

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 02/05/2026
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Nurse Practitioner interviews, the facility failed to notify the Physician/Nurse Practitioner when a resident did not receive his prescribed medication, Gabapentin, for diabetic polyneuropathy (a chronic nerve disorder caused by long-term high blood sugar in diabetes, leading to damage of multiple peripheral nerves, especially in the feet and legs) for 1 of 3 residents reviewed for notification (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus with diabetic polyneuropathy.A Physician order dated 10/24/25 revealed an order for Gabapentin (used to treat neuropathy), oral tablet 800 milligrams (mg), give one tablet by mouth three times a day related to diabetes mellitus.Review of Resident #1's Medication Administration Record (MAR) for January 2026 revealed an order for Gabapentin oral tablet 800 mg, one tablet by mouth three times a day for diabetes mellitus. The medication was marked as not administered on 1/26/26 for the 8:00 AM dose (Medication Aide #2) and the 8:00 PM dose (Nurse #1); on 1/27/26 for the 8:00 PM dose (Nurse #1); on 1/28/26 for the 8:00 AM (Nurse #2), 12:00 PM (Nurse #2), and 8:00 PM doses; and on 1/29/26 for the 8:00 AM and 12:00 PM doses (Medication Aide #1).On 2/04/26 at 2:15 PM, an interview was conducted with Medication Aide #2. During the interview, she stated on 1/26/26 at 8:00 AM Resident #1's Gabapentin was not in the medication cart to administer. The interview revealed she reordered Resident #1's medication in the electronic charting system but did not recall who she let know the resident did not receive his medication.On 1/29/26 at 2:00 PM, an interview was conducted with Nurse #1. During the interview, she stated Resident #1's medication was not in the medication cart on the two night shifts she had worked on 1/26/26 and 1/27/26. The interview revealed she documented on Resident #1's MAR that the medication was not administered and did not notify a provider that Resident #1 had missed doses of his prescribed medication, but she did not notify the provider because it had also been missed during the first shift and she thought the provider was aware.An observation conducted on 1/29/26 at 11:52 AM with Medication Aide (MA) #1 revealed MA #1 preparing Resident #1's 12:00 PM medication. During the observation, MA #1 stated Resident #1's medication, Gabapentin 800 mg, had been missing from the medication cart for at least three days. She explained that she had reordered the medication on 1/29/26 and let the Nurse on duty know (Nurse #2); however, it still was not in the medication cart, and she did not know why. The interview revealed as a Medication Aide, she would not notify a provider if a resident had missed a medication and she stated she told Nurse #2.On 1/29/26 at 1:03 PM, an interview was conducted with Nurse #2. During the interview, she stated on 1/28/26 the 8:00 AM dose of Gabapentin 800 mg was not in the medication cart for Resident #1. Nurse #2 stated that she did not notify the Nurse Practitioner or medical provider that Resident #1 had missed his medication because she thought it was just a pharmacy delay and the medication would be back in stock soon.On 1/29/26 at 2:35 PM, an interview was conducted with Unit Manager #1. During the interview,</p> <p>(continued on next page)</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
---	-------	-----------

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 02/05/2026
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>she stated she worked five to six days each week during first shift. Unit Manager #1 stated no staff member had come to her to let her know Resident #1 was missing medication. Unit Manager #1 stated she would have also called the Nurse Practitioner or Medical Director to let them know Resident #1's medication was not in the facility and would have followed up with the Pharmacy. On 1/29/26 at 5:10 PM, an interview was conducted with the Nurse Practitioner. During the interview, she stated she was unaware Resident #1 had missed doses of the medication Gabapentin. She explained he was taking the medication because he had a wound on his foot and could have adverse effects from not taking it, such as pain. The Nurse Practitioner stated missed doses of the medication would be significant for Resident #1's pain control. The Nurse Practitioner stated the facility should have notified her, and she would have called the Pharmacy and found out what the issue was with delivering his medication or ordered a substitute medication. On 2/04/26 at 3:14 PM, an interview was conducted with the Director of Nursing and Administrator. During the interview, the Director of Nursing stated the protocol for staff was to notify the Nurse Practitioner first, up until 5:00 PM daily, and if it were after 5:00 PM, to notify the on-call provider. The Director of Nursing stated nursing staff should have notified the Nurse Practitioner when Resident #19 missed his first dosage of the medication. The Administrator stated she also expected the nursing staff to notify the Nurse Practitioner immediately if a resident had not received their prescribed medication.</p>		

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 02/05/2026
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Pharmacist interviews, the facility failed to follow up with the pharmacy to ensure the availability and delivery of a resident's prescribed medication. The facility did not contact the pharmacy to verify the status of the resident's medication when it was unavailable in the medication cart, resulting in total of 8 missed doses of Gabapentin over a 4-day period. The deficient practice occurred for 1 of 3 residents reviewed for medication errors (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus with diabetic polyneuropathy (a chronic nerve disorder caused by long-term high blood sugar in diabetes, leading to damage of multiple peripheral nerves, especially in the feet and legs). A Physician order dated 10/24/25 revealed an order for Gabapentin (used to treat neuropathy) oral tablet 800 milligrams (mg), give one tablet by mouth three times a day related to diabetes mellitus.Review of Resident #1's MAR for January 2026 revealed an order for Gabapentin oral tablet 800 mg, one tablet by mouth three times a day for diabetes mellitus. The medication was marked as not administered on 1/26/26 for the 8:00 AM dose (Medication Aide #2) and 8:00 PM dose (Nurse #1); on 1/27/26 for the 8:00 PM dose (Nurse #1); on 1/28/26 for the 8:00 AM (Nurse #2), 12:00 PM (Nurse #2), and 8:00 PM doses; and on 1/29/26 for the 8:00 AM and 12:00 PM doses (Medication Aide #1).On 2/04/26 at 2:15 PM, an interview was conducted with Medication Aide #2. During the interview, she stated on 1/26/26 at 8:00 AM Resident #1's Gabapentin was not in the medication cart to administer. The interview revealed she reordered Resident #1's medication in the electronic charting system but did not recall who she let know the resident did not receive his medication.On 1/29/26 at 2:00 PM, an interview was conducted with Nurse #1. During the interview, she stated Resident #1's medication was not in the medication cart on the two-night shifts she had worked on 1/26/26 and 1/27/26. She stated the facility had a medication dispensing machine; however, she knew the machine did not have enough Gabapentin to cover Resident #1's prescribed dosage. Nurse #1 explained she had not reordered the medication from the pharmacy because it had also been missed on day shift, and they would typically be the ones who would reorder a medication from the pharmacy and she had not contacted the pharmacy to check on the resident's medication.On 1/29/26 at 1:03 PM, an interview was conducted with Nurse #2. During the interview, she stated on 1/28/26 the 8:00 AM dose of Gabapentin 800 mg was not in the medication cart for Resident #1. She explained that Medication Aides were typically on the cart and could not pull medication from the dispensing machine located in the medication storage room. She stated it was hard to remember but felt like they were trying to piece his medication together using the medication dispensing machine, and he eventually refused his 12:00 PM dose so she didn't attempt to get it from the medication dispensing machine. Nurse #2 stated the facility was experiencing issues with the Pharmacy obtaining medication. She explained the nursing staff would reorder medication, they wouldn't hear back from pharmacy, and then the medication would not be delivered. Nurse #2 stated she was unaware Resident #2 had missed several doses of the medication and had not personally contacted the pharmacy to check on Resident #1's medication status.An observation conducted on 1/29/26 at 11:52 AM with Medication Aide (MA) #1 revealed MA #1 preparing Resident #1's 12:00 PM medication. During the observation, MA #1 stated Resident #1's medication Gabapentin 800 mg had been missing from the medication cart for at least 3 days. She explained that she had reordered the medication that day (1/29/26) and let the Nurse on duty know (Nurse #2). MA #1 stated, he's alert so he knows he isn't getting it. MA #1 explained on 1/29/26 Resident #1 had missed his 8:00 AM dose and 12:00 PM dose because the medication was unavailable.On 1/29/26 at 5:19 PM, an observation and</p> <p>(continued on next page)</p>		

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 02/05/2026
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>interview were conducted with Nurse #2 of the medication dispensing machine located in the medication storage room at the nurse's station. The machine had no 100 mg Gabapentin in stock and only (2) 300 mg Gabapentin in stock. Nurse #2 confirmed that the in-stock medication wouldn't have covered one of Resident #1's scheduled doses of Gabapentin. On 1/29/26 at 2:35 PM, an interview was conducted with Unit Manager #1. During the interview, she stated she worked 5 to 6 days each week during first shift. Unit Manager #1 stated no staff member had come to her to let her know Resident #1 was missing medication. She explained she could pull the medication from the medication dispensing machine if it was unavailable on the medication cart. Unit Manager #1 stated she would have also called the Nurse Practitioner or Medical Director to let them know Resident #1's medication was not in the facility and would have followed up with the Pharmacy. On 1/29/26 at 1:33 PM, an interview conducted with the Pharmacist revealed the Pharmacy sent a 30-day supply of Gabapentin (90 tablets) to the facility on 1/09/26. He explained that supply was enough Gabapentin medication for Resident #1 until 2/09/26. The Pharmacist stated the facility had attempted to re-order the medication on 1/26/26; however, it was too soon to refill the medication because insurance would only allow the medication to be reordered 7 days prior to the 30-day period (02/02/26). The Pharmacist explained the facility could have called and requested the medication and billed it to the facility, as other facilities often did; however, based on his records, no staff member from the facility had called to check on the status of Resident #1's medication. The Pharmacy delivered to the facility twice a day and could have sent the medication to the facility the same day. The Pharmacist indicated the Pharmacy was closed on 1/26/26 but could have filled the prescription the following day on 1/27/26. On 1/30/26 at 11:10 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was the nurse's responsibility to reorder the medication from the pharmacy, which could be done through the electronic charting system. She explained on 1/26/26 the medication was reordered by the facility; however, the pharmacy was closed due to weather conditions and reopened on 1/27/26 at lunchtime. The DON stated the medication could have been delivered to the facility on the night of 1/27/26 if the nursing staff had called the Pharmacy to check on the medication. The DON stated she could have provided the pharmacy with an override for the medication so it would have been filled, billing it to the facility. She stated she was unaware Resident #1 did not have his medication until 1/29/26. The DON stated the Pharmacy was good about stocking the medication dispensing machine and had done so prior to the week of 1/26/26. The DON indicated the Pharmacy had not come back to restock the medication dispensing machine yet for the week but would expect them to come soon. On 2/04/26 at 3:14 PM, an interview was conducted with the Administrator. During the interview she stated nursing staff should have called Pharmacy the next day after not receiving Resident #1's medication. She stated he was prescribed a high dose of Gabapentin and the back-up medication dispensing machine would not cover his dosage; it had to come from Pharmacy. The Administrator stated Resident #1 should not be missing doses of his medication and expected staff members to follow up when medication was not in the facility.</p>		

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 02/05/2026
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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff, resident, Nurse Practitioner, Medical Director, Pharmacist, and Regional Pharmacy Consultant interviews, the facility failed to ensure a resident was free of significant medication errors when they failed to administer the medication Gabapentin for diabetic polyneuropathy (a chronic nerve disorder caused by long-term high blood sugar in diabetes, leading to damage of multiple peripheral nerves, especially in the feet and legs) for 1 of 3 residents reviewed for medication errors (Resident #1). Resident #1 missed a total of 8 doses of Gabapentin over a 4-day period. Resident #1 stated the pain in his legs was extremely bad and rated his pain at a 10 on a 0-10 scale (0 is no pain 10 is worst pain). Resident #1 also stated he experienced twitching in his legs that kept him from sleeping for 3 nights. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus with diabetic polyneuropathy. A Physician order dated 10/24/25 revealed an order for Gabapentin (used to treat neuropathy) oral tablet 800 milligrams (mg), give one tablet by mouth three times a day related to diabetes mellitus. Resident #1's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact. He was assessed as having frequent pain present during the assessment period that occasionally interfered with therapy activities and frequently interfered with day-to-day activities. Resident #1's pain intensity was assessed at a level 6 on a 0-10 scale. Review of a physician order dated 12/18/25 read; Oxycodone-Acetaminophen 10-325 mg 1 tablet by mouth 4 times a day. Additionally, the order read, Oxycodone-Acetaminophen 10-325 mg 1 tablet by mouth every 8 hours as needed and the resident may have it 2 hours before or 2 hours after scheduled dose. Further review of Resident #1's MAR for January 2026 revealed an order for Gabapentin oral tablet 800 mg, one tablet by mouth three times a day for diabetes mellitus. The medication was marked as not administered on 1/26/26 for the 8:00 AM dose (Medication Aide #2) and 8:00 PM dose (Nurse #1); on 1/27/26 for the 8:00 PM dose (Nurse #1); on 1/28/26 for the 8:00 AM (Nurse #2), 12:00 PM (Nurse #2), and 8:00 PM (Nurse #3) doses; and on 1/29/26 for the 8:00 AM and 12:00 PM doses (Medication Aide #1). On 1/29/25 at 12:46 PM an interview was attempted with Nurse #3 with no return phone call received. On 2/04/26 at 2:15 PM, an interview was conducted with Medication Aide #2. During the interview, she stated on 1/26/26 at 8:00 AM Resident #1's Gabapentin was not in the medication cart to administer. The interview revealed she reordered Resident #1's medication in the electronic charting system but did not recall who she let know the resident did not receive his medication. Review of Resident #1's MAR for January 2026 revealed the medication Gabapentin was scheduled to be administered on 1/26/26 at 8:00 PM and 1/27/26 at 8:00 PM and was coded with a (9) as not administered by Nurse #1. On 1/29/26 at 2:00 PM, an interview was conducted with Nurse #1. During the interview, she stated Resident #1's medication was not in the medication cart on the two-night shifts she had worked on 1/26/26 and 1/27/26. She stated the facility had a medication dispensing machine; however, she knew the machine did not have enough Gabapentin to cover Resident #1's prescribed dosage. She explained she had not reordered the medication from the pharmacy because it had also been missed on day shift, and they would typically be the ones who would reorder a medication from the pharmacy. Nurse #1 stated Resident #1 would typically come to her if he were in pain and request his as needed medication. Nurse #1 did not recall Resident #1 stating he had a pain level of 10 or experiencing twitching in his legs. Review of Resident #1's MAR for January 2026 revealed the medication was scheduled to be administered on 1/28/26 and was coded with a (9) as not administered by Nurse #2 for the 8:00 AM dose and coded with a (2) as the resident refused for the 12:00 PM dose. On 1/29/26 at 1:03 PM, an interview was conducted with Nurse #2. During the interview, she stated on 1/28/26 the 8:00 AM dose of</p> <p>(continued on next page)</p>		

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 02/05/2026
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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Gabapentin 800 mg was not in the medication cart for Resident #1. She stated it was hard to remember but felt like they were trying to piece his medication together using the medication dispensing machine, and he eventually refused his 12:00 PM dose so she didn't attempt to get it from the medication dispensing machine. Nurse #2 stated the facility was experiencing issues with the Pharmacy obtaining medication. She explained the nursing staff would reorder a medication, they wouldn't hear back from pharmacy, and then the medication would not be delivered. Nurse #2 stated she was unaware Resident #2 had missed several doses of the medication and had not personally contacted the pharmacy to check on Resident #1's medication status. Resident #1 did not report a pain level of 10 or experiencing twitching in his legs during her shift. An observation conducted on 1/29/26 at 11:52 AM with Medication Aide (MA) #1 revealed MA #1 preparing Resident #1's 12:00 PM medication. During the observation, MA #1 stated Resident #1's medication Gabapentin 800 mg had been missing from the medication cart for at least 3 days. She explained that she had reordered the medication on 1/29/26 and let the Nurse on duty know (Nurse #2). MA #1 stated, he's alert so he knows he isn't getting it. MA #1 explained on 1/29/26 Resident #1 had missed his 8:00 AM dose and 12:00 PM dose because the medication was unavailable. Review of the Medication Administration Record (MAR) for January 2026 revealed an order for Oxycodone- Acetaminophen tablet 10-325 mg give one (1) tablet by mouth every 8 hours for pain as needed (PRN) and the resident may have it 2 hours before or 2 hours after scheduled dose. The Oxycodone- Acetaminophen was initialed as administered on 1/26/26 at 5:20 AM and 3:35 PM with a pain rating of a 9 on a 0-10 scale. The order was initialed as administered on 1/27/26 at 6:50 PM with a pain rating of 2 on a 0-10 scale. Resident #1 also received Oxycodone-Acetaminophen tablet 10-325 mg one (1) tablet by mouth four times a day for pain scheduled. The pain assessment using a 0-10 scale or non-verbal scoring every shift revealed on 1/26/26 during day shift Resident #1's pain level was rated at a 2 and during night shift rated at a 2. On 1/27/26 Resident #1's pain level was rated as a 2 for day shift and a 0 for night shift. Resident #1's pain level was rated at 0 during day and night shift on 1/28/26 and 1/29/26. On 1/29/26 at 5:19 PM, an observation and interview were conducted with Nurse #2 of the medication dispensing machine located in the medication storage room at the nurse's station. The machine had no 100 mg Gabapentin in stock and only (2) 300 mg Gabapentin in stock. Nurse #2 confirmed that the in-stock medication wouldn't have covered one of Resident #1's scheduled doses of Gabapentin. On 1/29/26 at 5:20 PM, an interview was conducted with Resident #1. Resident #1 stated he had been having issues not receiving his medication Gabapentin in the facility and had not received it for a week. He explained he was taking the medication for nerve pain because he had neuropathy. Resident #1 stated, the pain in my legs is extremely bad, I would rate it as a 10 on a 0-10 scale during the day and at night. He stated he was up all night due to twitching pain and had not slept in at least 3 nights. Resident #1 stated he didn't understand how someone could be in a facility and not receive their medication and that he had never refused his medication. He stated he would ask staff members about his medication, and they told him they would check on it; however, they never returned to the room. On 1/29/26 at 2:35 PM, an interview was conducted with Unit Manager #1. During the interview, she stated she worked 5 to 6 days each week during first shift. Unit Manager #1 stated no staff member had come to her to let her know Resident #1 was missing medication. She explained she could pull the medication from the medication dispensing machine if it was unavailable on the medication cart. Unit Manager #1 stated she would have also called the Nurse Practitioner or Medical Director to let them know Resident #1's medication was not in the facility and would have followed up with the Pharmacy. On 1/29/26 at 1:33 PM, an interview conducted with the Pharmacist revealed the Pharmacy sent a 30-day supply of Gabapentin (90 tablets) to the facility on 1/09/26. He explained</p> <p>(continued on next page)</p>		

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 02/05/2026
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)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	<p>that supply was enough Gabapentin medication for Resident #1 until 2/09/26. The Pharmacist stated the facility had attempted to re-order the medication on 1/26/26; however, it was too soon to refill the medication because insurance would only allow the medication to be reordered 7 days prior to the 30-day period (02/02/26). The Pharmacist explained the facility could have called and requested the medication and billed it to the facility, as other facilities often did; however, based on his records, no staff member from the facility had called to check on the status of Resident #1's medication. The Pharmacy delivered to the facility twice a day and could have sent the medication to the facility the same day. The Pharmacist indicated the Pharmacy was closed on 1/26/26 but could have filled the prescription the following day on 1/27/26. On 1/30/26 at 12:47 PM, an interview was conducted with the Regional Pharmacy Consultant. During the interview, she stated if Resident #1 took the medication Gabapentin for diabetic nerve pain and did not receive the medication for several doses, Resident #1 would experience the reoccurrence of the pain sensation. She stated he may have psychological dependence on the medication because it can have sedating effects, making it difficult to sleep without it, especially if taking a large dosage such as 800 mg three times a day. The interview revealed Gabapentin was also prescribed for mood disorders and had a calming effect on patients. She stated that without the medication, mood, behaviors, and sleep may be disrupted. On 1/29/26 at 5:10 PM, an interview was conducted with the Nurse Practitioner. During the interview she stated she was unaware Resident #1 had missed doses of the medication Gabapentin. She explained he was taking the medication because he had a wound on his foot and could have adverse effects from not taking it, such as pain. The Nurse Practitioner stated missed doses of the medication would be significant for Resident #1's pain control. The Nurse Practitioner stated Resident #1 received scheduled and as needed Oxycodone and it would have helped with his pain control however, the medications focus on different nerve receptors and the Oxycodone may or may not have resolved the missed doses of the residents Gabapentin but possibly could have helped. On 1/30/26 at 2:20 PM, an interview was conducted with the Medical Director. During the interview, he stated missing doses of the medication Gabapentin would have affected Resident #1's pain level. The Medical Director stated Resident #1 had other options for pain management. On 1/30/26 at 11:10 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was the nurse's responsibility to reorder the medication from the pharmacy, which could be done through the electronic charting system. She explained on 1/26/26 the medication was reordered by the facility; however, the pharmacy was closed due to weather conditions and reopened on 1/27/26 at lunchtime. The DON stated the medication should have been delivered to the facility on the night of 1/27/26, and if it did not arrive, the nursing staff should have called the Pharmacy on 1/28/26 to check on the status of the medication. She stated she was unaware Resident #1 did not have his medication until 1/29/26 and they were able to get him the Gabapentin for the 8:00 PM dose on 1/29/26. The DON stated the Pharmacy was good about stocking the medication dispensing machine and had done so prior to the week of 1/26/26. The DON indicated the Pharmacy had not come back to restock the medication dispensing machine yet for the week but would expect them to come soon. On 1/30/26 at 12:49 PM, an interview was conducted with the Administrator. During the interview she stated nursing staff should have called Pharmacy the next day after not receiving Resident #1's medication. She stated he was prescribed a high dose of Gabapentin and the back-up medication dispensing machine would not cover his dosage; it had to come from Pharmacy. The Administrator stated Resident #1 should not be missing doses of his medication and expected staff members to follow up when medication was not in the facility.</p>		