STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Cove Health and Rehabilitation Center	511 Windmill Street Walnut Cove, NC 27052

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff, resident and resident RP (Responsible Party) interviews, the facility failed to protect a resident's right to be free from misappropriation of property leading to a monetary loss of $1309.99 for 1 of 3 residents reviewed for misappropriation of resident property (Resident #23).The findings included:Resident #23 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction. Resident #23's admission Minimum Data Set (MDS) assessment revealed she was cognitively intact.The facility 24 Hour Initial Allegation Report completed by the Administrator dated 6/25/25 revealed the Director of Nursing was notified of an allegation that Resident #23 reported a missing debit card on 6/25/25 at 5:56 PM. The Administrator was notified on 6/25/25 by the Director of Nursing about the allegation. The report noted Resident #23's RP (Responsible Party) informed her there were potentially unauthorized charges on her debit card. Resident #23's RP informed her she had called the company that processed the charge and was informed the charge was related to a monthly rent payment. There was no physical injury or harm. There was no mental anguish. No alleged perpetrator was identified in the initial report, and the local police were notified. The facility 5 Day Investigation Report completed by the Director of Nursing and dated 7/1/25 documented the following:- Resident #23 reported her RP had informed her about the transaction on her debit card. She reported that her RP had contacted the company that made the charge for the funds to clarify the purpose of the charges. The manager of the company reviewed the charge and indicated it was related to a rent payment for a tenant of the apartment community. The manager disclosed the tenants' name to the RP. Resident #23 asked the facility to call her RP for more details. Resident #23's RP confirmed there was a charge made to the apartment community for a tenant that was an employee (Nursing Assistant #5) of the facility.- Resident #23 and her RP were informed by the facility that Nursing Assistant (NA) #5 would be suspended pending investigation. NA #5 was called and suspended pending the results of the investigation.-On 6/25/25 the local Sheriff's Department was notified and a deputy came to the facility and interviewed Resident #23. The facility followed up with the deputy and was informed that the case had been turned over to the criminal investigative unit and a detective would be available to answer any additional questions.-On 6/26/25 the Director of Nursing notified Adult Protective Services (APS) of the incident.An addendum to the facility investigation dated 7/16/25 written by the Director of Nursing noted the detective had notified the facility that a warrant had been issued for the arrest of NA #5 who used Resident #23's debit card. The detective indicated enough evidence had been collected to charge NA #5 with three separate felony charges related to the unauthorized use of Resident #23's debit card.An attempt to contact the law enforcement officer on 8/19/25 at 3:38 PM was unsuccessful.An attempt to contact the alleged perpetrator (NA #5) on 8/19/25 at 3:42 PM was unsuccessful.During an interview with Resident #23 on 8/20/25 at 9:45 AM she stated she had called to check her account balance the morning of 6/25/25 because she was expecting a deposit. Resident #23 reported her account balance was at $51.00 and a charge of $1309.99 had been charged to her card. Resident #23 stated she called her RP to have her find out information about the charge. Resident #23 stated she kept her debit card in her purse in the top drawer of the dresser. Resident #23 stated she never missed her debit card. Resident #23 denied that she used the funds to pay for any part of her stay at the facility. Resident #23 stated she was surprised that someone used her debit card without her consent. Resident #23 stated she did not feel afraid or that she could not trust staff that worked with her. Resident #23 stated the bank reimbursed her the money back in July.An interview with Resident #23's RP on 8/19/25 at 3:21 PM revealed she was notified by Resident #23 the morning of 6/25/25 to review her debit card account because she was missing some money. The RP stated she noticed a charge for $1309.99 was charged to Resident #23's account and neither the RP nor resident recognized the charge. The RP stated she called the number attached to the transaction and learned that the payment was to a rental agency for NA #5. The RP stated she explained to Resident #23 that she needed to report the charge to the facility. The RP stated she had not had any interaction with NA #5. The RP stated the facility notified both Resident #23 and her that the local law enforcement would be notified. During an interview with Nurse #4 on 8/19/25 at 4:53 PM she stated she was informed by another NA on the unit on 6/25/25 that Resident #23 had made a complaint about missing money from her debit card. She was unable to recall which NA informed her of this. Nurse #4 stated she went to speak with Resident #23, and she reported that someone had made an unauthorized charge to her debit card. Nurse #4 stated she immediately reported the information to the

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 3 of 3 residents reviewed for resident assessment (Resident #55, Resident #81, Resident #85).The findings included:a.Resident #55 was admitted to the facility on [DATE].Review of Resident #55's medical record revealed he was discharged to another facility on 4/11/25.Review of Resident #55's medical record revealed the last completed MDS assessment was a comprehensive assessment dated [DATE]. There was no discharge assessment completed or transmitted.b. Resident #81 was admitted to the facility 3/27/25.Review of Resident #81's medical record revealed he was discharged home on 4/12/25.Review of Resident #81's medical record revealed the last completed MDS assessment was a comprehensive assessment dated [DATE]. There was no discharge assessment completed or transmitted.c. Resident #85 was admitted to the facility on [DATE].Review of Resident #85's medical record revealed she was discharged home on 4/10/25.Review of Resident #55's medical record revealed the last completed MDS assessment was a comprehensive assessment dated [DATE]. There was no discharge assessment completed or transmitted.During an interview with the MDS Coordinator on 08/21/25 at 10:53 AM while viewing the medical records she stated all three residents had missing discharge MDS assessments. The MDS Coordinator stated when she knew a person was discharged , she completed a discharge MDS assessment that indicated whether the person was coded as discharge return not anticipated, or discharge return anticipated. The MDS Coordinator indicated the discharge MDS assessment had to be completed 14 days after discharge. The MDS Coordinator stated she was not sure how she had missed completing the discharge MDS assessments for the three residents. She further stated the assessments did not trigger on her MDS progress list. During an interview with the Administrator on 08/21/25 at 3:16 PM, he stated he expected that the discharge MDS assessment would be completed and transmitted according to guidelines.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to develop a person-centered care plan in the areas of diabetes management (Resident #13) and smoking status (Resident #23). This deficient practice was for 2 of 29 residents whose care plans were reviewed. The findings included: 1. Resident #13 was admitted to the facility on [DATE] with diagnoses which included diabetes. An active physician order included insulin glargine (long-acting insulin) inject 15 units subcutaneously in the morning related to diabetes. An active physician order included insulin glargine inject 20 units subcutaneously at bedtime for diabetes. An active physician order included metformin (medication used to treat diabetes) 500 milligram tablet; give one tablet twice a day for diabetes. Resident #13’s care plan which was last reviewed on 7/08/25 revealed no care plan for the management of diabetes. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #13 had moderate cognitive impairment. Resident #13 was coded for diabetes diagnosis and the use of hypoglycemic (which included insulin) medication. An interview was conducted with the MDS Nurse on 8/21/25 at 9:37 am who revealed she was responsible for Resident #13’s care plan. The MDS Nurse reviewed Resident #13’s care plan in the presence of the surveyor and reported that she did not see that a care plan for diabetes had ever been implemented. The MDS Nurse stated she should have caught the missing care plan when she completed the comprehensive review, but she just missed it. An interview was conducted with the Director of Nursing (DON) on 8/21/25 at 12:35 pm who revealed the MDS Nurse was responsible to ensure that Resident #13’s care plan for medical diagnoses were in place when she completed the review. 2. Resident #23 was admitted to the facility on [DATE]. Review of the admission MDS assessment with an Assessment Reference Date (ARD) dated 5/1/25 revealed Resident #23 was cognitively intact. Review of the medical record revealed a smoking assessment dated [DATE] which indicated the resident was a safe smoker and she required assistance to get outside to go smoke. Resident #23’s care plan last revised on 8/12/25 revealed no care plan for smoking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation of Resident #23’s medical record with the MDS Nurse on 08/21/2025 at 10:53 AM she stated she was responsible for completing the care plan. Review of Resident #23’s care plan by the MDS Nurse revealed she did not see a smoking care plan for Resident #23 had been implemented. During an interview with the Director of Nursing on 8/21/25 at 3:00 PM, she stated the MDS Nurse was responsible for making sure Resident #23’s care plan reflected her smoking status. During an interview with the Administrator on 08/21/2025 at 3:16 PM, he stated the MDS nurse was responsible for care plans.

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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 observations, record review, resident and staff interviews, the facility failed to revise the care plan in the areas of use of a wander/elopement alarm (Resident #13) and smoking status (Resident #39) for 2 of 29 residents whose care plans were reviewed. The findings included:1. Resident #13 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease. The Elopement Risk Evaluation assessment completed on 6/24/25 revealed Resident #13 was not determined to be at risk for elopement. The care plan which was last reviewed on 7/08/25 revealed Resident #13 had a care plan in place for elopement risk with an intervention for the use of a wander/elopement alarm. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #13 had moderate cognitive impairment and was not coded for the use of the wander/elopement alarm. Review of Resident #13's active physician orders revealed no physician order for the use of a wander/elopement alarm.An observation on 8/18/25 at 12:47 of Resident #13 revealed no wander/elopement alarm was in place. An interview was conducted with the MDS Nurse on 8/21/25 at 9:37 am who confirmed Resident #13 did not have a wander/elopement alarm in use. The MDS Nurse stated she did not see the wander/elopement alarm was still listed as an intervention for Resident #13 when she completed her care plan review and it was just missed. An interview was conducted with the Director of Nursing (DON) on 8/21/25 at 12:35 pm who revealed Resident #13 had a wander/elopement alarm in the past but no longer had the wander/elopement alarm. The DON stated the MDS Nurse was responsible to ensure that Resident #13's care plan was accurate when she completed the review. 2. Resident #39 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder and nicotine dependence.The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #39 was cognitively intact. The quarterly smoking evaluation dated 8/02/25 revealed Resident #39 was determined to be an unsafe smoker.The care plan last reviewed on 8/14/25 revealed Resident #39 was a safe smoker with a goal that Resident #39 would not participate in unsafe smoking practices. The care plan had interventions which included educating the resident on the smoking policy, smoking locations and times. During an interview on 8/18/25 at 3:55 pm Resident #39 stated he smoked cigarettes daily and the facility had him on the unsafe smoking list, so he was not allowed to go out by himself to smoke. An observation was conducted on 8/20/25 at 2:10 pm of Resident #39 smoking with staff present with no identified concerns.An interview was conducted with Nurse Aide (NA) #1 who revealed Resident #39 had previously been a safe smoker and was allowed to go out by himself to smoke. NA #1stated Resident #39 was recently changed to an unsafe smoker and he now needed to be supervised when smoking. During an interview with the MDS Nurse on 8/21/25 at 9:46 am she revealed she was aware that Resident #39 was determined to be an unsafe smoker, but she had not updated Resident #39's care plan yet. The MDS Nurse stated she should have updated Resident #39's care plan to reflect the unsafe smoker status when she completed the review. The Director of Nursing (DON) was interviewed on 8/21/25 at 12:38 pm who revealed Resident #39 was determined to be an unsafe smoker and the MDS Nurse was notified of the change. The DON stated the MDS Nurse should have updated Resident #39's smoking care plan to reflect the current smoking status.