STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Penick Village	401 East Rhode Island Avenue Southern Pines, NC 28387

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 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 observations, record review, family member and staff interviews, the facility failed to maintain a resident's dignity by not placing a cover over her urine collection bag for 1 of 1 resident reviewed for dignity (Resident #21). A reasonable person would not want their urine visible to the public. The findings included:Resident #21 was readmitted to the facility on [DATE] with diagnoses that included retention of urine and neuromuscular dysfunction of bladder.Resident #21's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was severely cognitively impaired and coded as having an indwelling urinary catheter.An observation was completed on 4/15/26 at 11:27 AM of Resident #21 sitting in the Activity Room with other residents and staff (Life Enrichment/ Activity personnel). Resident #21's urine collection bag was observed without a cover in place. Her urine was observed at a level of 200 milliliters (ml) volume and yellow in color.An observation was completed on 4/15/26 at 3:22 PM of Resident #21 in the Activity Room during the 3:00 PM activity with the Chaplain, along with other residents. Resident #21 was observed in her wheelchair. Her urine collection bag remained exposed and uncovered which was visible through the glass windows from the hallway. Her urine was observed to be yellow in color. An observation was completed on 4/15/26 at 3:50 PM of Resident #21 observed sitting in her wheelchair in the small dining area adjacent to the nurse's station. Other residents, staff, hospice staff and visitors were observed passing the small dining area or entering the small dining area during this time. Resident #21's urine collection bag was observed without a cover in place and yellow urine was visible from the hallway.A telephone interview with Resident #21's Family Member was conducted on 4/16/26 at 2:28 PM. She revealed Resident #21 would absolutely want her urine collection bag concealed with a cover when out of room and in activities. An interview with Nurse Aide (NA) #1 was completed on 4/15/26 at 4:00 PM and revealed she was assigned to Resident #21. NA #1 stated she assisted Resident #21 into her wheelchair with the assistance of another staff person due to Resident #21 being a mechanical lift transfer. NA #1 explained she was agency staff but had received training on urinary catheter care and maintaining a resident's dignity. NA #1 explained she would transfer the urine collection bag from the bed to the wheelchair and back as care was provided to Resident #21. NA #1 further stated she would inform her nurse of any concerns regarding the urinary catheter and the urine collection bag. NA #1 did not recall if Resident #21's urine collection bag had a cover in place on 4/15/26. NA #1 indicated she was not aware of where covers for urine collection bags were located and stated the nurse would take care of any catheter needs except for rendering care if the NA was not available. An interview was completed with Medication Aide #1 on 4/15/26 at 4:35 PM. Medication Aide #1 stated she had been trained for urinary catheter care and maintaining dignity for residents with urinary catheters. Medication Aide #1 expressed the training included ensuring urine collection bags had a cover in place or was placed in a dignity bag concealing the urine collection bag. She confirmed she overlooked the application of the cover for Resident #21 when she emptied the urine collection bag around 2:00 PM on 4/15/26. Medication Aide #1 explained she would normally empty the urine collection bag in the afternoon, make sure the anchor for the catheter remained in place, and check for any other issues. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Then she would make sure the urine collection bag had a cover in place. Medication Aide #1 verbalized this was an oversight by not making sure Resident #21's urine collection bag had a cover in place after completing the above tasks.An interview was completed with the Director of Nursing (DON) on 4/16/26 at 10:05 AM. She reported residents with urine collection bags should have covers in place unless care was being rendered. She confirmed that covers were available and staff have been trained in proper application. She was uncertain as to the reason why Resident #21 did not have a cover in place for her urinary catheter.On 04/16/26 at 3:33 PM an interview was conducted with the Administrator. She reported a dignity cover should be in place for all residents with urine collection bags. The Administrator was uncertain as to why Resident #21 did not have a cover in place.

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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 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 review and staff interviews, the facility failed to provide the CMS Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services for 1of 3 residents reviewed for the beneficiary protection notification review (Resident #1).The findings included: Resident #1 was readmitted on [DATE]. A review of Resident #1's medical record revealed a CMS-10123 Notice of Medicare Non-Coverage (NOMNC) form was issued to Resident #1 which explained Medicare Part A coverage for skilled nursing and therapy services would end 3/26/26. The NOMNC was reviewed and signed by the Care Navigator, via telephone consent from the Responsible Party (RP) on 3/24/26. Resident #1 resided in the facility during the time the survey was conducted from 4/13/26 to 4/16/26. A review of Resident #1's medical record revealed a CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form was not provided to Resident #1 or Resident #1's RP.On 4/16/26 at 3:02 PM an interview was conducted with the Care Navigator, who confirmed the CMS-10123 NOMNC form was issued to Resident #1 when Medicare Part A services were ending. The Care Navigator stated the CMS-10055 SNF-ABN for Resident #1 was not provided to Resident #1 or the RP. The Care Navigator further stated she was unaware that residents who remained in the facility after Medicare Part A coverage ends should receive a CMS-10055 SNF ABN. The Care Navigator communicated Resident #1 had 37 days left of Medicare Part A coverage.On 4/16/2026 at 3:35 PM an interview with the Administrator revealed the facility's process for SNF beneficiary notification for residents that remain in the facility required that both a NOMNC and SNF-ABN be accurately completed and provided, by the Care Navigator, to residents who remained in the facility. The Administrator confirmed Resident #1 should have received a CMS-10055 SNF-ABN form.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to ensure clean dishware was dry prior to stacking for 1 of 2 kitchen observations. Wet nesting has the potential for bacterial growth on dishware and could affect the food served to residents.The findings included:The initial tour of the kitchen occurred on 04/13/26 at 11:10 AM with the Dietary Manager and Director of Dietary. The initial observation of the dishware storage area revealed dishware that was ready for use, put away and stacked wet. The following clean dishes were observed wet and nesting: 3 metal 1/3 serving pans and 2 metal half serving pans were stacked upside down visibly wet with pooled water on the sides and water pooled around the rim. An interview with the Dietary Manager on 04/13/26 at 11:28 AM revealed dishware should be cleaned, dried thoroughly, and stored facing down to prevent wet nesting. The Dietary Manager stated wet nesting could cause bacteria to grow. The Dietary Manager was unable to identify which dietary staff was responsible for stacking the serving pans while wet. An interview was conducted with the Administrator on 4/13/26 at 4:20 PM. The Administrator indicated items should not be stored wet, as retained moisture could promote bacterial growth.