

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2025
NAME OF PROVIDER OR SUPPLIER Lenoir Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 322 Nuway Circle Lenoir, NC 28645	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review, and Nurse Practitioner, and staff interviews, the facility failed to provide supervision to prevent accidents when a resident (Resident #1) with left sided weakness, muscle wasting, vascular dementia and at risk for falls fell from the bed in low position on 5/25/2025 and the facility failed to implement a new intervention for fall prevention. The resident had another fall from bed that was not in the low position on 6/1/2025 and was found face down on the floor. Resident #1 was transferred to the hospital for emergency medical treatment where it was discovered Resident #1 had sustained a large scalp laceration with significant bleeding that was cleaned and repaired with staples and a cervical spine (one of the vertebrae of the neck) fracture that required wearing a cervical collar at all times. This deficient practice occurred for 1 of 3 residents reviewed for falls (Resident #1).</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff, pharmacist and Nurse Practitioner interviews, the facility failed to prevent a significant medication error when an ordered medication was not available to be administered and when Medication Aide (MA) #1 pulled an incorrect dose of a potassium supplement and crushed and administered the potassium supplement that was labelled as a do not crush medication for 1 of 3 residents reviewed for medication errors (Resident #4). The findings included: Resident #4 was admitted to the facility on [DATE] with diagnosis that included end stage renal disease on hemodialysis, other specified disorders of the brain, secondary hyperparathyroidism of renal origin, and dysphagia oral phase. Review of Resident #4's hospital records prior to admission revealed the following lab results: On 6/4/2025 a Potassium level of 3.8 (Normal range 3.5-5.2) On 5/30/2025 a Potassium level of 3.9, a Calcium level of 9.6 (normal range 8.5-10.2), Phosphorus 2.7 (Normal range 2.5-4.5) Review of Resident #4's care plan 6/6/2025 revealed resident was care planned at risk for cardiac complications secondary to chronic kidney disease with interventions that included administer medication as ordered. Review of Resident #4's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact and indicated Resident #4 received hemodialysis. A. Review of a Physician's order dated 6/4/2025 stated Cinacalcet HCL (cinacalcet mimics the action of calcium in the body and is used to treat hyperparathyroidism with chronic kidney disease and also helps regulate calcium and phosphorus levels which reduce the risk of bone disease and cardiovascular issues) 60 milligrams (mg) tablet take one tablet by mouth once daily with food. Review of the Medication Administration Record (MAR) for June 2025 revealed cinacalcet HCL 60mg daily was coded as not available to be administered to Resident #4 as scheduled on 6/19/2025 and 6/23/2025. Review of the MAR for July 2025 revealed cinacalcet HCL 60mg daily was coded as not available to be administered to Resident #4 as scheduled on 7/3/2025 and 7/7/2025. On 7/7/2025 at 9:06 AM Medication Aide (MA) #1 was observed as she prepared Resident #4's medications. MA #1 noted that Resident's cinacalcet 60mg was not available and MA #1 was observed as she reported the unavailable medication to Nurse #3. MA #1 was asked prior to administering the medications if she had completed pulling Resident #4's medication. MA #1 confirmed she had all of Resident #4's medication and was ready to administer them. During an interview on 7/7/2025 at 9:15 AM MA #1 stated Resident #4's cinacalcet 60mg had been unavailable on other days as well and she had asked the nurses to reorder it. During an interview on 7/8/2025 at 11:54 AM Nurse #3 stated MA #1 had reported that Resident #4 did not have any cinacalcet available. Nurse #3 stated she called and reported the unavailable medication to the dialysis center. During an interview on 7/8/2025 at 9:03 AM the Pharmacist stated that seven tablets of cinacalcet 60 mg had been sent to the facility from the pharmacy on 6/5/2025, 6/11/2025 and 6/23/2025. The Pharmacist stated that medication (cinacalcet) was supposed to be supplied from the dialysis center, but they had sent a week supply when the facility requested to try to help the facility have a supply until it was received from dialysis center. The Pharmacist stated missing doses of cinacalcet may cause a difference in residents serum lab values. During an interview on 7/8/2025 at 10:24 AM the Dialysis Charge Nurse stated the facility had called the week prior for a refill of Resident #4's cinacalcet and it had been processed for refill. The Dialysis Charge Nurse stated the facility would receive the medication by mail and it was likely in transit. B. Review of a Physician's order dated 6/5/2025 stated Potassium Chloride Crys ER (extended release) (extended-release potassium chloride is used to treat or prevent low potassium levels. It is crucial for proper functioning of the heart, muscles, kidneys and nervous and digestive systems) 20 milliequivalents (MEQ) tablet extended release take two tablets by mouth once daily for supplement. On 7/7/25 at 9:06 AM MA #1 was observed as she pulled one tab of potassium chloride 20 MEQ and placed it in a medication cup for Resident #4. MA #1 completed preparing Resident #4's medications and put several medications in a plastic sleeve to crush them. MA #1 was asked prior to crushing the medications if she had completed pulling Resident #4's medication. MA #1 confirmed she had all of Resident #4's medication and was ready to administer them. The MA #1 and surveyor reviewed Resident #4's order for potassium chloride and verified the order read to administer two tablets of potassium chloride 20 MEQ. MA #1 stated she had missed that and only pulled one tablet and verified she would have administered an incorrect dose. MA #1 pulled a second potassium chloride 20 MEQ tablet, placed it into a plastic sleeve and crushed the two potassium tablets along with several other medications and administered Resident #4 the medications that had been prepared. During an interview on 7/7/2025 at 9:15 AM MA #1 verified she had prepared an</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and resident, staff, and pest control contractor supervisor interviews, the facility failed to maintain an environment free from flies in 2 of 2 resident rooms (Resident #2 and #3) on 1 of 4 halls and the kitchen. In addition, the facility failed to notify the pest control contractor of the increased fly activity. Findings included:a. Resident #3 was admitted to the facility on [DATE].Review of Resident #3's Minimum Data Set (MDS) admission assessment dated 7/01/25 indicated he had moderately impaired cognition.An observation on 7/07/25 at 10:20 AM in Resident #3's room noted 6 flies at the same time on the bed and privacy curtain. Resident #3 stated he could not sleep due to flies crawling on him and thought it was an awful environment. He also stated he had reported his concerns about the flies to multiple staff members.b. Resident #2 was admitted to the facility on [DATE].Review of Resident #2's Minimum Data Set (MDS) quarterly assessment dated [DATE] indicated he had moderately impaired cognition.An observation on 7/07/25 at 11:50 AM in room [ROOM NUMBER]'s room noted 3 flies at the same time on the bed and bedside table. Resident #2 stated he had trouble eating since he did not like eating food after he saw flies crawling on his food.c. An observation on 7/07/25 at 12:15 PM in the kitchen revealed 1 fly on a metal cart and 3 flies on the temperature logbook lying on the counter by the food preparation area where food was being plated for the lunch meal. The Dietary Manager stated the pest control service technician had been there recently to treat. She also stated they cleaned between meals and stored the food between meals.An interview on 7/07/25 at 7:33 PM with Nursing Assistant (NA) #1 revealed she had not reported seeing flies in the facility electronic software maintenance system. She stated the Administrator was already aware since it had been mentioned in the facility group chat text messaging. An interview on 7/07/25 at 8:36 PM with NA #2 revealed he knew there was a book at the nurses' station to write maintenance concerns. He had not reported the flies in the facility as it was a known issue.An interview on 7/07/2 at 2:22 PM with the Maintenance Director revealed they had a pest control service company who serviced the facility monthly and as needed for pest control. He also revealed they currently had a fly pest problem which had gotten worse in the last couple of weeks. He stated his first reported fly concern was on 6/20/25. He also stated he had not asked the pest control service technician about other treatment options available to treat the flies. He stated he had not notified his Regional Maintenance Director of the increased number of flies. The Maintenance Director stated he believed the increased presence of flies was a result of the new automatic doors which were installed to allow easier access to the outside courtyard and smoking area. He stated he had recently had them adjusted to close faster. He stated about a year ago, the facility started utilizing an electronic software program where staff reported maintenance concerns. He stated based on this electronic software program, the first reported flies were reported on 6/20/25, but the report did not provide any further details.An observation was conducted on 7/07/25 at 9:30 AM of the automatic doors exiting the facility into the smoking area and courtyard. The automated doors opened with a hand wave sensor. No air curtain was observed to engage when the door was opened.Observations conducted on 7/08/25 at 5:55 AM and at 6:15 AM both revealed the left side of the automatic door was not fully closed and there was an open area of approximately 3 inches between the door and the door frame.Review of the pest control summary sheets on 7/07/25 at 2:25 PM, was conducted in conjunction and in the presence of the Maintenance Director. The review of the summary sheets revealed the pest control service had been to the facility and provided pest control services most recently on 6/23/25, 6/20/25, 5/27/25, and 4/24/25. The pest control summary sheets all noted flies in multiple locations and had recommendations which read in part the insect light traps in multiple locations were not working properly and needed to be replaced. The Maintenance Director stated he thought the insect light traps were working properly. He also stated insect light traps had been ordered for the kitchen. An observation on 7/7/25 at 2:30 PM with the Maintenance Director of the 5 insect light traps. Each resident hall had an insect light trap mounted on the wall and 1 insect light trap was located at the nurses' station. Dead bugs were observed on the sticky trap sheets inside the machines. All the light traps had stickers which read the bulbs were replaced on the date of 3/25/24.An interview on 7/08/25 at 9:23 AM with the Pest Control Contractor Supervisor revealed he had not received any reports of increased fly activity from the facility. He stated this facility was noted to have fly activity on a regular basis. He also stated there were additional treatments which could have been done if they had been aware of the increased fly activity at the facility. An interview on 7/08/25 at 10:42 AM with the Administrator revealed she was aware of the fly</p>		