin refrigerator on 6/10/26 at 11:25 AM revealed four individual green cups with lids that had no label or date. The reachˆin refrigerator also contained a tray with 16 individual closed cups containing beverages. A storeˆbought opened cardboard box with soda cans had been placed on top of these cups. During an interview on 6/10/26 at 11:25 AM, the Dietary Supervisor stated staff should not store any boxes over the drinks intended for the afternoon lunch service. The Dietary Supervisor stated the four individual cups contained cream pie and fruit from the previous day's meal.2b. On 6/10/26 at 11:20 AM and on 6/11/26 at 2:10 PM, observations revealed a transparent bin with no lid containing a white powdered substance labeled as sugar, with a scoop inside the bin, resting on the powdered substance. The white powdered substance was open-to air. This transparent bin was placed on a rack, under the table which was near the hand-washing sink. During an interview on 6/11/26 at 2:11 PM, the Dietary Supervisor stated the white powder in the bin was a thickening product used to thicken liquids during meals. He stated the scoop should be removed and a lid should be placed on the bin after each use.2c. On 6/10/26 at 11:20 AM, an opened halfˆloaf of bread that was not labeled or dated was observed near the prep area. On 6/11/26 at 2:30 PM, a package containing six bread rolls, opened and not (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	labeled or dated, was observed on the steam table.During an interview on 6/11/26 at 2:30 PM, the Dietary Supervisor stated the opened bread loaf observed on 6/10/26 had been used for pureed bread at breakfast. He further stated the bread rolls were leftovers from lunch. The Dietary Supervisor indicated the bread and bread rolls should have been labeled and properly stored after use.3a. A continuous observation on 6/10/26 from 11:13 AM to 11:55 AM revealed two blue trash containers with no lids. One trash container was located near the rack holding clean dishes for airˆdrying, and the other was near the kitchen side door. The kitchen side door was propped open. The trash containers near the door was almost filled with trash and the other one was half filled with trash.Observation on 6/11/26 at 2:20 PM revealed the same two blue trash containers, still without lids. One trash container was near the kitchen door, and the other was near the coffee dispenser. Both the trash containers had trash in them.During an interview on 6/11/26 at 2:23 PM, the Dietary Supervisor stated he was unsure where the lids were. He looked around the kitchen but did not find the lids for the trash containers. The Dietary Supervisor stated the trash containers should always be closed with a lid.3b. Observation of the dishwashing area on 6/10/26 at 11:30 AM revealed the Dietary [NAME] mopping the kitchen floor using a yellow mopping bucket and a mop. He later placed the bucket and mop near a rack with cleaned dishes stored to airˆdry. The end of the mop handle was touching the rack.During an interview on 6/10/25 at 11:30 AM, the Dietary [NAME] stated the cleaning solution used for the floor was located at the end of the threeˆcompartment sink, close to the drying racks where clean dishes from the sink were placed. He stated the bucket and mop were usually kept in that area.During an interview on 6/10/26 at 11:40 AM, the Dietary Supervisor stated the dietary staff usually placed the cleaning bucket and mop at the end of the threeˆcompartment sink near the drying racks because the cleaning solution was hooked on the wall in that area. The Dietary Supervisor indicated there was no other place to place the cleaning bucket and mop.3c. Observations on 6/10/26 at 1:00 PM and on 6/11/26 at 2:33 PM revealed a cleaning brush with blue bristles and a long handle, and a squishy broom with a long handle, hanging on the wall below a rack holding clean dishes that were airˆdrying. A cutting board was hanging from the rack. The cleaning tools were approximately 1 to 1.5 feet away from the mop handle and broom handles.During an interview on 6/11/26 at 2:33 PM, the Dietary Supervisor stated the hooks used to hang the brooms and brushes were located on the wall beneath the drying rack. He further stated the dietary staff had always hung the brooms there and that there was no other place to store them.4. The trayˆline observation also revealed four out of 15 plates were chipped, and four out of 15 white cups had dried food on them. The Dietary Supervisor stated chipped plates and dirty cups should not be used for plating food and that the plates may have chipped during the washing process.5. Observation on 6/10/25 at 12:12 PM revealed Dietary Aide #1 assisting in bringing out the prepared beverages from the reach in refrigerator for the tray line. Dietary Aide #1 had facial hair near his chin (approximately a 1ˆ 1.5 inch long) and was not wearing a facial covering. During an interview on 6/10/25 at 12:13 PM, Dietary Aide #1 stated he had trimmed his beard the day before and did not think he needed to wear a facial covering for what he believed was a short length of facial hair.Observation on 6/11/25 at 2:13 PM revealed Dietary Aide #2 filling the ice box with ice. He had facial hair and was not wearing a facial covering.During an interview on 6/11/25 at 2:15 PM, Dietary Aide #2 stated he had just returned to the kitchen after his break and had forgotten to wear a facial covering.During an interview on 6/11/25 at 2:20 PM, the Dietary Supervisor stated all dietary staff should cover their hair with hairnets and cover facial hair with appropriate face coverings.7. Observation of the kitchen ceiling revealed multiple areas where paint was peeling. One area above the racks containing trays for the tray line measured approximately 2 feet by 2 feet, with a section measuring about 1 foot by 1 foot where paint was hanging from the ceiling. Additional areas of peeling paint measured approximately 4 feet by 4 feet near the steamˆtable passage, 2 feet by 2 feet near the mealˆpreparation area, as well as other smaller areas throughout the kitchen.During an interview on 6/10/26 at 3:00 PM, Maintenance Assistant #2 stated that management had been informed a year earlier that the kitchen ceiling needed (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	repainting. He stated the facility had indicated it would look into hiring private contractors to complete the work, but no painting had been done since.During an interview with the Dietary Supervisor on 6/11/26 at 2:10 PM, he stated he had notified the Administrator on May 20, 2026 that the kitchen ceiling needed a new paint was peeling, and no action had been taken since.During an interview on 3/11/26 at 4:15 PM, the Administrator stated the cleaning of the kitchen should be delegated to all dietary staff and should occur on a regular basis. The Administrator stated the Dietary [NAME] and Dietary Supervisor knew how to clean the oven and other equipment and should have been cleaning the equipment even without a formal schedule. He stated all equipment should be cleaned regularly and the steamˆtable guard should be cleaned after each meal. The Administrator reiterated that all dietary staff should be cleaning the kitchen routinely. The Administrator stated leftover food should be labeled and dated, and any opened food should be properly closed, labeled, and dated. He stated food stored in the refrigerator should be discarded within 3 to 5 days. The Administrator indicated all staff should wear hairnets and beard guards to cover any hair. The Administrator stated he was unsure why the trash containers were not covered. Regarding the peeling paint on the ceiling, the Administrator stated the kitchen roof had a major issue in August and September 2025. The roof had a hole that was patched and repaired. He stated the maintenance staff could paint the ceiling and complete the task.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to keep the dumpster area free of accumulated trash and debris for 3 of 3 dumpsters observed. This practice had the potential to attract pests and rodents.Findings included:On 6/8/26 at 10:40 AM an observation was conducted of the dumpster area located behind facility. There were 3 large green dumpsters. While facing the dumpsters the dumpster on the left side was observed with the lid and the sliding side doors closed. The middle dumpster was observed to contain broken down folded cardboard boxes that were protruding from an opening in the front. The lid was closed. The dumpster to the right had the lid and the side sliding door open. This dumpster was observed to contain food waste not contained in bags and bagged waste. Flies were observed on the waste in this dumpster. Non-contained waste debris was observed littering the ground in front of, between, beside and behind the dumpsters. This debris included disposable plates, cups, empty and full condiment packets, and soiled napkins. Food waste was also observed on the ground, and a squirrel was foraging in the food. Behind the dumpsters, leaf litter was observed approximately 3 inches deep dispersed with various trash items and debris, including empty plastic bottles and juice cartons. On 06/9/2026 at 9:42 AM a second observation of the dumpster area and an interview were conducted with the Maintenance Assistant. He reported he had been in his position for the past 2 years. He stated he normally arrived at work in the morning between 6:30 AM and 7:00 AM. He indicated that when he got to the facility in the morning, he could see the dumpster area from where he parked his car. He reported that he also he saw the dumpster area on 06/8/26 when he arrived at work at his usual time, and there was trash everywhere. He reported there had been trash on the ground including cups, plates, bowels, and other paper trash. He reported on 06/8/26, the dumpster area was the worst he has ever seen it. He reported the city waste corporation serviced the facility, and he thought the trash was falling out when the dumpsters were emptied. He stated he did not know what the trash collection schedule was. He indicated his usual workday priority was managing the inside of the building, and then when he could get to it, he worked outside the building after the sun came out. He stated on 6/8/26 around 11:00 AM, he went out to the dumpsters and cleaned up what he could. He stated there was still currently trash, including empty plastic bottles, cups, lids, condiment packets, plastic utensils, and food waste on the ground in front of, behind, and between the 3 dumpsters. He indicated the dumpsters did not have numbers, but the left and right dumpsters, if you were facing them were for normal waste including kitchen and food waste, and the middle dumpster was for cardboard. He confirmed that the side sliding door on the left dumpster was open, and unbagged food waste, and flies were observed. The top of the left dumpster was open, and the middle dumpster lid was open, and cardboard was sticking out above the rim of the dumpster. The right dumpster lid was closed, but the side door was open, and unbagged food waste and flies were present. He stated the lids and side doors of all dumpsters should always remain closed, to prevent attracting insects and animals. He confirmed that behind the cement wall of the kitchen ramp near the dumpster area, there was an approximately 30-gallon plastic trash bag filled with empty aluminum cans, and on the ground beside this bag, were approximately 100 loose empty aluminum cans. He indicated these cans had been there at least since 6/4/26 or 6/5/26, because he had seen them last week. He stated he thought one of the staff collected them for recycling, but he did not know who. He indicated regular monitoring and cleaning of the dumpster area was not something he recalled ever being assigned. He reported he felt that the housekeeping and kitchen staff should do this. He reported he sometimes did it, because he didn't want to wait for someone else. He stated he had never seen mice or rats at the dumpster area, but he had seen racoons and squirrels On 6/9/26 at 10:01 AM Floor Tech #1 was observed to arrive at the dumpster area and deposit bagged trash into the left trash dumpster and closed the side door. In an interview at this time, he reported his duty was to ensured that floors were cleaned in the building, and trash was emptied and disposed of. He stated there were times when he needed to break down cardboard and (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	place this in the middle dumpster that was for cardboard waste. He indicated that he knew that the lids and sliding side doors of dumpsters should always be closed. He reported he was not sure whose responsibility it was to make sure there was no trash or waste outside the dumpsters, and the lids were closed, but he thought kitchen staff should be responsible for the dumpsters. He reported he had never been assigned this duty. On 06/10/2026 9:25 AM an interview with the Maintenance Director indicated he started his role with the facility on 06/8/26. He reported that because the trash that went into the dumpsters was from housekeeping and dietary departments, he thought they would be responsible for managing the dumpster area. He stated the maintenance department was responsible for cleaning the perimeter of the building like the parking lot but were not responsible for maintaining the dumpster area. On 06/9/2026 10:21 AM an observation of the facility's dumpster and an interview were conducted with the Administrator. He indicated the trash observed on the ground in the dumpster area, and the aluminum cans on the side, should not be present. He reported this was a sanitation issue. He reported the boxes should be broken down, and the lids and side doors to the dumpsters should be kept closed at all times to contain refuse. He indicated he believed the issue was that when the waste management company emptied the dumpsters; they were spilling the trash onto the ground. He indicated the maintenance staff should be doing frequent monitoring of the dumpster area and ensuring that the area was kept clean and free from debris. He reported he thought the breakdown in the process was because there was a misunderstanding among the staff regarding what their roles and responsibilities were.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a review of the Resident Council meeting minutes and interviews with Resident Council members, the facility failed to resolve concerns voiced by the Resident Council members during 4 of the 7 previous Resident Council meetings (Resident Council meetings held on 3/30/26, 4/23/26, 5/20/26, and 5/27/26).Findings included:The Resident Council meeting minutes from January 2026, February 2026, March 2026, April 2026, and May 2026 were reviewed.The Resident Council meeting minutes dated 3/30/26 revealed residents voiced concerns the coffee was always cold, linen was not being stocked on all floors, call lights were not being answered, snacks and ice were not being passed out, and they were not being given a choice of cereal.No grievance report was located for the concerns voiced by the Resident Council from the 3/30/26 meeting.The Resident Council meeting minutes dated 4/23/26 revealed residents voiced concerns about cold coffee, snacks and ice not being passed out, call lights not being answered, staff being on their phone during work hours, and staff not going to the first floor to get sandwiches when asked and instead saying that there weren't any. The minutes further revealed the Administrator was present at this meeting.No grievance report was located for the concerns voiced by the Resident Council from the 4/23/26 meeting.The Resident Council meeting minutes dated 5/20/26 revealed residents voiced the concern they had not seen any changes since the last meeting. They voiced concerns regarding the food being overcooked, staff were not passing ice, water, snacks or sandwiches, and the coffee was cold.No grievance report was located for the concerns voiced by the Resident Council from the 5/20/26 meeting.The Resident Council meeting minutes dated 5/27/26 revealed residents voiced the concern they had not seen any changes since the last meeting. They voiced concerns about staff being on their phones during work hours and the food was overcooked food. The minutes further revealed the Administrator was present at this meeting.No grievance report was located for the concerns voiced by the Resident Council from the 5/27/26 meeting.A meeting of the Resident Council was conducted on 6/9/26 at 11:30 AM. Five cognitively intact members of the Resident Council attended the meeting including the Resident Council President. During this meeting, residents reported although they expressed the same concerns at Resident Council meetings, nothing ever changed. They stated they felt they weren't getting any responses to their concerns.On 06/10/2026 at 3:33 PM in an interview with the Activities Director she reported Resident Council members had repeatedly complained to her during Resident Council meetings that they were not getting a response to their concerns. She stated in an attempt to remedy the concerns not being resolved, she just started having resident council twice monthly in May 2026. She indicated the first monthly Resident Council meeting was to get the concerns and the second one was to ensure that the issues were responded to. She reported she did not fill out a written grievance complaint form for concerns expressed during Resident Council meetings. The Activities Director stated she went to each department head and talked with them about the concerns expressed during Resident Council, and what they were going to do to fix the problem. She reported she thought the reason the issues kept coming up was the issues were not getting adequately addressed. She indicated she was not sure why she wasn't filling out a grievance for the concerns reported by the Resident Council.On 6/10/26 at 4:39 PM an interview with the Administrator revealed he began getting invited to attend Resident Council meeting within the past 3 months. He reported he felt if there had been grievance forms completed for the group concerns that would have been super helpful. He stated while it was good for the Activities Director to bring the concerns expressed during Resident Council meetings to the team to discuss, concerns expressed by the Resident Council would definitely be grievances. He reported he did not know why the Activities Director was not completing grievances forms for these concerns in accordance with the facility's grievance policy. The Administrator stated the facility did not have a plan of correction in place for this issue.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews the facility failed to ensure 2 urinals (Resident #5 and #88) and 6 bath basins (Resident #5, #88, #21, #38, #65, and #85) were labeled for each resident and stored in a sanitary manner. The facility failed to ensure a privacy curtain was clean and was free from coming into contact with the floor (Resident #116). The facility also failed to ensure resident rooms were clean as evidenced by soiled and sticky floors (Resident #89 and #116), a sticky floor (Resident #6), failed to keep a Packaged Terminal Air Conditioner (PTAC) unit from dust and debris (Resident #57), and failed to keep a resident's room wall surface smooth and intact as evidenced by damaged sheetrock and missing paint (Resident #91). This deficient practice affected 11 of 16 residents (Resident #5, #6, #21, #38, #57, #65, #85, #88, #89, #91, and #116) reviewed for environment. Findings included: 1. a. An observation was completed on 06/08/26 at 12:02 PM of the bathroom for Resident #5 and Resident #88, who resided in the same room. The observation revealed 3 bath basins, which appeared dry, stacked together sitting on the side of the sink with no resident identifiers, and stored in a sanitary manner. The observation also revealed 2 urinals hanging on the hand grip rail beside the toilet with no names on them. One urinal was empty; one had approximately 100 milliliters (ml) of brown liquid in the bottom of it with no odors present. b. An observation was completed on 06/08/26 at 12:08 PM of the bathroom for Resident #21 and Resident #38, who resided in the same room. The observation revealed 2 bath basins stacked together sitting on the sink with no resident identifiers. One bath basin appeared to be wet, and the other one was dry. c. An observation was completed on 06/08/26 at 12:13 PM of the bathroom for Resident #65 and Resident #85, who resided in the same room. The observation revealed 1 wet bath basin sitting on the sink with no resident identifier. A continuous observation and interview were conducted on 06/08/26 from 12:17 PM through 12:31 PM with Nursing Assistant (NA) #4. Na #4 verified she was the direct care NA for Resident #5, #88, #21, #38, #65, and #85 from 7:00 AM-3:00 PM on 06/08/26. She stated she was new and she wasn't familiar with the facilities way of storing the bath basins or urinals. She stated she had been working at the facility since October 2025 (8 months ago). Na #4 explained she was aware the basins and urinals should have the resident's name on them and should be in separate plastic bags to prevent cross contamination. NA #4 indicated the storage room on the 200 hall did not stay stocked with needed supplies and she had not gone to another hall to look in the other storage closets. When she opened the door to the storage closet on the 200 hall an observation revealed bath basins, too numerous to count, and other supplies, including at least 9 urinals. NA #4 was observed discarding the bath basins and retrieving new ones for Resident #5, #88, #21, #38, #65, and #85's bathrooms, but none of the newly distributed supplies were observed to be being labeled by NA #4. NA #4 was observed gathering the basins, urinals, and plastic bags and she stated she would label them and redistribute them. An interview was conducted on 06/08/26 at 12:34 PM interview with Nurse #3, who was assigned to the 200 hall. She stated she had not realized the bath basins were not labeled for each resident and was not aware they were not stored in a sanitary manner in resident rooms. She then stated the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	storage closet was normally fully stocked and if they were to need something that was not in there they would just go to another floor and get it. An interview was conducted on 06/12/26 at 2:03 PM with the Director of Nursing (DON). The DON stated she would expect bath basins and urinals to be stored with a resident identifier and kept in separate plastic bags. She further stated she was unaware that the basins and urinals were being stored without resident names and not placed in plastic bags. 2a. During an observation conducted on 6/8/26 at 11:00 AM the floor in Resident #116's room was found to be sticky and tacky from the entry door to the window on the other side of the room as the floor was walked upon. The privacy curtain was observed to be in contact with the floor, and not suspended above the floor, and when the curtain was open and closed, the lower part of the curtain dragged along the floor. The portion of the curtain in contact with the floor had a black sticky residue and the bottom of the curtain was stained dark brown and black. Further observation revealed the lower portion of the curtain which was in contact with the floor was physically stuck to floor, and the curtain had to be manually pulled free of the floor. During an observation conducted on 6/9/26 at 9:00 AM, the floor in Resident #116's room remained in the same condition as the observation conducted on 6/8/26 at 11:00 AM with the floor being sticky, the status of the curtain being dirty and in contact with the floor, and the curtain being adhered to the floor. b. During an observation of Resident #89's room conducted on 6/9/26 at 11:00 AM the floor was sticky and tacky when walked upon from the entry doorway to the window on the other side of the room and visibly soiled with a dried discolored liquid on the floor, the area approximately the size of a watermelon. A follow up observation of Resident #116's room was conducted on 6/10/26 at 9:00 AM. The observation revealed the floor remained sticky and tacky when walked upon from the entry doorway to the window on the other side of the room and visibly soiled with a dried discolored liquid on the floor, the area approximately the size of a watermelon. During an interview conducted on 6/9/26 at 9:45 AM, Housekeeping staff #1, who was assigned to Resident # 89 and Resident #116's room, reported she had not yet reached Resident #116 or Resident #89's rooms for cleaning that morning. On 6/10/26 at 9:44 AM, Nurse #13 was interviewed, on conjunction with an observation of Resident #116's room. The nurse stated she was assigned to provide support to the Associate Director of Nurse (ADON) and worked on the unit where Resident #89 and Resident #116 resided. Nurse #13 reported she was called in from another location to provide support on the unit for the ADON. She reported she had been into both resident rooms since she arrived at the unit at 7:00 AM that morning and walked around the unit. During an observation Nurse #13 stated the floors in both rooms were visibly soiled and when walked upon the floors were found to be sticky and tacky. As the observation continued, Nurse #13 stated the soiled curtain draped on the floor in Resident #116's room should have been reported and replaced with a clean curtain of proper length. Nurse #13 explained Resident #116's curtain was too long and dragged on the floor. Nurse #13 stated when she observed small spills like a spilled drink or food, she wiped them up with water and paper towels and she reported larger soiled areas to housekeeping. Nurse #13 stated soiled curtains were to be entered into the work^order system and reported to the Unit Manager. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Housekeeping Staff #1 on 6/10/26 at 9:56 AM, she reported being assigned to the side of the unit where Resident #89 and Resident #116 resided on 6/8/26, 6/9/26, and 6/10/26. Housekeeping Staff #1 described routine cleaning tasks she completed including disinfecting surfaces, cleaning bathrooms, changing trash bags, mopping resident rooms and bathrooms, and changing mopheads between each room. She reported she completed all of these tasks on each day (6/8/26, 6/9/26, and 6/10/26) for Residents #89 and #116. Housekeeping Staff #1 stated a chemical treatment was used on sticky floors and had been applied in Resident #89 and #116's rooms. Housekeeping Staff #1 stated she was still in training and had not learned the procedure for reporting or replacing soiled curtains. She stated the curtain in Resident #116's room had been soiled since her supervised unit orientation began on 6/8/26. Housekeeping Staff #1 stated she was not aware that the privacy curtains were part of her housekeeping duties or she would have reported their soiled condition to her supervisor. Housekeeping Staff #1 stated she didn't know if they did scheduled deep cleaning of resident rooms and she had just been covering daily or routine cleaning tasks. On 6/9/26 at 10:15 AM, the Assistant Housekeeping Manager reported she was training Housekeeping Staff #1 and had just begun teaching her that privacy curtains were the responsibility of housekeeping to manage. She explained she had planned to instruct Housekeeping Staff #1 on the process for reporting soiled curtains but had not yet provided that training. She further stated the housekeeping department communicated environmental concerns and received direction through a group text message chat on their work cell phones. The Assistant Housekeeping Manager reported that housekeeping services completed deep cleaning once weekly on weekends, when unit traffic was lower, and on an asˆneeded basis. She reported it took around 5 to 6 weeks to get all resident rooms on a unit deep cleaned, which included washing the windows, washing baseboards and cabinetry, and stripping floors of protective barrier coating and reapplying a new coat of the protective barrier. The Assistant Housekeeping Manager did not have a schedule available for review. She stated she had not trained Housekeeping Staff #1 on the weekly deepˆcleaning schedule, explaining that initial training had focused on basic tasks as the priority. She reported her supervisor would be able to provide more specific information about the floor products and deep cleaning schedule. On 6/10/26 at 10:20 AM, the Housekeeping Supervisor stated the floorˆcleaning product utilized by the housekeeping staff caused the floors to be sticky. The Housekeeping Supervisor stated that on 6/8/26 due to her concern of the floor being sticky from use of the floor-cleaning product she decided to utilize a different product for cleaning the floors. The Housekeeping Supervisor stated curtains should not touch the floor and must be ordered according to room dimensions, and she stated Resident #116's curtain was an oversized curtain borrowed from another facility two weeks earlier while awaiting replacements. She stated they have a weekly deep cleaning process where they clean the unit floors in sections on the weekends. The Housekeeping Supervisor stated the recent holiday in May had put them behind schedule. She stated there was not sufficient time to fully remove the sticky residue because the product needed repeated applications to break it down and remove it. On 6/10/26 at 2:56 PM, the Administrator stated he was unaware of the sticky or soiled floors in the rooms of Residents #89 and #116. The Administrator stated the expectation was for Housekeeping Services to identify and address soiled floors and to work with nursing and other departments to maintain a clean care environment. The Administrator further stated the expectation was for resident rooms and care areas to be kept clean, sanitary, and free of environmental hazards. The Administrator was not aware of what their cleaning routines and schedules were for daily tasks and deep cleaning and recommended talking with Housekeeping Manager for those details. 3. An observation of Resident #57's room was conducted on 6/8/26 at 9:44 AM. The Packaged (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Terminal Air Conditioner (PTAC) unit was noted to have brown and white fuzzy debris all around the outer perimeter of the unit with chunky brown debris inside the unit and across the vents. The PTAC was running during the observation. On 6/10/26 at 2:38 PM a follow-up observation was completed of the PTAC in Resident #57's room. The PTAC was observed to remain in the same condition as observed on 6/8/26 with brown and white debris all around the outer perimeter of the unit with chunky brown debris inside the unit and across the vents. The PTAC was running during the observation. An interview was conducted in conjunction with an observation with Housekeeper #2 of the PTAC in Resident #57's room on 6/11/26 at 2:40 PM. The observation revealed the PTAC unit remained in the same condition as the observation completed on 6/10/26. Housekeeper #2 explained she normally cleaned the odd numbered rooms of the 200-hall where Resident #57 resided. According to Housekeeper #2, she was supposed to wipe down the outside of the PTAC when she cleaned each resident's room with daily cleaning, and she must have just missed cleaning the PTAC because Housekeeper #2 had already cleaned Resident #57's room earlier on 6/11/26. However, Housekeeper #2 stated the maintenance department was responsible for deeper cleaning inside the PTAC because it required specialty tools to reach inside. According to Housekeeper #2, resident rooms only were deep cleaned once a resident was discharged because most residents did not like the smell of the cleaning chemicals. On 6/11/26 at 2:48 PM the Housekeeping Director was interviewed and stated she had been filling in as Maintenance Director since the facility had not had one for a while (she did not declare as to how long the facility had not had a Maintenance Director). According to the Housekeeping Director, the PTAC in Resident #57's room was an older model, and the facility was in the process of changing out older PTAC units since they were hard to reach inside to clean. However, Resident #57's room was not on the list to have the PTAC changed at the time of the survey. The Assistant Housekeeping Director was interviewed on 6/11/26 at 2:55 PM. The Assistant Housekeeping Director stated Resident #57's room had an older PTAC unit, and the facility was in the process of replacing the older units. According to the Assistant Housekeeping Director, both residents and families would place flowers and plants on top of the PTAC units which caused plant debris to drop down into the units. He explained that the entire front of the PTAC unit had to be removed to vacuum inside, but it was difficult to clean all the units due to the housekeeping and maintenance departments being short staffed. The Assistant Housekeeping Director stated he was unsure when Resident #57's PTAC unit was last cleaned inside. On 6/12/26 at 2:55 PM the Administrator was interviewed and stated the maintenance department should have removed the front of the PTAC unit in Resident #57's room to clean it inside and out. 4. Resident #91 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #91 was cognitively intact. On 6/8/26 at 11:37 AM, an observation of Resident #91's room, conducted in conjunction with an interview with Resident #91, revealed wall damage to the left side of the room. The paint had peeled away, exposing the drywall. The damaged area was located to the right of the Packaged Terminal Air Conditioner (PTAC) and measured approximately 3 feet in length and 2 feet in height, extending (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	upward from the baseboard. Resident #91 stated he noticed the wall damage in his room about a couple months ago but was unsure how long it had been there. Resident #91 added he had not spoken to anyone in the facility about the wall damage On 6/10/26 at 9:37 AM a follow up observation was completed of Resident #91's room. The peeling paint and damaged drywall remained in the same condition as observed on 6/8/26 with paint that had peeled away from the wall exposing drywall. During an interview on 6/11/26 at 9:53 AM with the Housekeeping Director, who stated she had been filling in as Maintenance Director while the facility did not have one, stated she was not aware of the wall damage in Resident #91's room and there was no record indicating the maintenance department had been notified. The Housekeeping Director revealed staff received training on two options for reporting maintenance concerns which included staff could write the concerns in a notebook monitored by the Maintenance Department or enter the concerns in the online facility management system, which included work orders. She further stated housekeepers monitored the rooms daily during cleaning and if concerns were observed they also notified the Maintenance Department by using the notebook or entering the problem into the computer system. An interview was completed with Nurse Assistant (NA) #12 on 6/11/26 at 3:39 PM. NA #12 indicated she had not noticed wall damage in Resident #91's room. She stated staff reported concerns to the Maintenance Department by entering them into the computer system or by writing the concern in a notebook that is monitored by the Maintenance Department. During an interview with Nurse #11 on 6/12/26 at 9:12 AM she indicated that had not noticed wall damage in Resident #91's room. She stated staff reported concerns to the Maintenance Department by entering them into the online work order system or by writing the concern in a notebook that is monitored by the Maintenance Department. 5. On 6/8/26 at 11:53 AM, an observation of Resident #6's room revealed the floor throughout the room was sticky when walked upon despite there being no visible spills. On 6/9/26 at 9:13 AM a follow up observation was completed of Resident #6's room. The floor in the room remained in the same condition. The floor was observed to be sticky despite no visible spills or debris. During an interview on 6/11/26 at 9:53 AM with the Housekeeping Director, who stated she had been filling in as Maintenance Director while the facility did not have one, explained she was aware of issues with sticky floors throughout the facility. The Housekeeping Director explained the sticky floors were caused by a vendor provided floorˆcleaning product. Her corporate support had directed her to resume use of the product about one month earlier despite the historical persistent stickiness they had experienced with the same product about a year ago. The Housekeeping Director stated over the last few weeks she observed the floors had become sticky again because of the floor cleaning products. She indicated on 6/08/26 she switched to a different cleaner and had been monitoring the floors to determine if the change resolved the sticky cleaner buildup currently on the floors. She stated the floors throughout the facility were still sticky on 6/11/26. During an interview completed with the Administrator on 6/12/26 at 3:24PM he stated his expectation was for all rooms to be maintained in good repair and to provide a safe, home-like environment.

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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** Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the use of tobacco, indwelling urinary catheter, insulin and dental status for 4 of 20 residents (Resident #100, Resident #62, Resident #76, and Resident #6) reviewed for MDS accuracy. Findings included: 1. Resident #100 was admitted to the facility on [DATE] with a diagnosis of tobacco use. The Smoking Observation Form indicated a smoking observation was made on 12/7/25. The form indicated that the resident was a smoker and had a history of smoking. Based on the observation, Resident #100's smoking status was determined to be unsupervised smoker. The significant Change Minimum Date Set (MDS) assessment dated [DATE] revealed the resident was assessed as cognitively intact. Resident #100 assessment indicated no for current tobacco use. During an interview on 6/12/26 at 4:21PM, MDS Nurse #1 stated the facility was a smoke free facility and hence was documenting all residents as nonsmokers. MDS Nurse #1 acknowledged that Resident #100 was a smoker. MDS Nurse #1 indicated she realized only recently that residents who smoked should be marked as smokers and not as nonsmokers even though the facility was a smoke free facility and the residents signed out and went outside the facility to smoke. During an interview on 6/12/26 at 4:30 PM, the Director of Nursing (DON) stated the facility had a smoke free policy, however had some residents who smoked. Smoking observation was completed for these residents upon admission and were assessed as unsupervised smokers. DON stated Resident #100 was smoker and her smoking observation was completed on 12/7/25. DON indicated the MDS should reflect the current smoking status of the residents, and the residents should be marked for tobacco use. 2. Resident #76 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including bladder neck obstruction. A hospital discharge order dated 5/25/26 included use of an indwelling urinary catheter. A nursing readmission note dated 5/25/26 noted an indwelling urinary catheter was in place. A physician order dated 5/25/26 included an order for use of an indwelling urinary catheter. The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #76 to be cognitively intact and assessed her to be incontinent of urine. The indwelling urinary catheter was not documented. During an interview with MDS Nurse #1 on 6/11/26 at 9:57 AM, she reported she missed the resident returning from the hospital with an indwelling urinary catheter and should have documented its presence on the MDS assessment for Resident #76. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on 6/12/26 at 4:00 PM and stated he expected the MDS to accurately reflect the care needs of the residents. 3. Resident #62 was admitted to the facility on [DATE]. A review of the nursing admission assessment dated [DATE] revealed Resident #62 had obvious or likely cavities or broken natural teeth. A review of a care plan initiated on 1/14/26 revealed Resident #62 was not identified as needing supervision while smoking. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was not identified for Current Tobacco Use or as having any Oral/Dental Status problems. During an interview and observation with Resident #62 on 6/8/26 at 12:19 PM, he stated that he had smoked cigarettes for years and had continued smoking since his admission to the facility. An observation of Resident #62 noted he had missing upper and lower teeth and his remaining teeth were in poor condition, with evidence of breakage, decay, and discoloration. An interview conducted with MDS Nurse #1 on 6/11/26 at 2:32 PM revealed that Resident #62's Annual MDS Assessment had been completed by MDS Nurse #3, a remote MDS nurse. MDS Nurse #1 stated that MDS Nurse #3 relied solely on the documentation in the medical record to determine whether Resident #62 used tobacco or had any dental problems. She explained that if she had completed the assessment herself, she would have visually observed the resident prior to completing it; however, MDS Nurse #3 had no way to observe Resident #62. An interview with MDS Nurse #3 was conducted on 6/12/26 at 10:46 AM. She explained that she worked remotely for the facility, completing assessments offsite using the electronic medical record. She confirmed that she completed the MDS assessment for Resident #62 dated 3/29/26. MDS Nurse #3 stated that she relied solely on the documentation in the electronic record when determining tobacco use or whether the resident had dental problems. She reported that there was no documentation indicating tobacco use or dental issues for Resident #62. She added that if there was no documentation she had to assume none were present. When asked about the smoking care plan initiated on 1/14/26 she stated that she could not recall why she coded Resident #62 as not using tobacco and acknowledged that she may have overlooked the smoking care plan. During an additional interview with MDS Nurse #1 on 6/12/26 at 11:35 AM, she stated that she had observed that Resident #62 had dental problems. She indicated that the assessment dated [DATE] did not accurately reflect Resident #62's dental status. An interview with the Director of Nursing (DON) was conducted on June 12, 2025, at 12:27 PM. The DON stated that she expected assessments to accurately reflect a resident's dental status and current tobacco use. 4. Resident #6 was admitted to the facility on [DATE], with a diagnosis of diabetes mellitus. A review of Resident #6's May 2026 Medication Administration Record (MAR) revealed that insulin lispro was administered on 7 days during the lookback period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE], noted there were 0 days that an injection of any type had been received, and 0 days of insulin injections had been received. On June 11, 2026, at 2:32 PM, an interview with MDS Nurse #1 revealed that Resident #6's quarterly MDS assessment had been completed by MDS Nurse #3, a remote MDS nurse. She stated that MDS Nurse #3 relied solely on documentation in the medical record to determine whether Resident #6 had received insulin. On June 12, 2026, at 10:46 AM, an interview with MDS Nurse #3 revealed that she worked remotely for the facility, completing assessments offsite using the electronic medical record. She confirmed that she completed the MDS assessment for Resident #6 dated May 13, 2026. She explained that she relied solely on documentation in the electronic record when coding the assessment. MDS Nurse #3 acknowledged that Resident #6 did receive insulin during the lookback period and stated that the resident was coded as not receiving injections or insulin injections in error. An interview with the Director of Nursing (DON) was conducted on June 12, 2025, at 12:27 PM. The DON stated that she expected assessments to accurately reflect a resident's medications.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record reviews, resident and staff interviews, the facility failed to complete a smoking assessment (Resident #100) and complete a quarterly smoking assessment (Resident #100 and Resident #62). The facility failed to secure smoking material (cigarettes and ignition material) for 3 of 3 residents (Resident #100, Resident #62, and Resident #104) reviewed for safe smoking. The facility also failed to secure one oxygen cylinder stored in a resident's room for 1 of 1 resident (Resident #99) reviewed for accidents. Findings included: A review of the smokeˆfree policy revised on 2/10/26 revealed that, effective 1/1/15, smoking was not allowed on the facility premises by visitors, staff, or residents. The policy encouraged residents to participate in a smoking cessation program. The admission Director or admitting nurse informed residents and/or legal guardians of the smoking policy upon admission. The policy stated that residents should not keep smoking materials in their possession. Staff were to store and secure all smoking and ignition materials. The smokeˆfree policy stated in part, An assessment utilizing The Smoking Observation Form in the Electronic Health Record is completed at least quarterly thereafter only if the answer to either of the first two (2) questions indicates the resident either smokes or has a history of smoking. 1. Resident #100 was admitted to the facility on [DATE] with diagnoses that included gastroparesis, severe proteinˆcalorie malnutrition, chronic obstructive pulmonary disease, and tobacco use. A review of the Smoking Observation Form showed a smoking observation date of 12/7/25 and a completion date of 6/8/26 (first day of survey). The form indicated that the resident was a smoker and had a history of smoking. Based on the observation, Resident #100's smoking status was determined to be unsupervised smoker. Review of the medical records revealed Resident #100 did not have a quarterly Smoking Observation Form / assessment. Smoking Observation Form with observation date and completion date 6/8/26 indicated the resident was assessed as unsupervised smoker. During an interview on 6/10/26 at 3:00 PM, the Director of Nursing (DON) stated the facility was smokeˆfree but did admit residents who smoked. Nurses completed smoking observation assessments upon admission for resident who were current smokers and assessed whether the resident was a safe smoker. The DON stated the facility had five residents who smoked and all were assessed as unsupervised smokers. DON stated smoking assessments were completed at admission, when there was change in status and may be quarterly. She was unclear if quarterly smoking observations were completed on residents who smoked. During a reˆinterview on 6/12/26 at 4:17 PM, the DON stated Resident #100's smoking observation was completed on 12/7/25 as indicated in the Smoking Observation Form. DON further stated she did not know why the smoking observation form/ assessment initiated at the time of Resident #100's admission with a smoking observation completed on 12/7/25 was completed/closed on 6/8/26. She (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reiterated that smoking assessments should be observed and completed on the same day as the scheduled observation date. A review of the Significant Change MDS assessment dated [DATE] showed the resident was cognitively intact and mostly independent with most Activities of Daily Living (ADLs). The assessment indicated no for current tobacco use. A review of the care plan (initiated on 1/14/26 and revised/reviewed on 6/8/26) indicated Resident #100 was careˆplanned for smoking. The care plan indicated that the resident did not need supervision while smoking. The intervention required staff to keep the residents' cigarettes and lighters at the nurse's station. During an observation and interview on 6/8/26 at 1:00 PM, the resident entered the 300 hallway, went to the nurses' station, and signed in. She stated that she left the facility to smoke and kept her cigarettes and lighter with her. Resident #100 pointed to an open bag tied to her walker that contained her cigarettes and lighter. She also stated that she had been assessed as an unsupervised smoker and smoked near the bus stop without staff observation. During an interview on 6/8/26 at 1:10 PM, Nurse #7 stated that Resident #100 was cognitively intact, smoked, and could sign out to leave the facility to smoke. She stated the facility was smokeˆfree and was unsure where the smoking policy was located. She said Resident #100 was assessed as an unsupervised smoker at admission. Nurse #7 was unsure whether the resident could keep her smoking materials, as nursing staff had not received smoking policy instructions. During an interview on 6/9/26 at 8:05 AM, Nurse #8 stated that Resident #100 had signed out to smoke. Nurse #8 indicated he kept the resident's smoking materials locked in the medication cart and provided them upon request. Nurse #8 confirmed that he had given her the smoking materials that morning. On 6/9/26 at 8:10 AM, the resident returned to the 300 hallway. At 8:12 AM, she stated she typically kept smoking materials with her, but last night a nurse (name unknown) instructed her to place her smoking material in a labeled plastic bag to be stored on the medication cart. The resident showed a plastic bag with two cigarette packets and a lighter. The plastic bag had her name on it. Resident #100 stated she had not yet returned the smoking materials to her assigned nurse because the nurse was busy with medications. A continuous observation on 6/9/26 from 2:30 PM to 2:42 PM showed Resident #100 requesting her smoking materials from Nurse #8. Resident used a rolling walker to ambulate. She took the smoking material and left the facility using the farˆend elevator. At the bus stop, she sat on the bench with her rolling walker in front of her and smoked her cigarette. She ambulated back to the facility with her rolling walker. During an interview on 6/10/26 at 2:25 PM, the admission Director stated the facility was a tobaccoˆfree organization and residents and families were informed during admission. The information was also provided in the handbook that was given to the residents and family members. All tobacco products were prohibited inside the building. Nicotine cessation was offered to the residents. The admission Director indicated that there was no smoking agreement in the admission packet, however the information was in the handbook provided to the resident. (continued on next page)

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Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/26 at 3:00 PM, the Director of Nursing (DON) stated the facility was smokeˆfree but did admit residents who smoked. Nurses completed smoking observation assessments upon admission for resident who were current smokers and assessed whether the resident was a safe smoker. The DON stated the facility had five residents smoked and all were assessed as not requiring supervision. As the facility was smokeˆfree, residents signed out, retrieved their smoking materials from staff, and smoked at the bus stop. Upon return, they signed in and returned the smoking materials to staff. Smoking materials were stored in a locked Tacko box in the medication room. The DON stated no resident should keep smoking materials in their possession. She stated smoking assessments were completed quarterly or with changes in condition and that staff were verbally informed of the policy. Residents received cessation education materials. She reiterated that residents must sign-out before smoking and return materials afterward. During an interview on 6/12/26 at 4:04 PM, the Administrator stated the facility was smokeˆfree and residents and /or resident representatives were informed at admission. Residents who wished to smoke had to sign out and smoke beyond the bus stop. The facility had no designated smoking area and did not supervise residents who smoked. He stated residents sometimes denied smoking during admission but later began smoking. He stated smoking materials must be securely stored by staff and that his expectation was for staff to accurately document smoking status at admission, store materials safely, and ensure residents signed out before smoking. 2. Resident #104 was admitted to the facility 4/6/26. The admission Minimum Data Set assessment dated [DATE] assessed Resident #104 to be cognitively intact. Resident #104 was assessed to use tobacco products. Resident #104 was assessed to have full range of motion of his upper and lower body, he used a walker for ambulation, and he was independent for eating, hygiene, toileting, dressing, and mobility. A smoking assessment dated [DATE] assessed Resident #104 to be a safe smoker. A smoking assessment dated [DATE] assessed Resident #104 to be an unsupervised smoker completed by the Director of Nursing (DON). A care plan that addressed smoking was developed on 6/8/26. Interventions included to educate Resident #104 on the smoking policy and to keep his cigarettes and lighter at the nursing station. During a 6/8/26 interview and observation at 12:15 PM, Resident #104 reported when he wanted to smoke, he signed out and walked to a bus stop a few hundred feet away several times per day. Cigarettes and a lighter were observed in the open drawer of his bedside table, and he stated he kept his smoking materials in his room since his admission to the facility, and no one had told him he could not have the lighter and cigarettes in his room. An interview was conducted with the admission Director on 6/10/26 at 2:25 PM, and she indicated that the facility was a tobacco-free organization and the residents and family were made aware of this during the admissions. The information was also provided in the handbook that was given to the residents and family members. Tobacco and any form of tobacco products were prohibited in the building. Nursing assistant (NA) #7 was interviewed on 6/10/26 at 2:30 PM and she reported she was assigned to Resident #104, but she had not noticed smoking materials in his room. NA #7 further noted that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #104 was mostly independent and she did not spend a lot of time providing him care. During a follow^up interview and observation on 6/10/26 at 2:35 PM Resident #104 reported he had given staff his cigarettes and lighter for storage, yet three packs of cigarettes, two partially full and one empty, were observed in his open bedside table drawer. He stated the packs were nearly empty and said he did not understand why he could not keep them in his room. He confirmed he had been educated on the smoking policy and stated he could manage his own cigarettes and lighter. An interview was conducted on 6/10/26 at 3:00 PM with the Infection Preventionist Nurse and Nurse #6. When informed Resident #104 had cigarettes in his room, the Infection Preventionist stated, We just took his cigarettes from him, how did he get another pack? Nurse #6 stated, He just came up here and asked for his cigarettes and lighter to go outside to smoke. Nurse #6 noted that he had not observed smoking materials in Resident #104's room when he administered medication to him earlier in the day. During an interview with the Director of Nursing (DON) on 6/10/ 26 at 3:00 PM. The DON stated the facility was a smoke free facility and they do admit residents who smoke. Upon admission the Nurses complete a smoking assessment by observing the resident during smoking and assess if the resident was safe smoker. The DON stated the facility had 5 residents who were smokers and all were assessed as safe smokers. As the facility was a smoke free facility, when the residents want to smoke, they sign themselves out, take their smoking material from the nurses and go out of the facility. The DON explained residents smoke near the bus stop or sit on the bus stop bench and smoke. Upon returning they sign themselves back in and the smoking material are given to the assigned nurse. Smoking materials were stored in a tackle box in the medication room. The DON indicated no resident should be holding the smoking material with them. Smoking assessments were conducted quarterly and when there was change in condition. The DON stated the smokers in the facility were alert and oriented and would report to staff if they had any accidents. The DON reiterated that the facility was a smoke free facility and the staff were verbally notified about the smoking policy. The staff could access the policy through the policy tech platform. Residents were also provided with smoking cessation and education material. The DON was interviewed again on 6/11/26 at 1:30 PM. She reported Resident #104 willingly turned in his cigarettes and lighter for storage at the nursing station on Monday 6/8/26 and she was not aware he had additional cigarettes in his room. The DON reported she completed Resident #104's smoking assessment on 6/8/26. She stated a smoking assessment was completed on admission and a care plan for smoking was developed. She explained residents signed themselves out to smoke off the facility property, usually at the bus stop at the end of the drive, and family members could also sign residents out. She stated she expected all residents to be screened for smoking on admission, have a care plan if they smoke, and store all smoking materials at the nursing station. A phone interview was conducted with the Physician on 6/12/26 at 2:27 PM and he reported that the facility was non-smoking and no residents should have smoking materials in their room. Nurse Practitioner #3 was interviewed by phone on 6/12/26 at 2:48 PM and she reported residents with smoking materials were a safety concern and no residents should have smoking materials in their room. The Administrator was interviewed on 6/12/26 at 4:00 PM. He stated the facility was non^smoking and new admissions who smoked required a smoking assessment, a care plan, and storage of all (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking materials at the nursing station. He reported the smoking policy was explained during admission and he expected staff and residents to follow these procedures including the storage of smoking materials. 3. Resident #62 was admitted to the facility on [DATE] with a diagnosis of hemiplegia (paralysis affecting one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body), which affected his dominant right side. A review of the admission assessment dated [DATE] completed by Nurse #11 included an initial smoking assessment and revealed that Resident #62 was a former smoker, vaper, and smokeless tobacco user. The assessment further revealed he had a history of smoking but was not currently using tobacco. During an interview with Nurse #11 on 6/12/26 at 9:12 AM, she stated she could not recall completing Resident #62's initial admission assessment, including the smoking assessment. She explained that she typically asked new admissions whether they had a history of smoking or currently smoked and then documented their response. Nurse #11 reiterated that she did not remember completing Resident #62's assessment but assumed he must have reported that he was not a smoker. She added that she had never observed him, or any other residents, with cigarettes. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #62's cognition was intact and that he did not use tobacco. The assessment further revealed Resident #62 had functional limitation in range of motion on one side of his upper and lower extremities and was independent with propelling himself 150 feet in a wheelchair. A review of the care plan revised 5/25/26 revealed that Resident #62 did not require supervision with smoking due to the facility's nonˆsmoking policy. The stated goal was that he abided by the facility's smoking policy. Interventions included keeping cigarettes and lighters at the nurse's station. An observation conducted on 6/8/26 at 12:19 PM revealed that Resident #62 had a pack of cigarettes on his bed. A blue lighter and an orangeˆcolored vape device were also on his bedside table. Resident #62 reported that he had been smoking for years and had not stopped after being admitted to the facility. He stated he was not permitted to smoke on the premises and had been told he needed to go to the bus stop to smoke. Resident #62 reported that in the past he would go to the bus stop to smoke, but due to limitations from a previous stroke and the incline leading to the bus stop, it was difficult for him to propel himself there and back. He stated that it was easier for him to propel himself to the edge of the property, in the parking lot, to smoke. Resident #62 also reported that he keeps his smoking materials in a bag in his room. Review of the medical record revealed after 4/23/25 the next smoking assessment was completed by Nurse #12 on 6/8/26 and indicated that Resident #62 was determined to be safe as an unsupervised smoker. The assessment also documented that the facility's smoking policy was reviewed with him on 6/8/26. During an interview with Resident #62 on 6/10/26 at 9:44 AM, he reported that he had continued to smoke cigarettes since his admission to the facility and had always kept his cigarettes and lighter with him. He further stated that staff took his vape on Monday (6/8/26) but told him he could retrieve it when he went outside, provided he returned it afterward. He reported that he forgot to return the vape on Tuesday (6/9/26) and had left it on his bed that morning when a staff member removed it (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from his room. Resident #62 stated that upon admission, he was informed that the facility was nonˆsmoking and that if he wanted to smoke, he needed to go to the bus stop beside the facility to ensure he was off the premises. An observation on 6/10/26 at 11:04 AM revealed Resident #62 sitting in his wheelchair on the left side of the facility at the edge of the parking lot, approximately 150 feet from the facility entrance, smoking. An observation on 6/10/26 at 11:08 AM was made of the bus stop located in front of the facility. The bus stop is approximately 100 feet to the right of the facility entrance. It is situated on the right side of the roadway and was connected to the facility parking lot by a sidewalk. There was a small incline from the parking lot up to the sidewalk. An interview conducted on 6/10/26 at 11:18 AM with Nurse #15 revealed that the facility was a nonˆsmoking facility and that any residents who chose to smoke must go off the premises to do so. She stated residents were directed to go to the bus stop beside the facility. Nurse #15 explained that smoking assessments were only completed during the initial admission assessment because the facility was nonˆsmoking. She reported she was not aware of any residents who had been grandfathered in as being permitted to smoke. Nurse #15 further stated that although new admissions were informed the facility was nonˆsmoking, once they observed other residents going outside to smoke, they would often begin doing the same. An interview conducted on 6/10/26 at 12:34 PM with the Social Services Director revealed that the facility was a nonˆsmoking facility and that residents were informed of this at the time of admission. She stated that if residents chose to smoke, they must go off campus to do so. The Social Services Director explained that she assisted in ensuring residents who smoked were included in the care plan but did not participate in smoking observations. She further stated that staff should not be taking residents to smoke and that, if residents were unable to leave the campus independently, their families would need to take them. She added that smoking materials were not permitted in residents' rooms and should be stored at the nurses' station. During an interview with the Admissions Director on 6/10/26 at 2:25PM, she stated that the facility was a tobaccoˆfree organization and that residents and their families were informed of this during the admission process. She explained that this information was also included in the handbook provided to residents and family members. An interview conducted on 6/12/26 at 1:23 PM with Nurse #12 revealed that she was from a sister facility and had been assisting in the facility since 6/8/26 when she was asked to create a notebook listing all residents who smoked on each unit, to be kept at the nurses' station. The purpose of the notebook was to ensure staff were aware of which residents were smokers. Nurse #12 stated that Resident #62 was oriented and able to answer the assessment questions and used return demonstration to evaluate his smoking safety. During an interview with the Director of Nursing on 6/12/26 at 12:18 PM, she explained that although the facility was nonˆsmoking, a smoking assessment should be completed at the time of admission and whenever the facility became aware that a resident was smoking. She further stated that no residents should have smoking materials in their possession and that such items should be kept at the nurses' desk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator was conducted on 6/12/26 at 3:24 PM. He stated that although the facility was a nonˆsmoking facility, he expected a smoking assessment to be completed for each resident upon admission and again whenever the facility became aware that a resident was smoking. The Administrator further stated that it was his expectation that smoking materials be kept at the nurses' desk and that no residents should have smoking materials in their rooms. 4. Resident #99 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). A review of Resident #99's quarterly Minimum Data Set (MDS) dated [DATE] revealed that she was cognitively intact and was receiving supplemental oxygen therapy while residing in the facility. A review of Resident #99's physician orders revealed an order dated 6/3/26 for supplemental oxygen at 3 liters per minute, to be administered continuously, for COPD. On 6/10/26 at 2:55 PM, an observation was made of Resident #99 sitting on the side of her bed, wearing continuous oxygen via nasal cannula at a flow rate of 3 liters per minute. Two additional oxygen cylinders were also observed in Resident #99's room. One full cylinder was standing upright in a transport caddy beside the bed. The second full cylinder was stored in a canvas bag designed to secure oxygen tanks to the back of wheelchairs; however, it was leaning against the right side of a stationary chair and was not secured. On 6/10/26 at 3:13 PM, Nurse #10 was notified by the surveyor that an oxygen cylinder in Resident #99's room was unsecured. Nurse #10 confirmed the oxygen cylinder was full. She immediately removed the unsecured cylinder and returned the full cylinder to the designated oxygen storage closet. During an interview on 6/10/26 at 3:15 PM, Nurse #10 confirmed she was Resident #99's assigned nurse that day. Nurse #10 reported that portable oxygen cylinders were stored in a designated locked closet on each floor of the facility. She stated that nurses had keys to the oxygen storage area on each unit. Nurse #10 explained that empty oxygen cylinders were stored upright in individual holders on the left side of the oxygen closet, while full cylinders were stored upright in individual holders on the right side. She further stated that when an oxygen cylinder was taken to a resident's room, it should be transported in an upright position using a secured individual caddy. She added that when oxygen cylinders were stored in canvas bags, the bag should be secured to the wheelchair with the cylinder kept upright. Nurse #10 acknowledged that someone had removed the canvas bag containing an oxygen cylinder from Resident #99's wheelchair and had leaned it against a stationary chair in the room. She stated it was unsafe for an oxygen cylinder to be left leaning on its side and unsecured. Nurse #10 explained that staff had been trained that oxygen cylinders should be stored upright and secured in individual holders. She reported that she had not observed the oxygen cylinder in Resident #99's room when she administered medication earlier that day. On 6/10/26 at 3:20 PM, an interview was conducted with the Unit Manager, who explained that oxygen cylinders should be stored upright in holders within the designated oxygen storage closet. The Unit Manager stated that she had not noticed the oxygen cylinder stored in Resident #99's room on 6/10/26. During an interview with the Director of Nursing (DON) on 6/12/26 at 12:27 PM, she explained that oxygen cylinders should be stored in the designated oxygen storage closet, and if a cylinder was (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Pharmacist, Medical Director and staff interviews, the facility failed to prevent a significant medication error when lacosamide and zonisamide (anticonvulsant medications used to treat epilepsy) were transcribed and administered to Resident #127 incorrectly. This was for 1 of 10 residents (Resident #127) whose medications were reviewed. The findings included: Resident #127 was originally admitted to the facility on [DATE] with diagnoses that included traumatic brain injury and post traumatic seizures. He was readmitted to the facility on [DATE] after a hospitalization for seizure activity.A physician order dated 01/06/25 read; zonisamide suspension (used to treat seizures); 10 milligrams (mg)/milliliter (ml); amount to administer: 4ml (40 mg) via gastric tube at bedtime for seizures. Order discontinued on 10/29/25.Another physician order dated 01/06/25 read; lacosamide solution (used to treat seizures); 10 mg/mL; amount to administer: 5ml (50mg) via gastric tube twice a day at 9:00 AM & 9:00 PM. Order discontinued on 10/29/25.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #127's cognition was severely impaired. Resident #127 received scheduled anticonvulsant medications during the MDS review period.Resident #127's verified Hospital Discharge summary dated [DATE] revealed he was sent to the emergency department (ED) on 10/27/25 due to seizure activity and was discharged back to the facility on [DATE]. The new anticonvulsant medication orders included the following: zonisamide suspension; 20mg/ml; amount to administer: 5ml (100mg) via gastric tube at bedtime, start date: 10/29/25 and lacosamide solution; 10 mg/ml; amount to administer: 10ml (100mg) via gastric tube every 12 hours, start date: 10/29/25.A physician order dated 10/29/25 read: zonisamide suspension; 10mg/ml; amount to administer: 10ml (100 mg) via gastric tube at bedtime for seizures at 9:00 PM.Another physician order dated 10/29/25 read: lacosamide solution; 10 mg/mL; amount to administer: 10ml (100mg) via gastric tube every 12 hours at 9:00 AM & 9:00 PM.Resident #127's October 2025 Medication Administration Record (MAR) revealed the following medication orders were entered into the electronic medical record (EMR): -Order dated 10/29/25 zonisamide suspension; 10mg/ml; amount to administer: 4ml (100mg) via gastric tube at bedtime for seizures at 9:00 PM. Order discontinued on 10/31/25. The correct dose of zonisamide 100 mg was initialed as given on 10/30/25.-Order dated 10/30/25: zonisamide suspension; 10mg/ml; amount to administer: 10ml (100mg) via gastric tube at bedtime for seizures at 9:00 PM. Order discontinued on 10/31/25. The correct dose of zonisamide 100 mg was initialed as given on 10/30/25.-Order dated 10/31/25: zonisamide suspension; 10mg/ml; amount to administer: 4ml (40mg) via gastric tube at bedtime for seizures at 9:00 PM. The MAR was initialed as the incorrect dose was given on 10/31/25.A physician order dated 11/20/25 read; zonisamide oral suspension; 10mg/ml; amount to administer: 10ml (100mg) via gastric tube at bedtime for seizures per neurology.Further review of Resident #127'2 October 2025 MAR revealed the following medication orders were entered into the EMR:- Order dated 10/29/25: lacosamide solution; 10 mg/mL; amount to administer: 10ml (100mg) via gastric tube every 12 hours at 9:00 AM & 9:00 PM. Order discontinued on 10/30/25. The MAR was initialed as the correct dose being given on 10/29/25 and 10/30/25. -Order dated 10/30/25: lacosamide solution; 10 mg/mL; amount to administer: 5ml (50mg) via gastric tube every 12 hours at 9:00 AM & 9:00 PM. Order discontinued on 11/02/25. The MAR was initialed as the incorrect dose being given on 10/31/25.A review of Resident #127's November 2025 MAR revealed the following medication orders were entered into the electronic medical record (EMR):-Order dated 10/31/25: zonisamide suspension; 10mg/ml; amount to administer: 4ml (40mg) via gastric tube at bedtime for seizures at 9:00 PM. The MAR was initialed as the incorrect dose being given 11/01/25 through 11/20/25.-Order dated 11/20/25: zonisamide oral suspension; 10mg/ml; amount to administer: 10ml (100mg) via gastric tube at bedtime for seizures per neurology. The MAR was initialed as the correct dose given 11/21/25 through the end of the month.-Order dated 10/30/25: lacosamide solution; 10 mg/mL; amount to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administer: 5ml (50mg) via gastric tube every 12 hours at 9:00 AM & 9:00 PM. Order discontinued on 11/02/25. The MAR was initialed as the incorrect dose was given on 11/01/25 through 11/02/25.-Order dated 11/02/25: lacosamide solution; 10 mg/mL; amount to administer: 10ml via gastric tube Every 12 hours at 9:00 AM & 9:00 PM. The MAR was initialed as the correct dose given 11/02/25 through the end of the month.An interview was conducted on 06/11/26 at 9:47 AM with the Director of Nursing (DON). The DON stated that during a review of Resident #127's admission orders on 10/30/25 she revealed the anticonvulsant medication orders appeared to be incorrect. The DON explained that the orders that the admitting nurse (Assisted Director of Nursing) had entered into the electronic Medication Administration Record (eMAR) on 10/29/25 included zonisamide oral suspension; 10 milligrams (mg)/milliliter (ml); amount to administer: 100 mg via gastric tube at bedtime and lacosamide solution; 10 mg/mL; amount to administer: 10 ml via gastric tube every 12 hours. The DON went on to say that she compared those orders to the 8 page preliminary discharge summary that had been received from the hospital prior to the arrival of Resident #127. The DON then stated the orders listed on the preliminary discharge summary included zonisamide oral suspension; 10mg/ml; amount to administer: 40 mg; via gastric tube at bedtime for seizures (give 4ML) and lacosamide solution; 10 mg/mL; amount to administer: 5 ml; (50 ml) via gastric tube every 12 hours for seizures. The DON indicated she did not realize she was viewing the preliminary discharge summary, not the final verified discharge summary. The DON then stated she changed the two anticonvulsant medication orders for Resident #127 to match the preliminary hospital discharge summary on 10/30/25. During a review of the preliminary discharge summary with the DON, she verified that there was a note that revealed Resident #127 was hospitalized from [DATE] through 10/29/25 due to seizure activity. The DON also verified a note above the medication list read: Changes Made to Medications: increased lacosamide and zonisamide following subtherapeutic levels. The DON explained that although on the preliminary discharge summary had a note that read that Resident #127 was in the hospital for seizure activity and that his zonisamide and lacosamide were increased during the hospital stay due to increased seizures she did not confer with the admitting nurse or call the hospital to clarify the anticonvulsant medication orders. The DON indicated she should have reviewed the verified finale discharge summary for the correct orders.An interview was conducted on 06/11/26 at 10:09 AM with the Assistant Director of Nursing (ADON). The ADON stated she was the admitting nurse for Resident #127 on 10/29/25 and she entered the admission orders per the final verified discharge summary. The ADON obtained Resident #127's discharge summary and demonstrated and explained her steps when transcribing Resident #127's medications. She explained the finale orders were located at the bottom of the discharge summary which had a heading that read Your medication list: START taking these medications: zonisamide 20mg/ml oral suspension; take 5mls (100mg total) by G tube at bedtime. These medications have changed: lacosamide 10mg/ml; take 10mls (100mg total) by G tube every 12 hours. The ADON correctly demonstrated and transcribed the correct orders and was unsure why the DON had changed them back to the orders that Resident #127 was on prior to the hospitalization. A phone interview was conducted on 06/11/26 at 11:30 AM with the Medical Director (MD). He stated he could not recall the exact date but he was made aware of the medication error for Resident #127's lacosamide and zonisamide orders after admission. The MD indicated that although the potential for significant side effects were possible such as increased seizures, Resident #127 did not exhibit any ill effects due to the medications being entered on 10/30/25 for the incorrect amount. The MD did expect the nursing staff to follow the finale verified discharge summary when a resident was admitted . A phone interview was conducted on 06/11/26 at 1:19 PM with Nurse Practitioner (NP) #1. NP #1 reported that she did not know the DON was reviewing Resident #127's preliminary discharge summary when she adjusted his anticonvulsant medication orders on 10/30/25. She explained that she expected all medication orders to be taken from the final, verified discharge summary, and indicated that any questionable medication should have been clarified directly with the prescribing hospital physician. NP #1 reported recalling a phone (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call from the neurologist on or around 11/20/25 to discuss the resident's medication orders but stated she could not remember the specific details of that conversation.A phone interview was conducted on 06/12/26 at 9:56 AM with the Pharmacist. The Pharmacist explained that Resident #127 was on another anticonvulsant medication and although zonisamide suspension was given at a lower dose than ordered, there was a potential for ill effects, but it was unlikely. The Pharmacist also explained that Resident #127 had been on the medication for a while and it would take time for it to leave the body.An interview was conducted on 06/12/26 at 3:35 PM with the Administrator. The Administrator stated he expected the nursing staff to use the verified finale discharge summary when reviewing and conducting the second check on admissions/readmissions to ensure the correct medication orders were carried out.

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Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on record review and interviews with the Registered Dietitian, staff and 5 of 5 residents present in the Resident Council Group Meeting (Resident #17, Resident #4, Resident #85, Resident #91 and Resident #92) the facility failed to serve a nourishing snack to residents at bedtime.Findings included:A review of the scheduled mealtimes provided by the facility revealed the time between dinner (the evening meal) and breakfast the following day was 15 hours.On 06/9/26 at 11:30 AM a Resident Council meeting was conducted with 5 cognitively intact members of the Resident Council (Resident #17, Resident #4, Resident #85, Resident #91 and Resident #92). All 5 members stated they were not regularly offered a snack at bedtime but could get one if they asked. The residents reported they had not approved of a time of greater than 14 hours between the dinner meal and breakfast the next morning.On 06/9/2026 at 7:33 PM Nurse Aide (NA) #1 was observed delivering snacks on the 100 Hall. She reported she had worked at the facility for 15 years on the 3:00 PM to 11:00 PM shift. She stated that the snacks currently present on the snack cart, which were observed to be vanilla and chocolate ice cream, crackers, fig bar cookies, oatmeal pies, vanilla pudding, apple sauce, fruit juice, and zero sugar ginger ale were the usual snacks that were available for the evening. She indicated she normally passed these around to all residents at about 8:00 PM giving them a choice of what was available. She reported although she didn't offer sandwiches, sometimes a resident would ask for one, which were available in the kitchenette on the first floor. She stated sometimes a resident would ask for a sandwich if they didn't eat all of their dinner meal, but tonight everyone had eaten well, and no one had asked. An observation of the 100 Hall kitchenette refrigerator with NA #1 during this interview revealed there were no sandwiches. She reported there was no other place for sandwiches to be kept on the first floor, but if a resident asked for a sandwich and there weren't any in this kitchenette, she had in the past gone down to the kitchen and there were some available there. On 06/9/2026 7:36 PM an interview with Nurse #1 on the 100 Hall indicated she had worked at the facility for 3 years. She stated she was working the 3:00 PM to 11:00 PM and reported that for evening snacks, there were normally cookies, cakes, crackers, and sweets. She reported that if there were currently no sandwiches available, she did not know if the kitchen would be bringing any up. On 06/09/2026 at 7:51 PM Dietary Aide #1 was interviewed in the kitchen. She reported she had been a dietary aide at the facility for about 1 and a half years. She indicated her shift was normally 11:00 AM to 7:00 PM, and she was just finishing up in the kitchen for the day. She reported the NAs would bring the snack cart down for their unit in the mornings, to be stocked with snacks for the day which included cookies, cakes, crackers, and soda including sugar free. She stated the kitchen made turkey and cheese sandwiches for the residents daily which were sent up to the floors around 1:00 PM. She indicated these sandwiches were sent to the 100 Hall as they had a refrigerator, and some extras were sent to 300 Hall, but none were sent to the 200 Hall because that floor did not have a refrigerator. She reported that she thought the NAs were all aware of where the sandwiches were kept. Dietary Aide #1 stated no other snacks were sent up, but if staff needed extra snacks or sandwiches, they could access the reach in cooler after the dietary staff left for the day. An observation of the reach in cooler with Dietary Aide #1 during this interview revealed there were no sandwiches. She stated everything that was going to be sent for the day had already been sent, and the dietary staff would not be making any more sandwiches or sending anything else up to the halls this evening. On 06/9/2026 at 8:07 PM an interview with NA #2 on the 200 Hall indicated she had worked at the facility for about 8 months. She stated she normally worked from 2:00 PM to 10:00 PM. She reported snacks were available in the snack carts on the unit, and when she distributed these, she would go to each resident and offer the snacks. She indicated snacks included zero sugar soda, fruit juices, crispy rice treats, and crackers. NA #2 stated there were no sandwiches available for (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents normally. She reported that she had not provided snacks this evening as she had come in early today, so she was on her way out. An observation of the 200 Hall snack cart with NA #2 during this interview revealed of it contained rice crispy treats, oatmeal pies, crackers and fruit juices. In an interview on 06/9/2026 at 8:15 PM NA #3 on the 200 Hall she reported she had been at the facility for 10 months and worked on the 3:00 PM to 11:00 PM shift. She stated she normally passed out evening snacks at about 8:00 PM but had not done so yet on the 200 Hall. She reported there were no sandwiches available on the evening shift. She indicated if a resident asked for a sandwich, she told them there weren't any.On 6/9/26 at 8:28 PM in an interview with NA #4 on the 300 Hall he reported that snacks came from the dietary department on a cart and he went around and offered these to residents in the evening. An observation of the 300 Hall snack cart with NA #4 during the interview revealed it contained crackers, cookies, fruit juice, and sugar free soda. He stated this was the normal evening snack available for residents. He indicated sometimes there were sandwiches in the refrigerator on the 300 Hall, but there weren't any tonight. He stated if a resident asked for a sandwich, and there weren't any available on his floor, sometimes he would go to another floor to see if they had some. He indicated no one had asked for a sandwich this evening. On 06/10/2026 at 10:44 AM in an interview with Resident #91 who resided on the 200 Hall he stated he was not offered a snack last night (06/09/2026) before bed. He reported last year they used to do this, but not this year. He reported got offered snacks in the daytime like rice crispy treats, cookies, and brownies. He indicated at times, he did get hungry between dinner and breakfast the next morning. He stated he could get a snack if he asked, he did not ask for one last night. On 06/10/2026 at 10:54 AM an interview with Resident #4 who resided on the 200 Hall revealed he had not been offered a snack last night (06/09/2026). He reported he had a bag of unsalted chips from his personal supply, and he ate that.On 06/10/2026 at 11:04 AM an interview with Resident #17 who resided on the 100 Hall revealed that he had been offered a snack last night (06/09/2026) at bedtime, it was an applesauce. On 06/10/2026 at 11:09 AM an interview with Resident #92 who resided on the 300 Hall revealed she was offered drinks and cookies last night (06/09/2026) but she usually tried not to eat anything before bed. She reported she did not want a snack last night. She stated sometimes she did get hungry between dinner and breakfast, but she had some candy with nuts in it, and cookies that she kept at her bedside.On 06/10/2026 at 11:19 AM an interview with Resident #85 who resided on the 200 Hall revealed he was not offered a snack last night (06/09/2026) before bed. He reported he got hungry sometimes between supper and breakfast, but he was not hungry last night as he had not been feeling well. He stated there weren't ever any sandwiches available on his hall. He indicated he got tired of crackers for snack.On 06/10/2026 at 10:38 AM in a telephone interview with the facility's Registered Dietitian (RD) she stated that it was hard for her to say whether or not the snacks that were available, which included crackers, cookies, applesauce, fruit juices, and zero sugar soda constituted a nourishing bedtime snack. She reported a nourishing snack would include a combination of fats, protein and complex carbohydrates. On 06/10/2026 at 10:49 AM in a follow up telephone interview the RD reported she knew the facility's mealtime from dinner to breakfast the next morning exceeded 14 hours. She stated based on the snacks that were available, if a resident chose more than one option, it could possibly constitute a nourishing bedtime snack.On 06/10/2026 at 2:30 PM in an interview the Director of Nursing (DON) stated that she would not consider cookies, rice crispy treats, crackers, and soda a nourishing bedtime snack. She reported at one point in time there were sandwiches available for a bedtime snack; she could not say how long ago that was. She indicated she thought the sandwiches were being brought up to the halls for residents, but were all getting eaten before dinner.On 6/10/26 at 4:39 PM an interview with the Administrator revealed he did not think crackers, and cookies were a nourishing bedtime snack. He stated the process was supposed to be that staff should go to either the first floor or to the kitchen where they could obtain sandwiches for residents' bedtime snack because there was more than 14 hours between the dinner meal and breakfast the next morning at the facility. He reported sandwiches would be a nourishing snack, and (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he thought the facility had sandwiches available. The Administrator stated if no sandwiches were available on 06/09/2026 for the bedtime snack, it was possible that during the day, residents had eaten all the sandwiches that were provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident and staff interviews, the facility failed to maintain complete and accurate medical records for wound care (Resident #4, Resident #17, and Resident #76) for 3 of 6 residents reviewed for wound care. Findings Included: 1a. Review of the April 2026 Medication Administration Record (MAR) revealed treatment for the pressure ulcer to the left ischium was documented by Nurse #6 on 04/20/26, 04/21/26, 04/25/26, 04/26/26, and 04/27/26. Review of the May 2026 Medication Administration Record (MAR) revealed treatment for the Stage 4 pressure ulcer to the left buttock/ischium was documented by Nurse #6 on 05/26/26, 05/27/26, 05/28/26, and 05/29/26. Review of the June 2026 Medication Administration Record (MAR) revealed treatment for the Stage 4 pressure ulcer to the left buttock/ischium was documented by Nurse #6 on 06/01/26, 06/02/26, 06/03/26, 06/09/26, 06/10/26, and 06/11/26. The Wound Nurse documented the treatment on 06/04/26. On 06/09/2026 at 2:25 PM, an interview was conducted with the Wound Nurse. The Wound Nurse stated she was responsible for providing wound care in accordance with the wound physician's orders. When asked why she had not documented wound treatments on the MAR during April, May, and June 2026, the Wound Nurse stated she performed the wound treatments but often forgot to document them. The Wound Nurse stated Nurse #6 would sometimes sign the MAR on her behalf when she had not completed the documentation. The Wound Nurse explained Nurse #6 would document the treatment so he could continue with his own documentation responsibilities. When asked to identify the specific dates Nurse #6 documented wound treatments on her behalf, the Wound Nurse stated she could not recall the dates; however, she stated the lack of documentation by her occurred beginning around the end of May 2026. The Wound Nurse acknowledged that although she provided the wound care, the MAR documentation reflected Nurse #6 as the individual who completed the treatment. On 06/09/2026 at 2:43 PM, an interview was conducted with Nurse #6. When asked about documentation of wound care on the MAR for April, May, and June 2026, Nurse #6 stated the facility was understaffed and had only one Wound Nurse. Nurse #6 stated the Wound Nurse would sometimes fall behind on documentation. Nurse #6 stated that, as a result, he would sometimes document wound treatments on the MAR after verbally confirming with the Wound Nurse that the wound care had been completed. Nurse #6 stated he would occasionally verify the treatment had been completed by observing the wound or verbally asking the Wound Nurse. Nurse #6 stated there were also times when he personally completed the wound care. Nurse #6 acknowledged it was not best practice to document care performed by another staff member and stated it was the responsibility of the individual providing the wound care to complete their own documentation. b. Review of the Nurse Practitioner (NP) progress note dated 5/4/26 revealed Resident #17 had a history of an enterocutaneous fistula (EC fistula), urostomy, and colostomy. The physical examination documented two ostomies with leakage and a chronic fistula. The NP further documented the fistula (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was draining stool and that dressing changes were being performed by the wound nurse. However, under the integumentary assessment, the NP documented the exposed skin appeared clean, dry, and intact and indicated no open wounds were noted. On 06/12/2026 at 9:00 AM, an interview was conducted with the Nurse Practitioner (NP) regarding Resident #17's pressure ulcer. The NP stated she became aware of the pressure ulcer upon Resident #17's admission to the facility on 4/20/26 after reviewing the hospital discharge summary. The NP stated she assessed Resident #17 on 5/4/26 and observed the wound at that time. When informed that her progress note dated 5/4/26 documented no wounds, the NP stated the documentation was incorrect. The NP stated she should have completed an addendum to correct the record. The NP stated the addendum was not completed because she could not bill for it. On 06/12/2026 at 4:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for documentation is that staff document care as it is provided and enter documentation as soon as possible. The DON stated it was unacceptable for staff to delay documentation, including documentation that remained incomplete following a weekend shift. The DON stated staff were not permitted to document care performed by another staff member and that doing so would result in disciplinary action for both employees involved. The DON stated staff could not document care performed by another staff member even if they received a verbal confirmation that the care had been completed. The DON stated he had not been aware that staff were documenting wound care on behalf of the Wound Nurse. Upon review of the information, the DON stated such practice would constitute false documentation and was not consistent with facility expectations. On 06/12/2026 at 4:45 PM, an interview was conducted with the Administrator. The Administrator stated he was unaware that Nurse #6 had documented wound care on the MAR on behalf of the Wound Nurse. The Administrator stated each staff member was responsible for documenting the care and services they personally provided. The Administrator stated staff should not document care performed by another employee, regardless of whether they received verbal confirmation that the care had been completed. The Administrator stated documentation was expected to be accurate and reflect the care actually provided to the resident. Upon review of the information, the Administrator stated documenting care on behalf of another staff member was not consistent with facility expectations. 2. Resident #76 was readmitted to the facility 5/25/26. Review of the physician orders revealed an order dated 5/25/26 for wound care to be completed to the wound on the lower right leg: cleanse with antiseptic wound cleanser, apply Medihoney (a topical medication which creates a moist, acidic environment that promotes healing, naturally debrides dead tissue, and possesses antibacterial properties to combat infections) to the wound, apply a silicone bordered foam, change dressing every 3 days and as needed. a. A skin care assessment completed on 5/25/26 noted a skin tear to the right lower leg with an intact dressing and wound care ordered. Review of the Treatment Administration Record (TAR) for June 2026 revealed the wound care was documented as completed on 6/6/26 by Nurse #9. Resident #76 was observed on 6/8/26 at 11:35 AM in conjunction with an interview with the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound dressing was noted on her right lower leg. Written on the wound dressing was 6/5/26. Resident #76 reported she had a skin tear on her lower right leg and staff were changing the dressing every couple of days. During a phone interview with Nurse #9 at 6/10/26 at 1:38 PM, she reported she did not change the dressing to Resident #76's right lower leg on 6/6/26 and she did not know why her initials were on the Treatment Administration Record because she did not complete wound care. b. A skin assessment for Resident #76 dated 6/8/26 documented by Nurse #11 under alterations in skin none and under skin treatments none. An interview with Nurse #11 was conducted on 6/12/26 at 3:01 PM. The nurse reported she did not recall documenting none under Resident #76's skin assessment and reported if Resident #76 had a wound dressing, it should have been documented. The Director of Nursing (DON) was interviewed on 6/11/26 at 1:03 PM and she reported she was not certain why the nurse documented the wound care as completed if she did not complete the wound care and did not know why the wound or the dressing was not documented on 6/8/26. An interview was conducted with the Administrator on 6/12/26 at 4:00 PM. The Administrator reported he did not know why the nurse's initials were on the Treatment Administration Record. The Administrator did not know why the wound or wound dressing was not documented on the 6/8/26 assessment. The Administrator reported it was his expectation that staff accurately documented care provided. 3. Resident #4 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #4 was cognitively intact. A review of the hospital Discharge summary dated [DATE] revealed discharge orders for wound care included: Cleanse the wound with wound cleanser. Apply noˆsting barrier film to protect the periwound skin (skin surrounding the wound edge). Apply Aquacel (silver hydrofiber dressing that absorbs excess moisture and protects from bacteria) to the wound, ensuring it is gently packed into the depth. Palpate for the coccyx, then apply a sacralˆshaped foam dressing positioned to cover both the sacral wound and the coccyx area. Change every 2 days and as needed for soiling. A review of the physician's orders revealed that there were no woundˆcare orders for Resident #4 during February 2026. On 3/4/26, the Wound Care Nurse added an order for sacral pressure ulcer care. A review of the February 2026 Medication Administration Record (MAR) showed that from February 7 through February 28, 2026, there was no wound care order in place for treatment of Resident #4's sacral wound. The MAR also indicated that wound care was not documented as completed during this period. A review of the March 2026 Medication Administration Record (MAR) revealed that on March 1, 2, and 3, 2026, there was no wound care order in place for treatment of Resident #4's sacral wound. The (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MAR also showed that wound care was not documented as completed on those same dates. During an interview with Resident #4 on 6/10/26 at 9:33 AM, he stated that facility staff had provided wound care and applied a dressing to his sacral wound daily since his admission on [DATE]. During an interview with the Wound Care Nurse on June 12, 2026, at 8:51 AM, she explained that the Unit Manager typically entered admission orders into the medical record based on the hospital discharge summary. However, if the Unit Manager was assigned to a medication cart, the nurse admitting the resident was responsible for entering the orders. The February 2026 orders were reviewed with the Wound Care Nurse, and she confirmed that there were no treatment orders in the medical record for Resident #4. She also confirmed that the first wound care orders were entered by her on March 4, 2026. She stated that she did not know what happened or why the orders were missing. The Wound Care Nurse further explained that if wound treatment orders were included in the hospital discharge summary, the admitting nurse should have entered them into the medical record. She recalled providing wound care to Resident #4 immediately after admission and throughout February 2026. She added that she must have received a copy of the hospital discharge summary containing the wound care orders and provided care according to those orders, but she did not enter them into the medical record. An interview with the Unit Manager was conducted on June 12, 2026, at 9:38 AM. She stated that she did not enter the admission orders for Resident #4. She also confirmed that if wound care orders were included in the hospital discharge summary, they should have been entered into the medical record. During an interview on June 12, 2026, at 10:12 AM, Nurse #9 stated that she was the nurse who entered Resident #4's admission orders. She explained that she obtained the orders from the hospital discharge summary but could not recall whether wound care orders were included. She acknowledged that she did not enter any wound care orders but stated that she would have notified the Wound Care Nurse that the resident had a wound and needed wound care orders. Nurse #9 added that she knew the Wound Care Nurse would obtain the wound care orders. An interview with the Medical Director was conducted on June 12, 2026, at 11:51 AM. He stated that he was unsure why there was no wound care documentation for Resident #4 until March 4, 2026. He indicated that he would expect the facility to enter any wound care orders provided in the hospital discharge summary into the medical record. He added that if no wound care orders were included, he would expect the facility to contact the physician to obtain appropriate orders. An interview with the Director of Nursing (DON) was conducted on June 12, 2026, at 12:18 PM. She stated that she was unsure why wound care orders were not entered when Resident #4 was admitted on [DATE]. She explained that her expectation was for the admitting nurse to enter any wound care orders listed on the hospital discharge summary into the medical record. If no wound care orders were provided, the admitting nurse should immediately contact the physician to obtain them. The DON added that she expected wound care to be provided as ordered and documented as completed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Pharmacist, resident, responsible party (RP) and staff interviews, the facility failed to provide education regarding the benefits and potential side effects of the influenza immunization with documentation in the medical record and failed to offer the influenza immunization during the influenza season (October to March) for 6 of 7 residents reviewed for influenza immunization (Residents #38, #39, #56, #71, #77 and #121). The findings included: The facility's policy and procedure on influenza immunizations dated [DATE] was reviewed. The policy stated, in part, all patients who had no medical contraindications to the vaccine would be offered the influenza vaccine annually. The policy further indicated that the facility would provide pertinent information about the significant risks and benefits of the vaccine to patients and/or family members. Additionally, the policy read that current and newly admitted patients would be offered the influenza vaccine beginning on [DATE]st of each year, it would be offered for as long as the influenza viruses were circulating, and unexpired vaccine was available. A. Resident #38 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #38 had moderately impaired cognition. The influenza question regarding whether Resident #38 received the vaccine in the facility was marked no and the reason was coded as not offered. Resident #38's medical record revealed there was no documentation in the Electronic Medical Record (EMR) system or hard chart, to indicate whether Resident #38 or her responsible party (RP) had received education regarding the benefits and the potential side effects of the influenza vaccine for the influenza season of [DATE] to [DATE]. In addition, there was no documentation to indicate whether Resident #38 received or refused the influenza vaccine from [DATE] to [DATE]. Attempts to contact Resident #38's RP were unsuccessful. B. Resident #39 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #39 had severely impaired cognition. The influenza question regarding whether Resident #39 received the vaccine in the facility was marked no and the reason was coded as not offered. Resident #39's medical record revealed there was no documentation in the EMR system or hard chart, to indicate whether Resident #39 or her RP had received education regarding the benefits and the potential side effects of the influenza vaccine for the influenza season of [DATE] to [DATE]. In addition, there was no documentation to indicate whether Resident #38 received or refused the influenza vaccine from [DATE] to [DATE]. A phone interview occurred with Resident #39's RP on [DATE] at 12:29 PM, who stated they could not recall if the facility provided education and an opportunity for Resident #39 to receive the influenza vaccine for the most recent influenza season. C. Resident #56 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #56 was cognitively intact. The influenza question regarding whether Resident #56 received the vaccine in the facility was marked no and the reason was coded as not offered. Resident #56's medical record revealed there was no documentation in the EMR system or hard chart, to indicate whether Resident #56 or her RP had received education regarding the benefits and the potential side effects of the influenza vaccine for the influenza season of [DATE] to [DATE]. In addition, there was no documentation to indicate whether Resident #56 received or refused the influenza vaccine from [DATE] to [DATE]. A phone interview occurred with Resident #56's RP on [DATE] at 12:24 PM, who stated they could not recall being provided education or an opportunity for Resident #56 to receive the influenza vaccine for the most recent influenza season. An interview was conducted with Resident #56 on [DATE] at 1:45 PM. The resident could not recall being provided education or an opportunity to receive the influenza vaccine for the most recent influenza season. D. Resident #71 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #71 had severely impaired cognition. The influenza question regarding whether Resident #71 received the vaccine in the facility was marked no and the reason was coded as not offered. Resident #71's medical record revealed (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no documentation in the EMR system or hard chart, to indicate whether Resident #71 or his RP had received education regarding the benefits and the potential side effects of the influenza vaccine for the influenza season of [DATE] to [DATE]. In addition, there was no documentation to indicate whether Resident #71 received or refused the influenza vaccine from [DATE] to [DATE]. A phone interview occurred with Resident #71's RP on [DATE] at 12:31 PM and stated he could not recall being provided education or an opportunity for Resident #71 to receive the influenza vaccine for the most recent influenza season. E. Resident #77 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #77 had severely impaired cognition. The influenza question regarding whether Resident #77 received the vaccine in the facility was marked no and the reason was coded as not offered. Resident #77's medical record revealed there was no documentation in the EMR system or hard chart, to indicate whether Resident #77 or her RP had received education regarding the benefits and the potential side effects of the influenza vaccine for the influenza season of [DATE] to [DATE]. In addition, there was no documentation to indicate whether Resident #77 received or refused the influenza vaccine from [DATE] to [DATE]. A phone interview occurred with Resident #77's RP on [DATE] at 12:37 PM and stated he could not recall being provided education or an opportunity for Resident #77 to receive the influenza vaccine for the most recent influenza season. F. Resident #121 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #121 had severely impaired cognition. The influenza question regarding whether Resident #121 received the vaccine in the facility was marked no and the reason was coded as not offered. Resident #121's medical record revealed there was no documentation in the EMR system or hard chart, to indicate whether Resident #121 or her RP had received education regarding the benefits and the potential side effects of the influenza vaccine for the influenza season of [DATE] to [DATE]. In addition, there was no documentation to indicate whether Resident #121 received or refused the influenza vaccine from [DATE] to [DATE]. A phone interview occurred with Resident #121's RP on [DATE] at 3:40 PM and stated she could not recall being provided education or an opportunity for Resident #121 to receive the influenza vaccine for the most recent influenza season. An interview occurred with the Infection Preventionist on [DATE] at 12:00 PM who stated that influenza education and consents were to be reviewed with the residents and/or RP's yearly. The Infection Preventionist further stated that in [DATE] a batch of influenza vaccines were received but had to be discarded as they were not refrigerated when received. Another batch of influenza vaccines were received but she could not recall how many or when and then stated that there was a delay in obtaining influenza vaccines but couldn't recall when the vaccines were received. A phone interview occurred with the Pharmacist on [DATE] at 11:08 AM. The Pharmacist was able to pull the influenza shipment information for 2025 and stated that the facility received 60 doses of influenza vaccine on [DATE] and on the same date 40 additional influenza vaccines were requested by the facility. The pharmacy was only able to send 27 more doses of influenza vaccines instead of the 40 that had been requested. The Pharmacist stated that additional influenza vaccines were provided in [DATE], but she was unable to retrieve that information. Another interview was conducted with the Infection Preventionist on [DATE] at 12:47 PM. The Infection Preventionist again stated that a shipment of influenza vaccines came to the facility on an unrecalled date in [DATE] but was not refrigerated and had to be discarded. The facility reordered influenza vaccine and received a small amount. She was unable to recall the exact amount of influenza doses received but stated that she randomly provided influenza vaccines after providing education and obtaining consents from the resident and/or RPs. The Infection Preventionist stated she recalled receiving another shipment of influenza vaccines in [DATE] but could not recall the exact amount and when it was received. She stated that again she began providing random influenza vaccines to the residents. The Infection Preventionist reviewed the information for Residents #38, #39, #56, #71, #77 and #121 and explained that she utilized the Preventative Health tab in the EMR system for tracking who had and who had not received the influenza vaccine rather than a log of some type and must have overlooked the (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	referenced residents. The Infection Preventionist added that it was an oversight to have not provided education and an opportunity to receive the influenza vaccine for the most recent influenza season for Residents #38, #39, #56, #71, #77 and #121. The Director of Nursing (DON) was interviewed on [DATE] at 2:02 PM and stated that she was unaware that Residents #38, #39, #56, #71, #77 and #121 did not received education or the opportunity to receive the influenza vaccine during the most recent influenza season. The DON further stated it was her expectation that yearly influenza vaccine education be provided, immunizations to be administered as stated in their policy after consent was obtained, and documentation to be present in the medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, resident, responsible party (RP) and staff interviews, the facility failed to assess residents for the eligibility and ensure residents were offered the COVID-19 booster vaccination for 6 of 7 residents reviewed for COVID-19 booster immunizations (Residents #38, #39, #56, #71, #77 and #121). The findings included: The facility's policy and procedure on COVID-19 Vaccination, dated 5/3/24 was reviewed. The policy stated, in part, all partners, residents and patients who had no medical contraindications to the vaccine would be offered the updated COVID-19 vaccine per the Centers for Disease Control and Prevention (CDC) recommendations to encourage and promote the benefits associated with the vaccinations against COVID-19. The policy further indicated that the facility would provide pertinent information about the significant risks and benefits of the vaccine to partners, residents, patients and/or family members. A review of the CDC guidelines, dated 11/19/25, indicated that the CDC recommended a 2025 to 2026 COVID-19 vaccine for individuals that were age [AGE] and older, were at high risk for severe COVID-19, or had never received a COVID-19 vaccine. a. Resident #38 was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included type 2 diabetes, coronary artery disease and chronic kidney disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #38 had moderately impaired cognition. The COVID-19 question regarding whether Resident #38 was up to date with the vaccine was marked no. Resident #38's immunization record revealed that Resident #38 received a COVID-19 booster at the facility on 11/11/24. There was no documentation that Resident #38 had been offered, given, or refused additional doses of the COVID-19 vaccination. Attempts to contact Resident #38's RP were unsuccessful. b. Resident #39 was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included chronic obstructive pulmonary disease, congestive heart failure and dementia. A quarterly MDS assessment dated [DATE] indicated Resident #39 had severely impaired cognition. The COVID-19 question regarding whether Resident #39 was up to date with the vaccine was marked no. Resident #39's immunization record revealed that Resident #39 received a COVID-19 booster at the facility on 10/24/24. There was no documentation that Resident #39 had been offered, given, or refused additional doses of the COVID-19 vaccination. A phone interview occurred with Resident #39's RP on 6/12/26 at 12:29 PM, who stated they could not recall if the facility provided education and an opportunity for Resident #39 to receive a recent COVID-19 booster vaccine. c. Resident #56 was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included type 2 diabetes and chronic fatigue syndrome. A quarterly MDS assessment dated [DATE] indicated Resident #56 was cognitively intact. The COVID-19 question regarding whether Resident #56 was up to date with the vaccine was marked no. Resident #56's immunization record revealed that Resident #56 received a COVID-19 booster at the facility on 10/4/24. There was no documentation that Resident #56 had been offered, given, or refused additional doses of the COVID-19 vaccination. A phone interview occurred with Resident #56's RP on 6/12/26 at 12:24 PM, who stated they could not recall being provided with education or an opportunity for Resident #56 to receive a COVID-19 booster recently. An interview was conducted with Resident #56 on 6/12/26 at 1:45 PM and could not recall being provided with education or an opportunity to receive a recent COVID-19 booster. d. Resident #71 was admitted to the facility on [DATE] and was [AGE] years old. His diagnoses included dementia and anemia. A quarterly MDS assessment dated [DATE] indicated Resident #71 had severely impaired cognition. The COVID-19 question regarding whether Resident #71 was up to date with the vaccine was marked no. Resident #71's immunization record revealed that Resident #71 received a COVID-19 booster at the facility on 10/4/24. There was no documentation that Resident #71 had been offered, given, or refused additional doses of the COVID-19 vaccination. A phone interview occurred (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Resident #71's RP on 6/12/26 at 12:31 PM and stated he could not recall being provided with education or an opportunity for Resident #71 to receive a recent COVID-19 booster. e. Resident #77 was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included chronic obstructive pulmonary disease, type 2 diabetes and chronic respiratory failure. A quarterly MDS assessment dated [DATE] indicated Resident #77 had severely impaired cognition. The COVID-19 question regarding whether Resident #77 was up to date with the vaccine was marked no. Resident #77's immunization record revealed that Resident #77 received a COVID-19 booster at the facility on 11/26/24. There was no documentation that Resident #77 had been offered, given, or refused additional doses of the COVID-19 vaccination. A phone interview occurred with Resident #77's RP on 6/12/26 at 12:37 PM and stated he could not recall being provided with education or an opportunity for Resident #77 to an updated COVID-19 booster. f. Resident #121 was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included chronic obstructive pulmonary disease and congestive heart failure. A quarterly MDS assessment dated [DATE] indicated Resident #121 had severely impaired cognition. The COVID-19 question regarding whether Resident #121 was up to date with the vaccine was marked no. Resident #121's immunization record revealed that Resident #121 received a COVID-19 booster at the facility on 10/24/24. There was no documentation that Resident #121 had been offered, given, or refused additional doses of the COVID-19 vaccination. A phone interview occurred with Resident #121's RP on 6/12/26 at 3:40 PM and stated she could not recall being provided education or an opportunity for Resident #121 to receive an updated COVID-19 booster. A comprehensive review was completed of all resident immunization records from 10/1/25 to 3/31/26 and revealed that some residents were provided with the COVID-19 vaccine. An interview was conducted with the Infection Preventionist on 6/12/26 at 12:47 PM. She stated that every resident should be offered the opportunity to receive the COVID-19 booster based on the CDC guidelines. She explained that she utilized the Preventative Health tab in the Electronic Medical Record (EMR) system for tracking who had and who had not received the COVID-19 vaccines rather than a log of some type. She stated it was a random search, and she must have overlooked Residents #38, #39, #56, #71, #77 and #121 for providing them with an opportunity to receive an updated COVID-19 booster. The Infection Preventionist indicated she needed to develop a system so that resident immunizations were not overlooked. The Infection Control nurse added that she had been pulled to work on the medication carts frequently and that she had not been able to dedicate the time needed to ensure residents received their immunizations in a timely manner. The Director of Nursing (DON) was interviewed on 6/12/26 at 2:02 PM and stated that she was unaware that Residents #38, #39, #56, #71, #77 and #121 did not receive education or the opportunity to receive an updated COVID-19 booster. The DON further stated it was her expectation that COVID-19 vaccine education be provided, immunizations to be administered as stated in their policy after consent was obtained, and documentation to be present in the medical record.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews the facility failed to maintain a resident's dignity when staff spoke to a resident in an undignified manner. The resident stated she was upset by the way the staff member spoke to her when the staff told her not to hit her call bell (Resident #69). This deficient practice affected 1 of 5 residents reviewed for dignity and respect. The findings included:Resident #69 was admitted to the facility on [DATE] with hemiplegia (paralysis of one entire side of the body) and hemiparesis following CVA (cerebral vascular accident/stroke) affecting the left non-dominant side.A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 was moderately cognitively impaired. She was assessed as needing substantial assistance with turning in bed and dependent.During an observation of Resident #69 on 6/11/26 at 2:58 PM it was noted her call bell was draped across the foot of the bed and lying on the floor. Resident #69 stated the staff put it down there when they had assisted her earlier.An observation and interview of Resident #69 was conducted with Nurse Aide (NA) #1 on 6/11/26 at 3:01 PM. Upon entering the room with NA #1, Resident #69's call bell was observed draped across the bottom of Resident #69's bed lying on the floor. NA #1 stated she must have forgotten to return the call bell to the resident after changing the resident's clothes earlier. NA #1 handed the call bell to Resident #69. As the resident began rubbing the side of the call bell, NA #1 stated in a stern voice, Don't you hit that call bell, I'm standing right here. What do you need? Resident #69 looked away and did not respond. NA #1 then walked away and would not respond to any further questions asked by this surveyor. Resident #69 was interviewed on 6/11/26 at 3:22 PM who stated the way NA #1 spoke to her upset her.Nurse #4 was interviewed on 6/11/26 at 3:30 PM who stated Resident #69 liked to hold the bed control and would often throw other items off the bed trying to find it, such as the call bell. Nurse #4 further stated Resident #69 should not have been discouraged from using her call bell or spoken to her disrespectfully. On 6/12/26 at 2:02 PM the Director of Nursing (DON) was interviewed and stated NA #1 spoke inappropriately to Resident #69 regarding her call bell. According to the DON, it was the resident's right to be spoken to in a dignified manner.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, staff and Nurse Practitioner interviews, the facility failed to assess the ability of a resident to safely self-administer medications for 1 of 1 resident reviewed for self-administering medications (Resident #135).The findings included:Resident #135 was admitted to the facility on [DATE] with diagnoses of bipolar disorder and major depressive disorder, single episode, with psychotic features.Review of the annual Minimum Data Set (MDS) dated [DATE] indicated Resident #135 was cognitively intact without behavioral concerns.A review of the active orders revealed an order dated 6/3/26 through 6/9/26 for Cipro 500 milligrams (mg); 1 tablet orally twice daily.A review of the nursing progress notes for Resident #135 revealed the following written by the Director of Nursing: 6/3/26 5:38 PM Resident is refusing to have her blood drawn for a CBC (complete blood count that measures the types and numbers of blood cells in your blood) with diff . She also has her own antibiotics and refuses to give them to the nurse and refuses to take the antibiotics the facility has. Will notify NP (Nurse Practitioner) of the above.A review of the Medication Administration Record for June 2026 revealed Resident #135 refused the Cipro at 5:00 PM on 6/3/26 as signed by Nurse #2, refused at 9:00 AM and 5:00 PM as signed by Nurse #2 on 6/4/26; refused at 9:00 AM and 5:00 PM as signed by Nurse #1 on 6/5/26, 6/6/26 and 6/7/26; refused the 9:00 AM and 5:00 PM doses as signed by Nurse #3.The following nursing progress note regarding Resident #135 was written by Nurse #3:6/8/26 8:26 PM Resident showed to writer her ciprofloxacin 500 mg tablet, the same with facility stock. Resident stated to writer she got it from Walgreens pharmacy when she visited urgent care. Took 9 am ciprofloxacin 500 mg 1 tablet, but resident's stock. Refused the facility medicine packet. Showed to writer her notebook in which she wrote the date she started the medicine, 6-2-26 to 6-9-26. Writer notified Unit Manager. On 6/9/26 at 2:25 PM Resident #135 was interviewed who stated she had the CNA get her ready for the day on 6/2/26 and went out with her friend. According to Resident #135, when she was seen by the urgent care provider, she tested positive for a urinary tract infection (UTI). Resident #135 stated she told the urgent care provider to send her antibiotic order to a local pharmacy where she personally picked the medication up. Resident #135 explained when she returned to the facility later in the day on 6/2/26, she showed the staff her after visit summary and was not trying to hide what she had done. According to the resident, the nurse asked her to give her the bottle of medication, but Resident #135 refused and told the nurse she was going to take it herself. Resident #135 further explained she was in her right mind and capable of taking her own medication. Resident #135 showed a bottle of Cipro to the surveyor and a zippered pouch she kept at her bedside where she stored the medication. The resident denied being formally assessed by staff as being capable of independently taking medications.Nurse #2 was interviewed on 6/9/26 at 2:43 PM and stated she routinely worked with Resident #135. Nurse #2 was assigned to Resident #135 on 6/3/26, 6/4/26, and 6/9/26. According to Nurse #2, she attempted to administer Resident #135's Cipro on 6/3/26 and 6/4/26, but the resident refused each day. Nurse #2 stated the resident told her she had her own bottle of medication and was taking it herself. Nurse #2 specified she did not observe Resident #135 take her medication, and the resident refused to show her the bottle containing the medication until the morning of 6/9/26 when there was only one dose left. Nurse #2 indicated she informed the Unit Manager regarding Resident #135's refusals of medication as well as having a bottle of medication at bedside. She further indicated she wrote a note for the Nurse Practitioner in the provider's notebook kept at the nurse's station for review, but she did not call the provider to inform of the medication at bedside. Nurse #2 further expressed she was unaware if Resident #135 had been formally assessed for the ability to safely self-administer medications.The Unit Manager (UM) was interviewed on 6/9/26 at 2:50 PM who stated Nurse #2 informed her that Resident #135 refused her antibiotic on 6/3/26 and that the resident had obtained her own medications after visiting the local urgent care. The UM stated she spoke with Resident #135 on (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/3/26 who refused to show the bottle of medication to her and refused to allow her to lock the medication in the medication cart. The UM explained she informed the Director of Nursing regarding the refusal and Resident #135 having a bottle of medication at bedside. According to the UM, she did not write a note in the provider's notebook, and she did not call the Nurse Practitioner to inform her about the medication at Resident #135's bedside.On 6/12/26 at 10:29 AM Nurse Practitioner (NP) #2 was interviewed by phone and stated she had been informed about Resident #135 going to the local urgent care as well as the resident's refusal to give her medication to the staff members to place on the cart. According to NP #2, she assessed Resident #135 after the medication refusal was reported to her, and she educated the resident regarding the dangers of taking antibiotics incorrectly. NP #2 indicated she also educated the staff and Director of Nursing about taking antibiotics incorrectly as well. NP #2 stated she was not aware of Resident #135 having been formally assessed as being capable of self-administering medications, and it was beyond her scope of practice to deem her competent or incompetent.The Director of Nursing (DON) was interviewed on 6/12/26 at 2:02 PM who stated she spoke with Resident #135 on 6/3/26 and asked her to let the nurses lock her antibiotics in the medication cart. However, she stated Resident #135 refused to give them to her. According to the DON, she asked the Minimum Data Set (MDS) nurse to observe Resident #135 self-administer her Cipro each day.On 6/12/26 at 2:18 PM an interview was conducted with the MDS nurse who stated she had not been asked to monitor any resident self-administer their medications, and she had not observed Resident #135 take her antibiotic.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with Resident and staff, the facility failed to honor residents' choices of getting out of bed for 2 of 11 residents reviewed for self^determination (Residents #116 and #69). Findings included: 1. Resident #116 was admitted to the facility on [DATE] with diagnoses including incomplete quadriplegia (paralyzed from the neck down with minimal movement of his arms), traumatic brain injury, muscle weakness, spastic hemiplegia (involuntary jerking movements of his arms and legs). Review of the care plan for Resident #116 dated 4/13/26 for Activities of Daily Living (ADL) care due to impaired mobility included interventions to explain procedures prior to touching the resident, to report any rejection of care, and to encourage the resident to get out of bed as part of his long^term participation in activities he enjoys. The annual Minimum Data Set, dated [DATE] indicated Resident #116 was cognitively intact and was dependent on staff for bed mobility and activities of daily living, and used a wheelchair. Resident #116 was not coded for behaviors which included rejection of care. On 6/9/26 at 12:55 PM during observation and interview during the lunch meal, Nursing Assistant (NA) #3 was observed handing Resident #116's lunch tray to his Responsible Party. Resident #116 asked NA #3 to get in his wheelchair after lunch. NA #3 walked away from the bed without responding. On 6/9/26 at 1:10 PM NA #3 was interviewed and reported she was passing lunch trays and would notify Resident #116's assigned NA and that the Resident wanted to get out of bed into his wheelchair. On 6/9/26 at 2:45 PM, Resident #116 was observed in bed and reported no one had returned to assist him with getting out of bed, stating staff had only entered to remove his lunch tray. On 6/9/26 at 2:50 PM, NA #3 was interviewed and stated she had forgotten the resident wanted to get up and would inform the assigned NA. NA #3 stated she got busy passing meal trays and forgot to go back around and tell his assigned NA. An interview with NA #12 on 6/9/26 at 3:30 PM revealed she worked 3:00 PM to 11:00 PM that day. She reviewed the staffing assignment and stated that NA #3 had been assigned to Resident #116 from 7:00 AM to 3:00 PM and did not inform her until 3:05 PM that the resident wanted to get out of bed. NA #12 stated she obtained assistance from another staff member on her shift to use the mechanical lift to get the resident up into his chair. On 6/9/26 at 3:45 PM, review of the staff assignment sheet for Resident #116 indicated that NA#3 was assigned to him during the 7:00 AM to 3:00 PM shift on 6/9/26. On 6/10/26 at 3:54 PM, the Director of Nursing (DON) stated that when a resident requested to get up (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into their chair, staff were expected to work together to honor the request using appropriate assistance, including twoˆperson assistance or mechanical lift as needed. She stated she had been unaware the resident made requests on 6/9/26 and Resident #116 was not assisted in getting out of bed until approximately 3:00 PM on 6/9/26, only after the surveyor interviewed staff about his request. The DON stated delays in responding to resident requests were unacceptable and staff were expected to routinely round and follow-up. On 6/10/26 at 2:56 PM, the Administrator stated he was unaware that staff were failing to get Resident #116 into his wheelchair when requested. He stated staff should have gotten Resident #116 up as he asked and confirmed the expectation that resident requests to get out of bed must be honored. 2. The findings included: Resident #69 was admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis of one entire side of the body) and hemiparesis (weakness or partial paralysis affecting only one side of the body) following CVA (cerebral vascular accident/stroke) affecting the left non-dominant side. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 was moderately cognitively impaired. She was assessed as needing substantial assistance with turning in bed and dependent. Resident #69 was not coded for behavioral concerns or rejection of care. A review of Resident #69's care plan last updated 5/18/26 did not reveal behaviors or rejection of care. On 6/11/26 at 2:58 PM an interview was conducted with Resident #69 who stated she had asked multiple staff members at various times throughout the previous week to get her out of bed, but they always told her no. Resident #69 stated it had been several days since she was last out of bed. Nurse Aide (NA) #1, who was assigned to Resident #69 on 6/11/26 3:00 PM to 11:00 PM, was interviewed on 6/11/26 at 3:01PM. NA #1 stated, we do not get Resident #69 out of bed because once we get her up, she complains and wants to go right back to bed. NA #1 could not recall the last time she got Resident #69 out of bed. The Director of Nursing (DON) was interviewed on 6/12/26 at 2:02 PM and stated staff should get Resident #69 out of bed when she asked to get up. According to the DON, even if the resident wanted to go back to bed 30 minutes later, she had the right to get out of bed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff and Health Care Power of Attorney interviews, the facility failed to distribute the funds within 30 days of discharge for 1 of 3 residents reviewed for refund of deposit (Resident #127).Findings included:Resident #127 was admitted to the facility on [DATE].A review of the discharge tracking Minimum Data Set (MDS) dated [DATE] revealed Resident #127 had a planned discharge to another facility on 03/07/26.On 06/09/26 at 1:30 PM a phone interview was conducted with Resident #127's Health Care Power of Attorney (HCPOA). The HCPOA explained Resident #127 was discharged to another skilled nursing facility on 03/07/26 and was owed a refund of approximately $1000. On 06/12/26 at 9:05 AM an interview with the Business Office Manager was conducted. She stated she received an email from the accepting facility in April 2026 indicating that they had not received Resident #127's funds. The Business Office Manager stated she initiated the the refund for Resident #127 on approximately 04/18/26 and the funds were sent to the accepting facility on 04/21/26. The Business Office Manager did verify the transfer took place more than 30 days after Resident #127 was discharged from the facility (03/07/26). The Business Office Manager could not provide the email she received from the accepting facility or the date she received it due to the system automatically deleting the email after 30 days. The Business Office Manager explained that no one communicated to her that Resident #127 was discharged to the other facility. She verified the team had discussed the transfer in the morning meeting prior to Resident #127's discharge and that she did see it on the census report however it did not trigger her to look to see what facility he went to. She went on to say she had been employed with the facility for 6 months and was still learning.An interview was conducted with the Administrator on 06/12/26 at 3:35 PM. The Administrator stated that the refund of funds for Resident #127's account should have occurred per the regulation.

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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 record reviews, observations, and staff interviews, the facility failed to develop an individualized and comprehensive care plan for the potential for or history of behavioral symptoms as well as the use of psychotropic medications (Resident #35) and dental concerns (Resident #62). This deficient practice affected 2 of 10 residents reviewed for dementia and dental concerns. The findings included: 1. Resident #35 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, mood disorder, dementia with other behavioral disturbance, anxiety disorder and depression. A review of Resident #35's nursing progress notes from 3/26/26 to 4/2/26 revealed episodes of disrobing in the hallway and propelling self in wheelchair to other residents' rooms. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #35 had severe cognitive impairment and displayed wandering behavior one to three days during the seven-day look back period. He was coded for the use of antipsychotic and antidepressant medications. A review of the Care Area Assessment (CAA) summary dated 4/8/26 indicated dementia was triggered to proceed to care planning but the decision was marked no, behavioral symptoms and psychotropic drug use were triggered to proceed to care planning, and the care planning decision was marked yes. Resident #35's active care plan initiated on 4/8/26 did not address the potential for or history of behavioral symptoms or the use of psychotropic medications. MDS Nurse #1 and MDS Nurse #2 were interviewed on 6/11/26 at 3:07 PM. They reviewed Resident #35's most recent MDS assessment dated [DATE] as well as his active care plan and indicated that a care plan should have been created for the use of psychotropic medications and was an oversight. MDS Nurse #1 and MDS Nurse #2 stated the Social Services Director was responsible for coding the MDS assessment and developing care plans for mood and behavior concerns. On 6/11/26 at 3:09 PM, the Social Services Director was interviewed and explained that she reviewed each residents' medical record and progress notes to determine if mood and behavior concerns were present to ensure it was coded correctly on the MDS assessments as well as care plans had been created. The Social Services Director reviewed Resident #35's active care plan and verified there were no care plans present for the potential for or history of behavioral symptoms. She stated it was an oversight and a care plan should have been created following the completion of the admission MDS assessment. The Social Services Director verified she had coded the mood and behavior section of the MDS assessment and was aware of Resident #35's diagnoses. The Director of Nursing (DON) was interviewed on 6/11/26 at 2:35 PM. She reviewed Resident #35's active care plan and verified there were no care plans to address the potential for or history of behavioral symptoms or the use of psychotropic medications. The DON explained that the MDS Nurses were responsible for creating a care plan for Resident #35 regarding the use of psychotropic medications and the Social Services Director was responsible for creating a care plan for Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#35's mood and behavior concerns. The DON indicated it was an oversight for the lack of these care plans for Resident #35; however, she would have expected the care plan to be person centered. 2. Resident #62 was admitted to the facility on [DATE]. A review of the nursing admission assessment dated [DATE] revealed Resident #62 had obvious or likely cavities or broken natural teeth. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #62 was not identified as having any dental problems. A review of Resident 62's active care plan reviewed 4/15/26 did not address dental problems. An observation of Resident #62 was conducted on 6/8/26 at 12:53 PM. Resident #62 was noted to have missing upper and lower teeth. The remaining teeth were in poor condition, with evidence of breakage and black decay observed. An interview with Resident #62 was conducted on 6/10/26 at 9:44 AM. He explained that he had experienced dental problems for years and had decided he wanted to have his remaining teeth extracted. He added that he had a dental appointment scheduled for later this month. An interview conducted with MDS Nurse #1 on 6/12/26 at 2:32 PM, revealed that Resident #62 was not coded on the Annual MDS Assessment as having dental problems, although he should have been. She stated that the MDS Nurse is responsible for coding the assessment and developing care plans for identified dental issues. MDS Nurse #1 indicated that if Resident #62 had been coded as having dental problems on the MDS Assessment, it would have triggered the MDS Nurse to develop a care plan related to his dental problems. She stated that a dental care plan should have been initiated. An interview with the Director of Nursing (DON) was conducted on 6/12/26 at 12:27, PM. During the interview, the DON stated that she expected care plans to be personˆcentered and include resident care concerns.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a comprehensive care plan within 7 days of the admission Minimum Data Set assessment for 1 of 3 residents (Resident # 104) reviewed for smoking. The findings included:Resident #104 was admitted to the facility 4/6/26.A smoking assessment dated [DATE] assessed Resident #104 to be a safe smoker. The admission Minimum Data Set assessment dated [DATE] noted Resident #104 was cognitively intact and was coded for Current Tobacco Use.Review of Resident #104's medical record on 6/8/26 at 12:00 PM revealed no care plan that addressed smoking.An interview was conducted with the Director of Nursing (DON) on 6/11/26 at 1:30 PM. The DON reported she was not certain why Resident #104 did not have a care plan for smoking in place. The DON reported that the nurse completing the admission assessment should have initiated the smoking care plan. The DON reported she expected all smokers to have smoking addressed in a care plan on admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Medical Director, and staff interviews, the facility failed to administer insulin per the parameters in the physician order (Resident #62) for 1of 1 resident reviewed for well-being. The findings included: Resident #6 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus.Review of Resident #6's active physician orders showed the following: An order dated 10/13/25 for insulin lispro insulin pen, 100 units/milliliters (mL). Administer 10 units subcutaneously once daily with breakfast. Special instructions: hold if blood glucose is less than 90; give half dose (5 units) if blood glucose is less than 120; do not administer if the resident is not eating. An order dated 5/17/26 for insulin lispro insulin pen, 100 units/mL. Administer 8 units subcutaneously twice daily at 12:00PM and 5:00PM. Special instructions: hold if blood glucose is less than 90; give half dose (4 units) if blood glucose is less than 120; do not administer if the resident is not eating.Review of the May 2026 and June 2026 Medication Administration Records (MARs) revealed that Resident #6 received insulin doses outside the ordered parameters on the following dates: 5/5/26: Blood glucose (BG) was 187 at 12:00 PM; 4 units instead of 8 units were administered by Nurse #3. 5/6/26: BG was 126 at 9:00 AM; 5 units instead of 10 units were administered by Nurse #2. 5/8/26: BG was 160 at 9:00 AM; 5 units instead of 10 units were administered by Nurse #3. 5/14/26: BG was 185 at 9:00 AM; 5 units instead of 10 units were administered by Nurse #3. 5/14/26: BG was 137 at 12:00 PM; 4 units instead of 8 units were administered by Nurse #3. 5/15/26: BG was 175 at 9:00 AM; 5 units instead of 10 units were administered by Nurse #3. 5/15/26: BG was 147 at 12:00 PM; 4 units instead of 8 units were administered by Nurse #3. 5/17/26: BG was 128 at 9:00 AM; 5 units instead of 10 units were administered by Nurse #3. 6/5/26: BG was 278 at 9:00 AM; 5 units instead of 10 units were administered by Nurse #3. 6/11/26: BG was 173 at 12:00 PM; 4 units instead of 8 units were administered by Nurse #3.An interview with Nurse #2 was conducted on 6/12/26 at 9:30 AM. She reported that she was aware Resident #6 had parameters requiring administration of half the scheduled insulin dose if the blood glucose (BG) level was less than 120. She stated she would typically check the resident's blood glucose, document it on the MAR, and administer the insulin according to the ordered parameters. The May 2026 MAR was reviewed with Nurse #2 during the interview which included on 5/6/26 at 9:00 AM 5 units of insulin lispro was administered by Nurse #2 despite the BG level being above 120. Nurse #2 acknowledged the discrepancy and stated she should have administered 10 units of insulin instead of 5 units. Nurse #2 added that she did not realize she only administered half of the ordered insulin dose.Nurse #3 was interviewed by phone on 6/12/26 at 12:29 PM. The May 2026 and June 2026 MARs were reviewed with her. Documentation showed that insulin lispro 5 units were administered at 9:00 AM on 5/8/26, 5/14/26, 5/15/26, 5/17/26, and 6/5/26 despite the blood glucose (BG) level being above 120. Nurse #3 confirmed that, based on the physician's order and the documented BG levels, Resident #6 should have received 10 units on those dates. Further review of the May 2026 and June 2026 MARs revealed that insulin lispro 4 units was administered by Nurse #3 at 12:00 PM on 5/5/26, 5/14/26, 5/15/26, and 6/11/26, again despite the BG levels being above 120. Nurse #3 confirmed that Resident #6 should have received 8 units according to the order and BG levels. Nurse #3 confirmed that the order instructed staff to hold the insulin dose if the resident was not eating. She stated she believed the discrepancies were mistakes but noted they may have been influenced by concerns regarding Resident #6's meal intake. Nurse #3 stated that Resident #6 had a continued history of poor meal intake; however, she did not document whether the insulin dosage was adjusted in response to the resident's reduced food consumption.During an interview with the Medical Director on 6/12/26 at 11:58 AM, Resident # 6's BGs results and insulin doses given outside of the ordered parameters in May 2026 and June 2026 were reviewed. He stated he did not believe Resident #6 would have experienced any serious harm because she received lower doses of insulin lispro that were outside of the ordered parameters. He (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated that Resident #6 would likely have been fine without the parameters in place and receiving the lower scheduled doses. However, he emphasized that he would expect nursing staff to follow the physician's orders as written. The Director of Nursing was interviewed on 6/12/26 at 12:36 PM. She stated that she expected the nursing staff to follow physician orders, including administering insulin according to the established parameters based on blood glucose levels.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, physician, and staff interviews, the facility failed to provide wound care for a non-pressure wound as order by the physician for 1 of 6 residents reviewed for wound care (Resident #76).The findings included:Resident #76 was readmitted to the facility 5/25/26 with diagnoses including hypertension, diabetes, and an unspecified open wound.Review of the physician orders revealed an order dated 5/25/26 for wound care to be completed to the wound on the lower right leg: cleanse with antiseptic wound cleanser, apply medi-honey (a topical antiseptic that provides moisture and protection to healing wounds) to the wound, apply a silicone bordered foam, change dressing every 3 days and as needed.A skin care assessment completed by Nurse #3 on 5/25/26 noted a skin tear to the right lower leg with an intact dressing and wound care ordered.The quarterly Minimum Data Set assessment dated [DATE] documented Resident #76 was cognitively intact and did not reject care. The assessment did not document open wounds for Resident #76.Review of the Treatment Administration Record (TAR) for June 2026 revealed the wound care was documented as completed on 6/2/26 and 6/6/26 by Nurse #9. A skin assessment dated [DATE] documented under alterations in skin none and under skin treatments none.Resident #76 was observed on 6/8/26 at 11:35 AM. A wound dressing was noted on her right lower leg. Written on the wound dressing was 6/5/26. Resident #76 reported she had a skin tear on her lower right leg and staff were changing the dressing every couple of days.Resident #76 was observed on 6/9/26 at 12:36 PM. The wound dressing on her right lower leg was dated 6/5/26. Resident #76 reported no one had changed her wound dressing since 6/5/26 and she didn't know why.During an observation of Resident #76 with the Wound Nurse and the Assistant Director of Nursing (ADON) on 6/10/26 at 9:50 AM the Wound Nurse reported she was not aware of the wound on Resident #76's leg and she knew nothing about the wound care that was to be provided. The ADON reported she entered the wound care orders on 5/25/26 and she thought she had communicated the wound to the Wound Nurse but was not certain. The ADON reported that new wounds were reported verbally to the Wound Nurse and the Wound Nurse confirmed this.A follow-up interview was conducted with the Wound Nurse on 6/10/26 at 11:49 AM. The Wound Nurse explained that nurses on the medication carts had been providing wound care when she was assigned to work on a medication cart. The Wound Nurse reiterated she did not know anything about Resident #76's wound.During a phone interview with Nurse #9 at 6/10/26 at 1:38 PM, she reported she did not change the dressing to Resident #76's right lower leg on 6/6/26 and she did not know why her initials were on the Treatment Administration Record because she did not complete wound care. Nurse #9 reported she had notified the Wound Nurse of the wound on Resident #76's lower right leg, but did not recall the date she reported it, or if she reported it verbally or in writing.A follow-up interview was conducted with the ADON on 6/11/26 at 3:17 PM and she reported after thinking about it, she was not certain if she reported the wound to the Wound Nurse on 5/25/26.The Director of Nursing (DON) was interviewed on 6/11/26 at 1:03 PM and she reported she was not certain why the wound care was not completed as ordered. The DON reported she was not certain why the nurse documented the wound care as completed if she did not complete the wound care.A phone interview was conducted with the Physician on 6/12/26 at 2:27 PM, he reported that the skin tear on Resident #76's right lower leg was minor but it should have been reported to the Wound Nurse for treatment.An interview was conducted with the Administrator on 6/12/26 at 4:00 PM. The Administrator reported he did not know why the wound care was not completed on the due date, and why the nurse's initials were on the Treatment Administration Record. The Administrator did not know why the Wound Nurse was not notified of the wound on Resident #76's lower right leg. The Administrator reported it was his expectation that wound care orders were accurate and the physician orders were followed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff, and Physician interviews, the facility failed to apply a right^hand palmar guard orthosis (type of hand splint designed to protect the palm of the hand from injury caused by severe finger flexion contractures, also called palm protectors) as outlined in the care plan for 1 of 1 resident (Resident #8) reviewed for contractures and range of motion (ROM). Findings included:Record review showed that Resident #8 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side) following a cerebral infarction (stroke) affecting the right dominant side, a right wrist contracture, and a right^hand contracture. Review of the Occupational Therapy (OT) Discharge summary dated [DATE] showed the resident received OT services from 4/14/26 through 4/30/26. At discharge, the resident had plateaued at the maximum producible end^range Passive Range of Motion (PROM) and tolerated the right palmar guard orthosis for 3-4 continuous hours with no adverse signs. The summary showed staff received training in Right Upper Extremity (RUE) PROM techniques and orthotic management. The established care plan required preparatory PROM followed by application of the right palmar guard orthosis for up to 4 continuous hours daily, up to 7 days per week.Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] showed the resident was readmitted on [DATE], had adequate hearing, no speech, and cognitive impairment. Assessment indicated the resident had impairment on one side of her upper extremities. Resident #8 did not exhibit any behaviors or rejection of care. The assessment showed the resident exhibited no behaviors, was dependent on staff for Activities of Daily Living (ADLs) and was not receiving therapy services. Care plan review, last updated 5/22/26, showed the resident required splint/brace assistance to the RUE up to 7 days per week due to hypertonicity (a condition characterized by an increased state of muscle tone or tension leading to stiffness and resistance movement) and right^hand contracture. Interventions included providing PROM to the RUE from shoulder to hand; monitoring for pain; maintaining ROM within tolerance; applying the right palmar guard orthosis after PROM; ensuring straps were fastened to allow two fingers under the strap; monitoring skin integrity; and referring to OT for concerns. Review of the Point of Care (POC) documentation from 5/11/26 through 6/10/26 showed inconsistent and incomplete documentation for PROM minutes and splint/brace assistance minutes. PROM minutes:- On 5/17/26, 5/18/26, and 5/28/26: documented as unavailable.- On 5/19/26, 5/22/26, 5/30/26, and 5/31/26: documented as refused.- On 5/20/26, 5/23/26, 5/24/26, 5/26/26, 5/29/26, 6/2/26, and 6/6/26: documented as combative.- On 6/1/26, 6/3/26, 6/4/26, 6/5/26, 6/7/26, 6/9/26, and 6/10/26: documented as no information or not observed.- On 5/25/26, 6/4/26, and 6/8/26: no documentation present. Splint/brace assistance minutes:- On 5/17/26 and 5/18/26: documented as unavailable.- On 5/19/26, 5/22/26, 5/30/26, and 5/31/26: documented as refused.- On 5/28/26: documented as could not assess.- On 5/20/26, 5/23/26, 5/24/26, 5/26/26, 5/29/26, 6/2/26, and 6/6/26: documented as combative.- On 6/1/26, 6/3/26, 6/4/26, 6/5/26, 6/7/26, 6/9/26, and 6/10/26: documented as no information or not observed.- On 5/25/26, 6/4/26, and 6/8/26: no documentation present.Observation on 6/8/26 at 11:03 AM revealed Resident #8 lying in bed with contractures to the right hand and wrist. The resident was not wearing a palmar guard. No splints were observed on the bedside table or in the immediate area. Observations on 6/9/26 at 10:30 AM and again at 3:30 PM showed Resident #8 in bed without a palmar guard or any splints in place.Observation on 6/10/26 at 8:15 AM showed Resident #8 without a palmar guard.During an interview on 6/10/26 at 8:32 AM, Nurse #7 stated that Occupational Therapy (OT) evaluated residents with contractures and determined their need for splints. Nurse #7 stated that once a resident was discharged from OT, therapy staff provided training to nursing assistants on the restorative program and splint application. Nurse #7 stated nurse aides were (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for applying the splints and were expected to notify the nurse if the resident refused or if concerns arose. She stated OT updated the care plan and wrote orders for splint use. Nurse #7 reported that Resident #8 had contractures of the right hand and wrist, had palm guards/splints, and staff had been trained on their application and use. She stated the resident returned from the hospital on 5/16/26. Nurse #7 was unaware of the location of the resident's splints and indicated the resident should be wearing her splints for at least 3-4 hours. She stated that prior to hospitalization, the resident sometimes refused splints.During an interview and observation on 6/10/26 at 12:17 PM, the Occupational Therapist stated Resident #8 received OT services from 4/14/26 through 4/30/26. She stated the discharge recommendations included PROM exercises and use of the palmar guard for 4 hours daily as tolerated. She stated nurse aides were trained on the PROM program and palmar guard application. She stated she provided an order and updated the care plan to reflect PROM expectations and splint wear time. She reported this information was also listed on the nurse aide task sheets because the aides who were trained were not always assigned to the resident. The Occupational Therapist stated Resident #8 tolerated the palmar guard for about 4 hours daily. During the interview, she searched the resident's bedside table and found two palmar guards in the bottom drawer under personal items. She stated the resident still had the palmar guards and they had not been lost; staff had not looked for them after the resident returned from the hospital. She stated the resident would benefit from consistent use of the palmar guards.During an interview on 6/10/26 at 12:25 PM, Nurse Aide (NA) #4 stated Resident #8 had a rightˆhand contracture and had splints that needed to be worn daily. She stated that before the hospitalization, staff assisted the resident with splint use, but the resident did not prefer them and sometimes refused. NA #4 stated she had not recently applied the palmar guard because she did not know where it was located.During an interview with the Director of Nursing (DON) on 6/10/26 at 2:00 PM, the DON stated OT staff trained nurse aides and wrote orders indicating how long the resident should wear the splint. The DON observed Resident #8 with the surveyor and acknowledged the resident was not wearing a palmar guard and stated the resident should be wearing one. She stated the resident had been hospitalized from [DATE] through 5/16/26 and the resident's orders may have been dropped on readmission. When asked how nurse aides documented palmar guard use and who ensured orders were in place, the DON stated palmar guard and PROM tasks were included in the care plan. She stated nurses were responsible for ensuring the resident had a palmar guard and for rewriting orders if needed so nurse aides could document use. During a reˆinterview at 2:59 PM, the DON stated that based on Point of Care documentation, the resident had refused or was agitated when the palmar guard was applied. She was unsure whether staff notified Therapy regarding refusals.During a telephone interview on 6/11/26 at 11:30 AM, the Physician stated the resident had contractures of the right hand. He stated OT evaluated residents and provided orders for splint use, and nurse aides were trained by OT. The Physician stated the palmar guard was potentially helpful and that refusals or pain with use should be reported to Therapy for reevaluation. He stated that if OT had written an order or if the care plan indicated palmar guard use, the splints should be applied as directed.

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Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Nurse Practitioner, resident, and staff, the facility failed to implement an active order to obtain a urinalysis with culture and sensitivity for a resident who exhibited symptoms of a urinary tract infection. This deficient practice resulted in missed diagnostic evaluation and affected 1 of 6 residents reviewed for urinary care management (Resident #135).The findings included:Resident #135 was admitted to the facility on [DATE] with diagnoses of cognitive communication deficit and prediabetes.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #135 was cognitively intact. A review of the Nurse Practitioner (NP) progress note dated 5/29/26 signed by NP #2 read Resident #135 was seen on 5/29/26 and endorsed feelings of dysuria (pain, burning, or discomfort with urinating) and would like a urinalysis (UA) with culture and sensitivity ordered. In the orders section of the progress note was an order for a UA with culture and sensitivity to be obtained. A review of the May 2026 physician orders for Resident #135 did not reveal an order for the UA with culture and sensitivity. Likewise, a review of the lab results for May 2026 and June 2026 did not reveal results for a UA with culture and sensitivity having been completed or pending.On 6/9/26 at 2:24 PM Resident #135 was interviewed and stated she had asked NP #2 in May 2026 to order a urine test because she felt like she had a urinary tract infection (UTI). Resident #135 stated she was familiar with the symptoms of a UTI as she has had one in the past. According to Resident #135, the facility never obtained a urine sample for testing, so she had her friend take her to the local urgent care clinic where she obtained a urine test on 6/2/26, was diagnosed with UTI, and had antibiotics ordered.Nurse #1 was interviewed on 6/10/26 at 3:00 PM who stated she thought Resident #135 had complained of a UTI recently in May 2026 when NP #2 saw her. Nurse #1 stated NP #2 and other providers would enter their orders in the computer ordering system if any testing was needed, and then the nurses would verify the order. According to Nurse #1 the only time nurses put orders in the system was in the case of an emergency. Nurse #1 indicated she did not see any orders for lab work for Resident #135 after NP #2's visit.The Unit Manager (UM) was interviewed on 6/10/26 at 3:04 PM and stated she did not see that a UA with culture and sensitivity was ordered for Resident #135 when NP #2 saw her on 5/29/26. According to the UM, the nurses transcribed the NP's orders after each visit. The UM further stated NP #2 did not inform her she had orders during her visit, and the progress note had been uploaded under resident documents instead of progress notes. The UM stated due to this reason she did not see NP #2's progress note.An interview was conducted with NP #2 on 6/12/26 at 10:29 AM who stated the company she worked for had just assumed care of the residents at the facility in early May 2026. She stated at the time of her visit with Resident #135 she did not have access to the facility's computer system to enter orders herself. NP #2 explained that she did not have access to put orders in the facility's computer system yet, she had emailed the order to the Director of Nursing (DON) to input the order for a UA with culture and sensitivity for Resident #135 after her visit. NP #2 stated she was notified by someone (unable to recall who) at the facility on 6/3/26 that Resident #135 had gone to a local urgent care for testing where she was identified as being positive for a UTI.On 6/12/26 at 2:02 PM the DON was interviewed and stated NP #2 did send progress notes to her to enter in the computer system, but NP #2 would also talk to her and let her know she had orders for residents after completing her visits. The DON indicated she did not recall if NP #2 told her that Resident #135 needed a UA with culture and sensitivity after her visit in May. The DON further stated she was unable to recall if she had received an email from NP #2 asking her to enter an order a UA with culture and sensitivity for Resident #135 in May 2026.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Nurse Practitioner and staff interviews, the facility failed to transcribe blood glucose monitoring orders on admission to monitor the use of an oral diabetic medication for 1 of 10 residents whose medications were reviewed (Resident #130). The findings included: Resident #130 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes. A review of Resident #130's hospital discharge medication list dated 9/25/25 included an order for blood glucose monitoring (accucheck) three times a day. The discharge summary indicated Resident #130 utilized Metformin (a hypoglycemic medication used to treat diabetes) 500 milligrams (mg) one tablet daily with breakfast to control the type 2 diabetes. The September 2025 physician orders did not include an order for blood glucose monitoring three times a day, however, it did include the order for Metformin 500 mg one tablet daily with breakfast. An interview occurred with Nurse #6 on 6/10/26 at 11:05 AM, who admitted Resident #130 on 9/25/25. He confirmed that he had entered Resident #130's hospital discharge orders upon admission to the facility on 9/25/25. After reviewing Resident #130's hospital discharge summary and the September 2025 facility physician orders, Nurse #6 verified the order for blood glucose monitoring had not been transcribed and stated it was an oversight. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #130 had moderately impaired cognition and was coded with the use of a hypoglycemic. A review of the Medication Administration Records (MARs) for September 2025 and October 2025 revealed that Resident #130 received Metformin 500 mg as ordered. A phone interview was completed with Nurse Practitioner (NP) #1 on 6/11/26 at 1:05 PM. A review of Resident #130's hospital discharge summary and September 2025 facility physician orders occurred, and NP #1 stated the order should have been transcribed for blood glucose monitoring three times a day. She added that by having the blood glucose results, it would have allowed her the opportunity to assess Resident #130's blood glucose results to determine if the Metformin needed adjustment or the blood glucose monitoring to be adjusted or discontinued. NP #1 stated that while she reviewed the hospital discharge summaries on her first resident assessment, she did not compare the orders to the facility physician orders to determine if something was missing. The Director of Nursing (DON) was interviewed on 6/11/26 at 2:35 PM. A review of Resident #130's hospital discharge medication list and the September 2025 physician orders occurred. The DON stated that she normally did a second check for new admissions to ensure medications were transcribed correctly but was unsure if a review was completed for Resident #130. The DON stated it was her expectation for physician orders to be transcribed correctly and completely per the hospital discharge medication list. If there was a question or concern regarding a specific order, she would have expected the nursing staff to reach out to a provider for clarification.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with the resident, Physician, and staff, the facility failed to secure prescribed medications stored at bedside for 2 of 6 residents reviewed for medication storage (Resident #84 and Resident #104). The findings included: 1. Resident #84 was admitted to the facility on [DATE] with a diagnosis of seborrheic dermatitis (a skin condition that causes redness, scaley patches, and rashes on areas of the body). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #84 had severe cognitive impairment. A review of the physician's orders revealed an order dated 6/4/26 for Triamcinolone Acetonide Cream 0.025% (cream used to relieve redness, itching, and dryness caused by skin conditions), with instructions to apply a small amount of the cream to the red area on the right side of his back and to the forearms daily for treatment of seborrheic dermatitis. A review of Resident #84's medical records revealed he had not been assessed for self-administration of medication. An observation conducted on 6/9/25 at 3:10 PM revealed three containers of Triamcinolone Acetonide Cream 0.025% sitting on top of the nightstand beside Resident #84's bed. An observation conducted on 6/10/26 at 9:36 AM revealed three containers of Triamcinolone Acetonide Cream 0.025% sitting on top of the nightstand beside Resident #84's bed. During an observation and interview conducted with the Unit Manager (UM) on 6/10/26 at 3:39 PM, she stated that the Triamcinolone Acetonide Cream should be kept in the locked treatment cart rather than left unattended in Resident #84's room. She removed all three containers from Resident #84's room and stated she had not noticed the containers of Triamcinolone Cream on the resident's nightstand earlier that day or on 6/8/26. The UM stated Resident #84 would not be capable of using the medication. During an interview on 6/12/26 at 10:12 AM, Nurse #9 stated she was assigned to care for Resident #84 on 6/9/26 during the day shift and she did not observe the Triamcinolone cream on his nightstand. She confirmed that the cream was a prescription medication and was required to be stored in the locked medication cart. An interview conducted on 6/11/26 at 3:39 PM with Nurse Aide (NA) #12, she revealed that she had not noticed any prescription creams on the nightstand in Resident #84's room. She added that if she had observed medication, she would have notified the nurse. During an interview with the Director of Nursing (DON) on 6/12/26 at 12:27 PM, she stated she was not aware that Resident #84 had Triamcinolone Cream in his room. She confirmed that the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescription cream should not have been in the resident's room and should have been stored in a locked medication cart. She added that she expected all medications to be secured in the medication carts. 2. Resident #104 was admitted to the facility 4/6/26. Resident #104 did not have a diagnosis for toenail fungus. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #104 was cognitively intact. Review of the physician orders revealed no order for ciclopirox topical nail lacquer (a prescription topical antifungal treatment for mild to moderate nail fungus). Review of the physician orders revealed no order for Resident #104 to self-administer medications. An assessment dated [DATE] for self-administering medications documented Resident #104 did not want to self-administer medications, he had modified independence making decisions, and he would not self-administer medications. An observation and interview were conducted with Resident #104 on 6/10/26 at 2:35 PM. A package of ciclopirox topical nail lacquer was noted on the desk inside his room beside the door. Resident #104 reported Another physician prescribed that. I'm supposed to put it on my (toe)nails. If I put it on my nails in a scheduled way, it would work better, but I forget (to apply it). I don't know if (the facility) knows I have this in my room, it's not their business and it's not your business, either. Nurse #6 was interviewed on 6/10/26 at 2:58 PM and he reported that Resident #104 did not have an order to self-administer medications and the ciclopirox topical nail lacquer should not be in his room. Nurse #6 reported he was not aware the nail lacquer was in the resident's room. The Director of Nursing (DON) was interviewed on 6/11/26 at 1:30 PM. The DON reported she was not aware Resident #104 had the ciclopirox topical nail lacquer was in his room and he should not have it. The Physician was interviewed by phone on 6/12/26 at 2:27 PM. The Physician reported that he was not concerned about Resident #104 having the ciclopirox topical nail lacquer, stating he didn't believe the resident would misuse it, however, residents should not have medication in their room.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation, resident and staff interviews, the facility failed to accommodate food preferences for 1 of 1 resident reviewed for food preferences (Resident #56).The finding Included:Resident #56 was admitted to the facility on [DATE].A review of Resident #56's records revealed a form titled Diet History/Food Preference List, completed by the Former Dietary Manager. The form indicated Resident #56 disliked foods such as bacon, beef liver, beef, veal, bologna, chicken liver, chicken, chili, enchiladas, fish, ham, lasagna, pork, sausage, shrimp, tuna, turkey, and other. The form was undated.The Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #56 was cognitively intact and able to eat independently.A dining observation of Resident #56's lunch tray occurred on 06/09/2026 at 1:30 PM. The observation revealed brown, ground-up food on the resident's tray that had been pushed to the side. Resident #56's dietary meal ticket identified the meat as Mech Soft (mechanical soft diet, a way of eating that makes food easy to chew and swallow) Beef Stir Fry. The top and bottom sections of the meal ticket indicated Resident #56 was a vegetarian, liked fish, and did not like beef or pork.An interview conducted on 06/09/2026 at 1:31 PM with Resident #56 revealed she had regularly received pork, beef, and other meats from the kitchen for breakfast, lunch, and dinner. Resident #56 stated she had discussed the concern with nurse aides, nursing staff, and the dietary department; however, she continued to receive meat with some of her meals. She further stated when she informed staff she had received food she disliked; they returned the tray to the kitchen and obtained a substitute meal.An interview conducted on 06/10/2026 at 1:45 PM with the Dietary Manager revealed he had served in that role since 07/2025. He reported he collected residents' dietary preferences on the day of admission using a form titled Diet History/Food Preference List, which included diet history, appetite, portion preferences, allergies, intolerances, cultural or religious needs, beverage preferences, and food dislikes. He explained he added resident dislikes and preferences to the bottom of each meal ticket. He described the tray-line process as a two-check system in which the cook verified the correct food consistency and the two food servers verified resident preferences and meal ticket accuracy. He reported errors occurred only when staff failed to read the meal ticket. The Dietary Manager stated when residents received food items they disliked, staff replaced the tray, although he believed such occurrences were infrequent. He confirmed he updated preferences daily when printing meal tickets but completed the full preference assessment only once, upon admission. The Dietary Manager reported staff training consisted of reviewing meal tickets and reminding staff to ask questions if they were uncertain. He added when errors occurred, he completed a plan of correction for either individual staff members or the entire dietary team. He emphasized staff were expected to pay close attention to meal tickets. He stated Resident #56 received beef despite the meal ticket indicating no beef because of a server error. He further stated he had not received concerns regarding Resident #56's meal trays.An interview conducted on 06/10/2026 at 2:35 PM with Nurse Aide (NA) #9 revealed she had worked at the facility for approximately one year. NA #9 stated during mealtimes, NAs were expected to review the meal ticket and meal tray for accuracy before providing the tray to a resident. She stated that when the meal ticket and tray contents did not match, staff were expected to notify the kitchen so the tray could be corrected. NA #9 verified she worked on 06/08/2026 and distributed lunch trays to resident rooms on Resident #56's hall. When shown Resident #56's lunch meal ticket from 06/08/2026, NA #9 stated serving Resident #56 Mech Soft Beef Stir Fry was a mistake because the ticket indicated Resident #56 was a vegetarian, liked fish, and did not eat pork or beef. Additionally, she stated that the food preferences were missed during meal tray delivery on 06/08/2026 during lunch. NA #9 stated when Resident #56 reported a concern, she notified the kitchen staff and obtained a substitute meal.An interview conducted on 06/10/2026 at 2:45 PM with Nurse #5 revealed she was familiar with (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56. Nurse #5 stated Resident #56 was not a vegetarian at admission but chose to become one several months earlier (exact date unknown) to help maintain weight loss. Nurse #5 stated she occasionally assisted with meal tray delivery and had heard concerns from Resident #56 regarding meal preferences not being followed approximately once or twice per month. She stated when a resident reported concerns that meal preferences had not been accommodated, she notified the kitchen and assisted in obtaining a replacement meal.An interview conducted on 06/12/2026 at 3:45 PM with the Director of Nursing (DON) revealed facility staff had recently informed her of the concern with Resident #56's food preferences. The DON indicated dietary staff should review meal tickets and trays during meal preparation and floor staff should review meal tickets and trays before delivering them to residents. She further stated resident meal preferences were expected to be accommodated. An interview conducted on 06/12/2026 at 4:05 PM with the Administrator revealed he expected facility staff to follow meal tickets and accommodate resident food preferences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, physician, Physician Assistant, and staff interviews, the facility failed to implement their infection control policy regarding hand hygiene when a staff member failed to perform hand hygiene while performing wound care (Resident #17). This deficient practice occurred for 1 of 28 staff observed for infection control (Wound care nurse).The findings included:Review of the facility policy Infection Prevention and Control with a revised date of 3/11/21 revealed the following: The Infection Prevention and Control Program will incorporate risk assessments, surveillance activities, evidence-based prevention practices, education, and communication to mitigate risks and decrease adverse outcomes related to Infection Prevention and Control.The responsibilities of the Infection Preventionist include directing all infection control activities and assessing, developing, implementing, monitoring, evaluating, and managing the Infection Control Program.Objectives include surveillance activities to identify infections and causative factors and identify opportunities for risk of blood/body fluid exposure in (staff) and implementation of methods for reducing the risks of exposure; continuous education for all (staff) relating to infection prevention and control, with emphasis on hand hygiene .transmission of infectious diseases .transmission-based precautions and susceptibility to residents to infectious diseases. An observation of Resident #17's wound care was conducted on 6/11/26 at 12:15 PM. The wound care nurse was observed as she performed hand hygiene then donned a gown and gloves prior to completing wound care. The nurse removed the soiled dressings from Resident #17's left buttocks then doffed her gloves and performed hand hygiene. The wound care nurse performed hand hygiene then donned a clean pair of gloves and used a single piece of gauze wet with Dakin's solution to wipe the upper and lower wounds on the left buttocks. The wound care nurse doffed her gloves and donned a clean pair of gloves without performing hand hygiene. She placed separate pieces of calcium alginate over each wound then covered the wounds with a single bordered foam dressing. The wound care nurse then doffed her gloves and applied a clean pair of gloves without performing hand hygiene in between. She then applied a skin protective ointment over the excoriation on Resident #17's scrotal area. The wound care nurse then doffed her PPE and performed hand hygiene prior to exiting the resident's room.An interview was conducted with the wound care Physician's Assistant (PA) on 6/11/26 at 12:25 PM who stated Resident #17's wounds were close in the same area, so she was labeling the wounds as a cluster. The PA explained that the wounds did not reveal any signs of infection. She further stated that the wound care nurse should have used separate gauze to clean the resident's wounds, but if each wound had its own piece of calcium alginate covering it, then it would be acceptable to use one bordered gauze over both sites.An interview was conducted with the wound care nurse on 6/11/26 at 12:37 PM who stated she realized she only performed hand hygiene once during wound care. The wound care nurse stated she should have performed hand hygiene with each glove change and between each separate wound care area. She related her lack of hand hygiene to being nervous while being observed. The wound care nurse further stated she should have used a separate gauze to clean both wounds for Resident #17.The Director of Nursing (DON) was interviewed on 6/12/26 at 2:02 PM who stated the wound care nurse should have performed hand hygiene with each glove change. She further stated the wound care nurse should have used a separate gauze to clean each wound.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on record review, observations and staff interviews, the facility failed to provide a working privacy curtain that allowed for full visual privacy to protect a resident from view of others during activities of daily living care while bathing. This deficient practice affected 1 of 3 residents reviewed for privacy curtains (Resident #57).The findings included:On 6/11/26 at 10:33 AM an observation was conducted for activities of daily living (ADL) care for Resident #57. Resident #57's bed was closest to the door of the room. NA #2 was providing Resident #57 a bed bath with the door closed and privacy curtain pulled between Resident #57 and her roommate who was resting in bed. This surveyor was standing at the foot of Resident #57's bed during the observation when Nurse #1 simultaneously knocked on and opened the door to the resident's room. Resident #57's bare bottom was exposed to the hallway while being washed. No other staff or visitors were observed in the hallway. Nurse #1informed NA #2 that the hospice NA needed to visit Resident #57's roommate then told hospice NA #1 she could enter and shut the door. NA #2 attempted to close the privacy curtain next to the door, but it failed to move due to multiple missing hooks, approximately a 2-foot span, that connected the privacy curtain to the ceiling. However, hospice NA #1 proceeded to enter the room and walked past Resident #57 whose bottom remained exposed and visible to the hospice NA as she walked past the resident.NA #2 was interviewed on 6/11/26 at 10:55 AM. NA #2 explained The privacy curtain would not pull all the way around so we could not give Resident #57 privacy. According to NA #2 it was the housekeeping department's responsibility to replace privacy curtains when needed.On 6/11/26 at 11:18 AM Housekeeping Assistant #1 was interviewed and stated housekeeping changed privacy curtains if they were dirty. He stated the last time the privacy curtains for Resident #57 were changed was approximately 2 weeks prior to the observation, but he could not provide a specific date. Housekeeping Assistant #1 stated it was the responsibility of maintenance to install hooks in the curtains when they were needed.The Housekeeping Director was interviewed on 6/11/26 at 11:20 AM. She stated she had been acting as the Maintenance Director for a while (unspecified timeframe) while the facility did not have a Maintenance Director. The Housekeeping Director stated the nurses were responsible for putting a work order in the TELS system (a web-based facility management system that helps manage maintenance concerns) when there was an issue with the privacy curtains not working. According to the Housekeeping Director she had not received a work order in TELS regarding Resident #57's privacy curtain not functioning. She reviewed the TELS orders with this surveyor, and no work orders for Resident #57's privacy curtain were noted.On 6/12/26 at 2:02 PM the Director of Nursing (DON) was interviewed and stated housekeeping should have checked Resident #57's privacy curtain and changed it if it was defective.The Administrator was interviewed on 6/12/26 at 2:55 PM who stated Resident #57's privacy curtain should have been maintained in a functional order. He stated a work order should have been entered in the TELS system so housekeeping could have checked the privacy curtain.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to accurately document actual working hours of licensed staff for 6 of 6 daily nurse staffing sheets reviewed (5/6/26, 5/15/26, 5/17/26, 6/1/26, 6/2/26, and 6/6/26). The findings included:Review of the posted nurse staffing sheets for 5/6/26, 5/15/26, 5/17/26, 6/1/26, 6/2/26, and 6/6/26 revealed the following:a. The posted nurse staffing sheet dated 5/6/26 indicated 2 Registered Nurses (RNs) worked the day shift (7:00 AM to 3:00 PM) and provided 24 hours of care during the 8-hour shift.The posted nurse staffing sheet indicated 3 Licensed Practical Nurses (LPNs) provided 36 hours of care during the 8-hour shift. The posted nurse staffing sheet for afternoon shift (3:00 PM to 11:00 PM) indicated 3 RNs provided 36 hours of care and 7 LPNs provided 84 hours of care during the 8-hour shift. The posted nurse staffing sheet indicated 1 RN provided 36 hours of care for the night shift (11:00 PM to 7:00 AM), and 2 LPNs provided 84 hours of care during the 8-hour shift.Review of the schedule for this date revealed hours of care provided should have been as follows: for day shift RN 16 hours, LPN 24 hours; for afternoon shift RN 24 hours, LPN 20.5 hours for afternoon shift; for night shift RN 8 hours, LPN 16 hours.b. The posted nurse staffing sheet dated 5/15/26 indicated that 3 RNs provided 36 hours of care, and 2 LPNs provided 24 hours of care during the 8-hour day shift, 4 RNs provided 48 hours of care, 5 LPNs provided 60 hours of care during the 8-hour afternoon shift, 1 RN provided 12 hours of care, and 2 LPNs provided 24 hours of care for the 8-hour night shift.Review of the schedule for this date revealed hours of care provided should have been as follows: for day shift RN 24 hours, LPN 16 hours; for afternoon shift RN 20 hours, LPN 20 hours; for night shift RN 8 hours, LPN 16 hours.c. The posted nurse staffing sheet dated 5/17/26 indicated that 3 RNs provided 36 hours of care, and 2 LPNs provided 24 hours of care during the 8-hour day shift, 5 RNs provided 60 hours of care, 5 LPNs provided 60 hours of care during the 8-hour afternoon shift, 1 RN provided 12 hours of care, and 2 LPNs provided 24 hours of care for the 8-hour night shift.Review of the schedule for this date revealed hours of care provided should have been as follows: for day shift RN 24 hours, LPN 16 hours; for afternoon shift; RN 20 hours, LPN 20 hours; for night shift RN 8 hours, LPN 16 hours.d. The posted nurse staffing sheet dated 6/1/26 indicated that 2 RNs provided 24 hours of care, and 2 LPNs provided 24 hours of care during the 8-hour day shift, 4 RNs provided 48 hours of care, 4 LPNs provided 48 hours of care during the 8-hour afternoon shift, 1 RN provided 12 hours of care, and 2 LPNs provided 24 hours of care for the 8-hour night shift.Review of the schedule for this date revealed hours of care provided should have been as follows: for day shift RN 24 hours, LPN 8 hours; for afternoon shift RN 20 hours, LPN 18 hours; for night shift RN 8 hours, LPN 16 hours.e. The posted nurse staffing sheet dated 6/2/26 indicated that 2 RNs provided 24 hours of care, and 3 LPNs provided 36 hours of care during the 8-hour day shift, 4 RNs provided 48 hours of care, 5 LPNs provided 60 hours of care during the 8-hour afternoon shift, 1 RN provided 12 hours of care, and 2 LPNs provided 24 hours of care for the 8-hour night shift.Review of the schedule for this date revealed hours of care provided should have been as follows: for day shift RN 16 hours, LPN 24 hours; for afternoon shift RN 16 hours, LPN 20 hours; for night shift RN 8 hours, LPN 16 hours.f. The posted nurse staffing sheet dated 6/6/26 indicated that 4 RNs provided 48 hours of care, and 1 LPN provided 12 hours of care during the 8-hour day shift, 6 RNs provided 72 hours of care, 2 LPNs provided 24 hours of care during the 8-hour afternoon shift, 2 RN provided 24 hours of care, and 1 LPN provided 12 hours of care for the 8-hour night shift.Review of the schedule for this date revealed hours of care provided should have been as follows: for day shift RN 32 hours, LPN 8 hours; for afternoon shift RN 28 hours, LPN 8 hours; for night shift RN 16 hours, LPN 8 hours.During an interview with the Staffing Coordinator on 6/12/26 at 10:34 AM, she revealed she was responsible for updating the posted daily nurse staffing sheet Monday through Friday and the charge nurse was responsible for updating the sheet on the weekends. The Staffing Coordinator reported she would check the weekend posted nurse staffing sheets sometimes for accuracy. The Staffing Coordinator explained that licensed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	nursing staff worked 12-hour shifts (from 7:00 AM to 7:00 PM, and 7:00 PM to 7:00 AM) and the nursing assistants (NAs) worked 8-hour shifts. The Staffing Coordinator described she counted the number of RNs and LPNs in the building and multiplied that number by 12 to get the total number of hours worked for each shift. The Staffing Coordinator reported she had not been instructed to count the number of hours worked by each nurse for the total number of hours worked each shift. The Staffing Coordinator reported she was aware the posted nurse staffing sheet should be accurate to reflect the current staffing in the facility.The Administrator was interviewed on 6/12/26 at 4:00 PM. The Administrator reported he was not aware the Staffing Coordinator was reporting inaccurate hours worked on the daily posted nurse staffing sheet and he expected the posted nurse staffing sheet to accurately reflect the current staffing in the facility.