STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siler City Center	900 W Dolphin Street Siler City, NC 27344

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews with staff, Wound Care Nurse Practitioner (NP), Orthopedic Specialist Nurse Practitioner (Orthopedic Specialist NP), and Physician, the facility failed to follow physician orders for a knee immobilizer for Resident #5 as specified in the hospital discharge summary. Despite documented skin assessments, a facility-acquired pressure ulcer was discovered on 11/11/25 under the knee immobilizer on the back of the resident's left lower leg after a nurse aide observed drainage on the resident's bed sheets. When the pressure ulcer was assessed on 11/13/25 it was described as an unstageable pressure ulcer/injury (obscured full-thickness skin and tissue loss) with a length of 3.45 centimeters (cm), width 2.84 and no depth. It was documented that the wound was 40% granulation tissue (pink-red moist tissue that fills an open wound, when it starts to heal) and 60% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft and stringy). The Orthopedic Specialist NP stated she was contacted by the facility on 11/13/25 and notified the resident had a new wound and wanted to know if they could remove the immobilizer and she gave a verbal order to remove the immobilizer. During the same phone conversation, the Orthopedic Specialist NP requested to see Resident #5 that same day and was told this was not possible due to transportation issues and an appointment was scheduled for 11/17/25. Interviews revealed through the process of elimination the knee immobilizer was not removed until 11/20/25 and potentially continued to put pressure on the pressure ulcer. Resident #5 was first seen by the Wound Care NP on 11/25/25 who noted the wound was a medical device related pressure ulcer and noted it to be stage 4 (a wound that is severe and extends through the skin and underlying tissues, exposing muscle, tendon and/or bone). On the same date the Wound Care NP debrided (the medical removal of dead, damaged or infected tissue to promote healing) a moderate amount of non-viable slough/necrotic tissue with forceps and scalpel. Treatments continued as ordered and the Wound Care NP debrided the pressure sore three additional times before the pressure ulcer was healed on 3/3/26. The deficient practice occurred for 1 of 1 resident with a pressure sore (Resident #5). A review of Resident #5's discharge summary from the local hospital dated 10/8/25 at 11:43AM, revealed she was admitted on [DATE] for a fractured patella (kneecap) after sustaining a fall while residing at a different facility. The discharge instructions stated ?Knee immobilizer in place when bearing weight. Knee immobilizer should be in place with your leg in extension any time you are trying to bear weight on your left leg. You may bear weight on that leg as long as the immobilizer is in place. When you are not bearing weight, the immobilizer may be removed for periods of time for comfort.' Also included in the discharge summary were orders to continue Eliquis 2.5 mg (milligrams) tablet, one tablet by mouth 2 times per day and Remeron 15 mg tablet, one tablet by mouth nightly. Resident #5 was admitted to the facility on [DATE] with diagnoses of left patella fracture, atrial fibrillation (A-fib), congestive heart failure (CHF), moderate protein-calorie malnutrition (1/13/26), hypothyroidism, and Alzheimer's disease. A review of Resident #5's Physician's order dated 10/8/25 at 1:21PM stated, Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture. Review of the resident's Electronic Medical Record (EMR) revealed this order was entered into by Nurse #4 (House Supervisor). A Physician Order dated (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	10/08/25 for Resident #5 stated Eliquis (blood thinner) tablet 2.5 mg to be given by mouth twice daily for A-fib. Review of Physican's orders for Resident #5 revealed an order dated 10/8/25 for Remeron 15 mg to be given at bedtime for depression. An interview was conducted with House Supervisor (Nurse #4) on 3/12/26 at 1:10PM. Nurse #4 stated that she and House Supervisor (Nurse #8) both do admissions and said that typically one will do the assessment documentation and the other will do the orders. She said that she had transcribed the order for the knee immobilizer for Resident #5 and explained she got this information from the discharge summary that came from the hospital. She explained the process of transcribing orders to a resident's EMR involved getting the discharge summary from the hospital and then taking those discharge orders off and entering them into the EMR. Nurse #4 stated usually the orders were double checked by the other House Supervisor, Nurse #8. Nurse #4 said that newly admitted residents are then discussed during a morning meeting the day after they are admitted to the facility but could not recall for certain what was discussed the morning after Resident #5 was admitted . She said they did not complete any orders in the EMR until the resident was in the room at the facility. Nurse #4 said the orders did not go to the physician immediately to be verified but if they had questions they would call the physician. She stated she did not recall calling the physician to clarify the order for the knee immobilizer for Resident #5. Nurse #4 was looking at the EMR and said she copied the order for the immobilizer from the discharge summary from the hospital, but when she read and compared the order on the hospital discharge summary with the order she had entered into the resident's EMR, they did not match. After Nurse #4 realized, they did not match, she said she did not recall where the information that she transcribed could have come from. Nurse #4 stated she would go back and look to see if she could find this documentation, but she was not able to produce this order. During an interview conducted on 3/12/26 at 1:30PM, Nurse #8 stated that when there was an admission to the facility she usually read through the discharge summary before she entered any orders into the resident's EMR. She said that she or Nurse #4 (both were working as House Supervisors on the day the resident was admitted) would have transcribed the orders and the other would have double checked them once they were transcribed into the EMR. She could not recall for certain who transcribed the orders for Resident #5, but once made aware that Nurse #4 had, she said that she would have double checked the orders. Nurse #8 reviewed Resident #5's EMR and compared the discharge summary orders with the order that was transcribed into the resident's EMR and stated she was not sure where the transcribed order for the knee immobilizer came from, as it did not match what the hospital discharge summary instruction, but that those orders ?had to come from somewhere.' Nurse #8 was not able to provide documentation of the order that stated the knee immobilizer was to be in place at all times. An interview was conducted on 3/13/2026 at 9:18AM with Physical Therapy Assistant (PTA) #2 who stated when it comes to the use of an immobilizer and someone had broken a bone, they have to be very conservative especially if they have mental limitations, to be sure they do not bear weight, and as a reminder. When reviewing Resident #5's Discharge summary dated [DATE] PTA #2 said the knee immobilizer would have needed to be on when bearing weight. He said in his professional opinion, this meant the resident could take it off, when she was not bearing weight. When asked should the immobilizer have been on the resident all the time, he replied ?probably not'. He said that he felt it was sufficient for staff to check the immobilizer for appropriate fitting and skin underneath the immobilizer twice daily and that if they were allowed to be removed, they should be removed. An admission progress note written on 10/08/25 at 2:46PM by Nurse #8 stated Resident #5 had arrived at the facility via ambulance on a stretcher. She noted that Resident #5 had a dark spot to her coccyx, an open area to her spine, and redness to her left knee. She also noted that Resident #5 had range of motion impairment and was unable to move left lower extremity. A review of Resident #5's Treatment Administration Record (TAR) for October 2025 revealed the order for the knee immobilizer which read, Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture. The start date for this was 10/8/25 and end date was 11/20/25. There were two spaces for (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the nurses to initial labeled Day and Night and it did not have specific times. All boxes were initialed by a nurse for the day spaces with the exception of 10/20/25 and 10/23/25. All night spaces were initialed by a nurse with the exception of 10/30/25. A review of Resident #5's care plan dated 10/09/25 revealed she was found to be at risk for skin breakdown. The goal dated 10/9/25 stated Resident #5 would not show any signs of skin breakdown for 90 days. The interventions also dated 10/9/25 included to pat (do not rub) skin when drying, observe skin for signs and symptoms of skin breakdown including redness, cracking, blistering, decreased sensation, and skin that does not blanch easily, provide preventative skin care (lotions, barrier creams as ordered), apply barrier cream with each cleansing, observe skin conditions daily with activities of daily living (ADL) care and to report abnormalities and the resident's skin was to be checked weekly by a licensed nurse. There were no care plans or interventions included for Resident #5 for the use of a knee immobilizer or directly speaking to the open area noted to her spine, or the dark spot on her coccyx observed on admission. Resident #5 was also care planned for exhibiting or being at risk for dehydration as evidenced by medications (diuretics, laxatives), dated 10/9/25. The goal also dated 10/9/25 stated the resident would not exhibit any signs or symptoms of dehydration for 90 days. The interventions dated 10/9/25 included to administer medications as ordered and monitor effectiveness and signs and symptoms of side effects. Staff were to asses contributive/causative factors, monitor for signs and symptoms of dehydration, monitor labs as ordered, and monitor weight per protocol and report as indicated. Resident #5 also had a care plan for nutritional risk dated 10/9/25. It stated she was at increased risk for weight fluctuations due to fluid shifts secondary to diagnosis of CHF and use of diuretic medication. It also stated she was on Remeron to stimulate appetite and that her intake of meals were 25-75%, with the average being 56%. It was noted the resident reported being hungry as a bear and added large protein portions. The goals dated 10/9/25 included that the resident would consume more than 50% of at least 3 meals every day and would maintain a stabilized weight without significant changes. Interventions dated 10/9/25 included to honor food preferences within meal plan, encourage resident to chew and swallow each bite, offer/encourage fluids of choice, instruct resident and family that anorexia (not eating), weight loss, and/or dehydration may be unavoidable due to advancing disease process, weigh as ordered and alert dietician and physician to any significant loss or gain, monitor changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated, monitor intake at all meals, offer alternate choices as needed, alert dietician and physician to any decline in intake, provide regular liberalized diet, offer snacks, provide supplements as ordered/tolerated, supervise/assist as needed with meals, and place call light in reach. There were no new interventions for nutritional risk, added after 10/9/25. A review of physician orders for Resident #5 revealed an order dated 10/10/25 for spironolactone (diuretic) 12.5mg to be given by mouth daily. Continued review of physician orders revealed an order dated 10/10/25 for Voltaren Gel (topical pain reliever) 1% to be administered to her left knee 3 times per day. Resident #5's admission Minimum Data Set (MDS) dated [DATE] revealed she was severely cognitively impaired and required extensive assistance with ADL, bed mobility, and transfers. The MDS noted that she was at risk for developing pressure ulcers/injuries but stated she did not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing or device. That MDS stated Resident #5 had no pressure ulcers or skin issues. Under ?Other ulcers, wounds, and skin problems' the MDS indicated none were present. The MDS did not indicate that Resident #5 was to have a pressure relieving device in her chair or have her participate in a reposition/turning program or be part of a nutrition and hydration program for skin. The MDS did not indicate that the resident had a dark spot to her coccyx or open area to her spine as noted in the admission note. It also indicated she did not have malnutrition or risk for malnutrition. Review of an Advanced Skin Check dated 10/16/25 at 7:12PM written by Nurse #6 included skin was warm and dry, skin color within normal limits and turgor was normal. It was documented that the Resident did not have an external device. A Braden Scale for Predicting Pressure Ulcer Risk (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Evaluation was documented on 10/16/25 at 7:13PM by Nurse #6 and revealed Braden Evaluation: Sensory Perception: Slightly limited. Moisture: Occasionally moist. Activity: Chairfast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significantchanges independently. Nutrition: Adequate. Friction and shear: Potential problem. Review of an Advanced Skin Check that was written on 10/25/2025 at 9:49AM by Nurse #16 stated skin was warm and dry, skin color within normal limits and turgor was normal. It was documented that the Resident did not have an external device. A review of the Orthopedic Specialist Nurse Practitioner's (Orthopedic NP) note dated 10/30/25 revealed that Resident #5 was seen for a follow up visit for her left patella fracture. The recommendations included for resident to be weight bearing as tolerated to left lower extremity with the knee immobilizer, continue knee immobilizer when sitting and lying, and physical therapy may take off knee immobilizer to work range of motion, limit flexion (bend) to 60 degrees, and a new referral was given for therapy. The resident was to return for follow up in 3 weeks. A review of Resident #5's Treatment Administration Record (TAR) for November 2025 revealed the order for the knee immobilizer which read, Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture. The start date for this was 10/8/25 and end date was 11/20/25. There were two spaces for the nurses to initial labeled Day and Night and it did not have specific times. All the blocks were initialed by a nurse from 11/1/25 through 11/19/25 and only the day box was initialed on 11/20/25. On 11/1/25 at 3:33PM, Nurse #6 Documented an Advanced Skin check which stated skin was warm and dry, skin color within normal limits and turgor was normal. Resident has an external device. External device(s) description: brace on Left leg External device removed and site inspected: Yes. Observe for any discoloration on the device / cast that may indicate drainage under the device / cast: Yes. Observe for any new edema, skin changes, or odor that may indicate skin / wound infection: Yes. An interview conducted with Nurse Aide (NA) #8 on 3/12/26 at 2:53PM revealed that she provided a bed bath to Resident #5 on 11/7/25 but was not very familiar with the resident as that was the only time she worked with her in 2025. She stated that she never completely opened the brace because she was not familiar with Resident #5 so she would have been a little bit scared to. NA #8 indicated she did not see any skin issues at the time she gave Resident #5 her bed bath, but she did not observe the back of resident's left leg, because she only opened the brace ?a little bit'. A telephone interview was conducted on 3/12/26 at 4:06PM with Nurse #14 who revealed that she had worked the night shift (7:00PM to 7:00AM) with Resident #5 on 11/7/25 and initialed the TAR for the immobilizer. Nurse #14 recalled that the resident had a brace on and that she had to apply the pain cream to that knee. She said that she believed she would have fully removed the brace, so she did not get any cream on the brace. Nurse #14 stated it was too hard to recall the details because it was 4 months ago and she always does what the instructions say to do. She said that she never saw any indication of a wound or skin issue, but she could not remember if she looked at the back of the resident's left leg. Nurse #14 indicated she also worked on 11/17/25, 11/18/25, and 11/19/25, but could not recall from memory if the immobilizer was still on. She stated that if she signed for it saying it was in place, then it was. A review of an Advanced Skilled Evaluation dated 11/8/25 at 3:19PM revealed that Nurse #3 documented Resident #5's as 1 which the key stated meant Resident #5's skin was warm and dry; skin color and turgor (skin elasticity) were normal. An interview was obtained on 3/12/25 at 2:38PM with NA #13 who provided the bed bath to Resident #5 on 11/8/25 during the 7:00AM to 3:00PM shift. NA #13 stated she fully removed the immobilizer from the resident's leg and rolled her over to bathe her back and back of legs as well and did not see any skin issues. A review of the physician's orders revealed an order for physical therapy dated 11/8/25 at 9:00AM which stated Physical Therapy Recertification Orders: patient to be seen 3-5 times a week for 4 weeks (for generalized weakness). Skilled services to include: Therapeutic Exercise, and Therapeutic Activity, gait training, neuro re-ed (therapeutic exercises that are designed to re-develop normal, controlled movement patterns), manual and wheelchair management. Individual, group, and concurrent treatment sessions as appropriate. A (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	review of Skilled Evaluation dated 11/09/25 at 6:29PM completed by Nurse #7 indicated a 1 which the key stated meant Resident #5's skin was warm and dry; skin color and turgor (skin elasticity) were normal. During a telephone interview conducted on 3/10/26 at 2:46PM with Nurse #7 revealed that she did not recall that Resident #5 had a brace. She said it had been too long ago to remember that, but that she followed whatever the instructions told her to do. She went on to explain that if the TAR said to remove the brace to do a skin check, she removed the brace to do the skin check. Nurse #7 could not recall the details of Resident #5's immobilizer. Once reminded what the order on the TAR stated, and she had initialed it on 11/9/25 (7:00AM to 7:00PM shift), Nurse #7 stated that based on the wording of the order, she did not feel that she would necessarily have had to remove the brace fully to mark the TAR as completed, but could not recall what she did for certain. A telephone interview with Nurse #9, conducted on 3/10/25 at 5:31PM revealed that she worked with Resident #5 on 11/8/25 and 11/9/2025 and recalled that she had initialed the TAR for the knee immobilizer for those dates indicating it was on at all times and could be removed for hygiene and skin checks. She stated she typically only worked 4-hour shifts, and she never had to remove the immobilizer. She said when she would remove Resident #5's patch or apply cream to the left knee this never required her to fully remove the brace. Nurse #9 stated she was able to see Resident #5's skin ?fine' without removing the brace fully. A skin check written on 11/08/25 at 3:48PM by Nurse #3 indicated Resident #5's skin was warm & dry; skin color and elasticity were normal. Nurse #3 further noted that the resident had a splint, and that the splint was removed and inspected. The Nurse documented that she did not observe any discoloration on the device that could have indicated drainage under the device and that she did not observe any new edema, skin changes, or odor that may have indicated skin or wound infection. An interview was completed with Nurse #3 on 2/27/26 at 1:00PM and she stated that she had worked with Resident on 11/8/25 and 11/10/25 from 7:00AM to 3:00PM but did not see any skin issues at all under the immobilizer. Nurse #3 indicated she would have noted skin issues if she had and she could not recall if she fully removed the immobilizer or not. During a follow up telephone interview with Nurse #3 conducted on 3/12/26 at 9:45AM, she revealed that she had worked on 11/8/25 and 11/10/25 from 7:00AM to 3:00PM and she did notice some redness and indentations from the brace those days but would just reposition Resident #5 in the bed and she felt this would correct the issue. Nurse #3 stated the indentations were usually present to the lower leg or back of the resident's thigh, but she did not see any wounds. She also said that she would usually just open the brace but did not have to fully remove the brace. Nurse #3 explained she completed her skin checks by herself (without the assistance of a 2nd staff member) and felt like she could see the back of Resident #5's leg ?pretty well'. She stated she never documented or reported the redness or indentations because she felt like they were not a big deal and that she never noticed any skin that was non-blanchable (redness or discoloration that does not fade when pressure is applied, indicating potential tissue damage or compromised blood flow). During an interview on 3/12/26 at 2:10PM, NA #14 revealed that she worked on 11/9/25 from 7:00AM to 3:00PM with Resident #5 but did not recall any details other than who the resident was and that she was ?always smiling'. She did provide a bed bath to Resident #5 but said she did not recall if she had a knee immobilizer on or not. A telephone interview was conducted on 3/11/26 at 9:45AM with Nurse #15 who had worked on 11/10/25 3:00PM to 11:00PM with Resident #5 and had signed the TAR that evening for the immobilizer. She stated she was familiar with Resident #5 but does not work with her much. Nurse #15 indicated she did not recall anything that happened in November. Nurse #15 could not say if the immobilizer was on or not or if she had to remove it or not. Nurse #15 explained they had to remove braces to check skin, but she did not recall if she ever had to do it personally. She said that typically if she had someone with a brace on, she would remove the brace and check the skin, but she would only go by what the order said. Once reminded of how the order for Resident #5's immobilizer was written on the TAR, Nurse #5 said she did not feel she would have had to remove it fully because it sounds like it was just off for baths. Nurse #15 further stated she never saw a wound and had no reason to take the brace off. An (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	located to the front of the leg because she easily got confused with directions (meaning front/ back/left right). The DON explained that she was aware that it was documented in the wrong location on the leg and explained that the documentation self-populated the wound location after that original nurse entered the wrong location, and if they changed it anytime afterward, it would look like a whole new wound, so they just left it. Nurse #6 described the wound bed as being yellow and red in color and had no drainage present. Nurse #6 then stated she thought the edges looked to have slight bleeding present, but not to the point of dripping blood. She did not see any drainage on the sheets or on the immobilizer and did not notice an odor to the wound. Nurse #6 indicated she did not measure the wound. She went on to say that they have an order to apply pain gel to Resident's left knee 3 times a day (at 9:00AM, 1:00PM, and 5:00PM) and they can look at the Resident's skin at those times. Nurse #6 said she had not applied the pain gel to Resident #5's knee yet that day, prior to the wound being found. She said the Resident did not show any signs or symptoms of pain. After observing the wound, she contacted the Nursing Supervisor and the Physician. Nurse #6 recalled that neither the Nursing Supervisor nor Physician assessed the wound that day. The DON indicated that the Nursing Supervisor did not always come to look at wounds when reported to her. The DON said that Nurse #6 notified her of the wound on 11/11/25 and she did not recall making an observation of the wound herself on 11/11/25. During an additional telephone interview conducted on 3/12/26 at 11:53AM with Nurse #6, the order on the TAR was reviewed which stated, Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture, was reviewed. Nurse #6 stated that this meant that she was going in and taking a look at it to make sure the knee immobilizer was in place at all times. She said it also ?meant that if the aides needed to take it off to give her a bath, we could do that'. Nurse #6 indicated she did not remove the brace when she applied the pain patch or cream and would only see a little bit of the skin during those times. When asked if Nurse #6 ever fully removed Resident #5's knee immobilizer, she stated only a couple times, so the aides could give her a bath. Nurse #6 stated that she did not provide wound care the day the wound was first observed. She only covered the wound with a dry dressing because she expected the wound care nurse to do the initial wound care treatment and assessment. A clarification of the time that she was first notified about the pressure ulcer from NA #7 was obtained from Nurse #6 during this interview. She said upon reviewing the ?change in condition' note written at 12:25PM and the physician order written at 12:30PM on 11/11/25, she concluded that she must have been notified by NA #7 about the wound no earlier than 11:35AM. A review of the TAR for November 2025 showed an order for a dressing change dated 11/11/25, which stated to cleanse left lower leg with wound cleaner and apply calcium alginate and foam. Change daily and as needed. The order was not initialed by a nurse as completed on 11/11/25. Further review of the TAR showed an additional order for a dressing change dated 11/12/25, which also stated to cleanse left lower leg with wound cleaner and apply calcium alginate and foam. Change daily and as needed. This order was initialed by staff daily on 11/12/29 through 11/19/25. Review of Skilled Evaluation dated 11/12/25 at 2:36PM revealed that Nurse #1 noted that Resident #5's cardiovascular assessment indicated skin was warm and pink with brisk capillary refill and no edema present. In the skin portion of the assessment, there was a ?1' documented which the key stated meant Resident #5's skin was warm and dry; skin color and turgor (skin elasticity) were normal. She went on to note that she had a ?skin issue' described as ?pressure ulcer/injury' which was acquired in-house which had ?not been evaluated'. A telephone interview was obtained from Nurse #1 on 03/05/26 at 10:50AM which revealed she had worked with Resident #5 on 11/12/25 from 7:00AM to 3:00PM, the day after the wound was found. She saw the wound and said it looked open and raw with red and yellow tissue present. Nurse #1 revealed there was not a lot of drainage noted, but the drainage present was ?yellowy-red' colored. She stated Resident #5 still had the immobilizer on and it was ?pushing into the wound' and noted it was a heavily padded

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 store a scoop in a manner that prevented it from becoming contaminated by direct contact with flour, maintaining a clean steam table hood, and ensuring plastic plate bases were dried before being stacked for 2 of 2 kitchen observations. This deficient practice had the potential to affect food served to residents. The findings included:1. The initial tour of the kitchen was on 2/23/26 at 10:17 AM with the Dietary Manager. A large bin of flour was observed by the prep table with the scoop stored in the container of flour.The Dietary Manager was interviewed on 2/23/26 at 10:17 AM. The Dietary Manager asked a kitchen aide to remove the scoop from the flour. The Dietary Manager explained the hook to hang the scoop was inside the container and when the lid to the container slid to the closed position, it often knocked the scoop back into the flour.2. At 10:19 AM on 2/23/26, a continuation of the tour revealed the underside of the steam table hood contained orange, brown residue and felt slick to touch. The Dietary Manager was interviewed on 2/23/26 at 10:20 AM. The Dietary Manager confirmed the buildup, stating the steam table was cleaned between each meal but did not think the underneath of the hood had been cleaned for a while. 3. During a follow-up kitchen tour on 2/25/26 at 11:45 AM 20 out of 30 plastic plate bases were stacked wet on the tray line ready for use.The Dietary Manager was interviewed on 2/25/26 at 11:50 AM. The Dietary Manager stated she had checked other dishware for dryness but had not checked the plastic plate bases. The Dietary Manager then removed the plastic plate bases, rewashed them, and ensured they were air dried, placing them back on the tray line.The Administrator was interviewed on 2/27/26 at 10:22 AM. The Administrator stated he did not know why the hood to the steam table was not clean or why the scoop was left in the flour, and he would want the kitchen staff to keep the kitchen clean and not leave the scoops in the bins. The Administrator also stated he would want all dishware clean and dry before placing it on the tray line.

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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 record review, observation, resident, staff, and Medical Director interviews the facility failed to assess a resident's ability to keep steroid nasal spray at bed side for self-administration for 1 of 1 resident reviewed for self-administration of medications (Resident #138).The findings included:Resident #138 was admitted to the facility on [DATE].Physician order dated 4/15/25 revealed an order for fluticasone propionate nasal suspension (steroid nasal spray for allergies) 50 micrograms 2 sprays in both nostrils twice a day for allergies.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #138 was cognitively intact.Resident #138's care plan dated 2/17/26 did not include any goals or interventions for self-administering medications.Review of Resident #138's medical record did not show an assessment for self-administration of medication.Resident #138 was interviewed on 2/23/26 at 11:16am. During the interview an observation was made of Resident #138's prescribed bottle of nasal spray sitting on the resident's overbed table. Resident #138 stated the nurse had left it in her room, but she was unable to state which nurse. Resident #138 stated she should not have the nasal spray in her room but that it made it easier for her to use when needed.An observation was made on 2/23/26 at 3:52pm of Resident #138's room. The observation revealed the bottle of nasal spray remained on her overbed table.Another observation was made on 2/24/26 at 10:38am of Resident #138's room. The bottle of nasal spray was observed on her overbed table.Nurse #1 was interviewed on 2/24/26 at 3:01pm and confirmed she was assigned to Resident #138 on 2/24/26. Nurse #1 discussed not being sure what the process was for a resident who self-administered medication because there were no residents on the 400 hall who could self-administer medication. She stated if she saw any medication left in a resident room, she would remove it immediately and clarified she had not seen any medication in any resident rooms today (2/24/26). Nurse #1 also clarified that she provided Resident #138's medication while the resident was in her room [ROOM NUMBER]/24/26. During the interview an observation of Resident #138's room was conducted and Nurse #1 found the bottle of nasal spray on the resident's overbed table behind a box of tissue. The Nurse discussed when she provided Resident #138 her medication in the morning (2/24/26), she did not notice the bottle of nasal spray. Nurse #1 was observed removing the nasal spray from Resident #138's room.An interview occurred with the Medical Director on 2/26/26 at 2:40pm. The Medical Director discussed Resident #138 being cognitively intact and stated he would not be concerned about the nasal spray being left at the resident's bedside. However, he explained the medication should not be left in a resident's room without an order/assessment and stated the nasal spray would not cause harm if taken more frequently than ordered. During an interview with the Director of Nursing (DON) on 2/24/26 at 3:11pm, the DON explained if a resident wanted to self-administer their medication, the facility would need to do an assessment to ensure the resident was safe to self-administer their medication. She stated once a resident was able to self-administer their medication, a lock box was placed in their room, and the resident would have a plan of care to self-administer their medication. The DON stated she did not believe there were any residents down hall 400 who self-administered their own medication. She explained Resident #138 had the potential to self-administer her own medication due to the resident's cognition. The DON stated if a nurse saw medication at a residents' bedside, she would want the medication removed, a conversation to be held with the resident about self-administering, an assessment to be completed, and an order obtained.The Administrator was interviewed on 2/24/26 at 3:38pm. The Administrator stated he was not sure if there were any residents in the facility who self-administered their own medication. He explained if a resident wanted to self-administer their medication, the nurse would need to complete an evaluation. The Administrator discussed if a nurse saw medication at a residents' bedside, he would want the medication removed and then an evaluation completed to see if the resident was safe to self-administer.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to protect the residents' right to be from physical abuse when Resident #86 hit Resident #14 with a grabber (handheld device used to assist in obtaining items out of reach) on 12/2/25 which resulted in an abrasion to Resident #14's forehead and Resident #86 hit Resident #54 with an open hand across the face while Resident #86 was receiving one-on-one (1:1) supervision on 12/24/25. This for 1 of 4 residents reviewed for abuse (Resident #86). The findings included:Resident #86 was admitted to the facility on [DATE] with diagnosis that included dementia, insomnia, psychotic disturbance, mood disturbance, mild cognitive impairment and anxiety.Review of Resident #86 Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired with no upper or lower extremity impairments, only required set up for mobility and had no physical or verbal behaviors directed towards others. Review of Resident #86 Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired, had no upper or lower extremity impairments, only required set up for mobility and had no behaviors directed towards others during the look back period. Review of Resident #86 care plan dated 11/28/25 and revised 12/3/25 and 12/26/25 indicated he exhibited or had the potential to exhibit behaviors related to cognitive loss and dementia. The care plan reflected resident to resident incidents (hitting other residents) on 10/19/25, 12/2/25 and 12/24/25. The goal stated Resident #68 would not harm another resident. The interventions included evaluating nature and circumstances (i.e., triggers) of physical behavior with resident, evaluating need for psychological/behavioral health consultation, observing the resident for non-verbal signs of physical aggression (rigid body position, clinched fist, etc.), remove resident from the environment if needed and diverting resident by giving alternative objects or activities. 1:1 supervision was written on the care plan 12/3/25.Resident #93 was admitted to the facility on [DATE] with a diagnosis that included mild dementia, major depressive disorder and agitation.Review of Resident #93's quarterly MDS assessment dated [DATE] revealed he was moderately cognitively impaired, had no upper or lower extremity impairments and had no physical behavior directed towards others. Review of the care plan dated 6/20/25 revealed Resident #93 exhibited physical behaviors of grabbing, pushing and being physically aggressive towards others related to dementia with behaviors. The goal stated Resident #93 would not harm others. The interventions included encourage resident to seek staff support for distressed mood, observe for non-verbal signs of physical aggression to include rigid body positioning, clenched fist etc., and remove resident from environment if needed.Care plan dated 6/20/25 and last revised 9/23/25 revealed Resident #93 exhibited verbal behaviors of threatening, cursing, agitation, delusions at times, screaming and accusing others related to dementia with behaviors. The goal stated Resident #93 would not exhibit verbal outbursts directed towards others. The interventions included, evaluate the nature and circumstances (i.e., triggers) of verbal behavior, provide consistent trusted caregiver and structured daily routine when possible; and divert resident by giving alternative objects or activities.The Initial Allegation Report dated 10/19/25 revealed resident-to-resident abuse. The facility became aware of the allegation on 10/19/25 at 4:30PM. The allegation details stated Resident #86 had made contact with Resident #93 in his face. Both residents were separated immediately and placed on 1:1 monitoring for residents' safety. According to the report there were no mental or physical injuries noted, and the incident was reported to law enforcement. The Initial Allegation Report was completed by the Director of Nursing (DON). Review of the facility Investigation Report dated 10/21/25 revealed resident-to-resident abuse occurred on the 500 hall. The report was signed by the DON. The attached investigative summary stated on 10/19/25 nursing assistant (NA #11) was sitting at the nursing station on the 500 hall at approximately 4:30PM, when she witnessed Resident #93 approach the desk smiling. She at the same time noticed Resident #86 in the hallway by his (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedroom door. NA #11 asked Resident #93, what did he do? Resident #93 responded that Resident #86 hit him and knocked him down. At this time Resident #86 was coming up the hall in his wheelchair, pointing and fussing that we better keep Resident #93 out of his room. Nurse #10 stated Resident #86 was visibly upset and fussing in his native language (Spanish) while pointing his finger at the nurse. The nurse reported Resident #86 stated he is gonna get what he deserves. The NA stated at this time Resident #86 hit Resident #93 on his left cheek with an open palm slap. The staff reported they were unable to separate the residents quickly enough to avoid the occurrence. Nurse #10 took Resident #86 to the dining room while the nursing supervisor took Resident #93 with her. Resident #86 stated when he was in his bathroom and coming into his room, he found Resident #93 on his side of the room looking through his belongings (not roommates). Resident #86 reported he asked Resident #93 what he was doing. Resident #93 walked up to Resident #86 and hit Resident #86 on the side of the head making him fall. The DON interviewed both residents and heard similar stories of the initial unwitnessed incident in Resident #86's room and the witnessed altercation at the nursing station. The report further stated upon completion of the facility investigation through resident interviews, skin assessments and psych provider evaluations, the facility substantiated the resident-to-resident altercation. Residents #86 and Resident #93 would remain separate and with 1:1 staff supervision until cleared by psychology and the medical director. As of 10/19/25 both residents remained on one-on-one with no behaviors noted since the altercation.Interview with NA #11 on 2/27/26 at 8:54AM revealed from what she could recall, she was sitting at the nursing station when Resident #93 was observed walking down the hall towards the nursing station laughing but could not recall the date during 2nd shift. She stated she saw Resident #86 sitting in his doorway, seated in his wheelchair. She did not see Resident #93 coming out of Resident #86's room but he was coming from the direction of Resident #86 room. She recalled asking Resident #93 what he had done because she could tell something had happened. NA #11 indicated she thought Resident #93 verbalized Resident #86 had hit him. She indicated she saw Resident #86 approaching the nursing station fussing in broken English. NA #11 revealed when Resident #86 got to the nursing station in his wheelchair, he stood up and hit Resident #93 in the face.Interview with Nurse #10 on 2/7/26 at 9:20AM revealed she was the nurse assigned to 500 hall when the altercation occurred with Resident #86 and Resident #93. She recalled Resident #93 already being at the nursing station when Resident #86 came down the hall to the nursing station in his wheelchair. Resident #86 appeared very upset. When Resident #86 got to the nursing station he stood up and shook his finger at Nurse #10 and was saying something she could not make out. She stated when she stood up to talk to Resident #86, Resident #86 smacked Resident #93. Nurse #10 couldn't remember what side of the face Resident #93 was hit. The residents were separated and Resident #86 was moved from the 500 hall with 1:1 supervision.a. Resident #14 was admitted to the facility on [DATE] with a diagnosis that included hypertension, schizoaffective disorder, major depressive disorder and bipolar disease. Resident #14's quarterly MDS assessment dated [DATE] revealed he was cognitively intact, had no behaviors directed towards others and required substantial to maximum assistance with activities of daily living (ADL).Review of care plan dated 7/8/25 and revised 12/13/25 revealed Resident #14 exhibited or was at risk for distressed/fluctuating mood symptoms of being agitated/restless/anxious related to schizoaffective disorder, personality disorder, post-traumatic stress disorder (PTSD) and history of hallucinations. The goal stated Resident #14 would express anxieties/fears to staff, including psych providers, regarding his changs in mood (anxiety/depression, etc.). The interventions included redirect and reassure Resident #14, observe for signs and symptoms of worsening anxiety/fear/anger or agitation. The interventions further included to observe for worsening signs and symptoms of existing psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.). Interview with NA #10 on 2/27/26 at 9:10AM revealed she recalled an argument that occurred with Resident #86 and Resident #14 who shared a room. Although she could not recall the date NA #10 could recall she was working 1st shift (7:00 am to 3:00 pm). The argument was over the volume of the televisions, and the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents were going back and forth for control. She indicated she recalled the argument taking place while she was passing dinner trays. She indicated Resident #14 had requested Resident #86 turn down his television and Resident #86 yelled back that it was his television. NA #10 indicated she had tried to intervene, but she was passing dinner trays. She stated she told Resident #14 and Resident #86 they both needed to turn down their televisions. She recalled Resident #86 peering over to Resident #14's side of the room (behind curtain) stating it was his television. NA #10 revealed she notified the nurse (could not recall name) that Resident #86 and Resident #14 could not agree on the volume of the televisions and to see if she could assist. NA #10 stated she did not know what the nurse told Resident #86 and Resident #14, but when the nurse came out of the room she verbalized everything was fine. NA #10 indicated her shift was over before the incident occurred.Interview with Nurse #12 on 2/27/26 at 12:30PM revealed she recalled being assigned to the 300 hall on the date of the incident involving Resident #14 and Resident #86. She indicated she worked first shift (7:00 AM to 3:00 PM) and the incident occurred on 2nd shift (3:00 PM to 11:00 PM). She recalled being approached by an NA (could not recall name) notifying her that Resident #14 and Resident #86 were arguing about the television. She indicated by the time she arrived at Resident #14 and Resident #86's shared room, the resident were no longer arguing about the television. The Initial Allegation Report dated 12/2/25 stated an allegation of resident-to-resident abuse between Resident #86 and Resident #14. The stated Resident #86 and Resident #14 were separated and placed on 1:1 supervision for monitoring and safety. The details of physical or mental injury/harm revealed Resident #14 had an abrasion to his forehead which was cleaned by nursing staff and Resident #86 had an injury to his finger. The Investigation Report dated 12/9/25 revealed the facility became aware of the incident on 12/2/25 at 9:00AM in room [ROOM NUMBER]. The report indicated the incident resulted in physical harm. Resident #14 had an abrasion to his forehead that was cleansed by nursing staff. Resident #86 had a scratch on his finger that was cleansed by nursing staff.Review of a late-entry nursing note dated 12/3/25 stated Resident #86 was expected to transfer rooms. He required a private room due to an altercation on 12/2/25. Resident #86 was moved immediately following the altercation.Interview with Nurse #5 on 2/27/26 at10:53AM revealed she recalled an incident in which Resident #86 hit Resident #14 on 12/2/25. She stated she recalled being by the medication cart when Resident #86 came out of his room and was waving his arms as if he wanted help. When she got to the shared room of Resident #86 and Resident #14, she observed the room to be in disarray and Resident #14 had blood on his forehead. Resident #14 verbalized Resident #86 hit him with his reaching device (device used to aid in reaching items) on his head. She indicated Resident #14 continued to verbalize there was an issue with the volume of the television. Nurse #5 believed Resident #86's universal television remote was controlling Resident #14's television. Following her observation, she brought Resident #86 out of the room, and he was immediately placed on 1:1 supervision. Nurse #5 requested assistance from another nurse (name unknown) for assistance and to assess Resident #14's injuries. Nurse #5 indicated prior to her shift, she was notified during shift change Resident #14 and Resident #86 had an issue with the television volume, but she was told the issue was resolved. The altercation with Resident #86 and Resident #14 was not observed by staff. Interview with the Director of Nursing on 2/27/26 at 10:41PM revealed following the 12/2/25 incident with Resident #86 and Resident #14 interventions were put into place and included 1:1 was initiated for Resident #86 continuously, education was provided to staff regarding abuse with the inclusion of roommate compatibility, a private room was provided for Resident #86 and psych evaluation.Interview with the Administrator on 2/27/26 at 11:49AM revealed his date of employment was 11/3/25. He stated Resident #86 and Resident #14 were involved in an argument over preference of the television volume on 12/2/25 in their shared room. He stated it was identified the resident's television remotes were synched with one another, so they were inadvertently controlling each other's television volumes. Following the incident Resident #86 was placed on 1:1 supervision and he was placed in a private room. A plan of correction was put into place where the facility identified a timeline of the events. Monitoring was put into place, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	education regarding abuse and roommate compatibility was included. b. Resident #54 was admitted to the facility on [DATE] with a diagnosis that included vascular dementia with mood disturbance, insomnia due to other mental disorder and anxiety disorder.Quarterly MDS assessment dated [DATE] indicated Resident #54 was severely cognitively impaired, was independent with mobility and had no physical behaviors directed towards others during the lookback period. Review of Resident #54 care plan dated 4/2/25 revealed he exhibited or had the potential to exhibit physical behaviors related to his cognitive loss/dementia. Resident #54 would go into other rooms and not leave when asked. Resident #54 showed little knowledge of personal space. He paced, wandered and yelled at others expressing frustration, agitation and restlessness. The goal stated Resident #54 would be kept safe in his living environment. The interventions included, remove him from the environment if needed, gently guide Resident #54 from the environment while speaking in a calm, reassuring voice and divert Resident #54 by giving alternatives objects or activities.Review of the facilities Initial Allegation Report dated 12/24/25 stated the facility became aware of an alleged incident of resident-to-resident abuse between Resident #54 and Resident #86 on 12/24/25 at 7:10PM. The residents were separated and each placed on 1:1 supervision for monitoring and safety. Law enforcement was contacted regarding the incident. The Investigation Report dated 12/31/25 revealed an attached investigation summary that included protect both residents, (Resident #54 and Resident #86) were immediately separated by the facility staff and placed on 1:1 supervision. Resident #54 was moved to a different hall on 12/25/25. On 12/24/25 NA #6 was providing 1:1 supervision to Resident #86 while they were by the nursing station. According to NA #8, Resident #54, who was ambulatory, was standing at the nursing station conversing with other staff. Resident #54 began to speak to Resident #86. In a matter of seconds, Resident #54 leaned in closer to Resident #86, still speaking but not making sense. At that time per NA #8, Resident #86 reached out and struck Resident #54 openhanded across the face. Both residents were interviewed by the DON, and the residents were immediately separated and taken back to their rooms and placed on 1:1 supervision. Based on the accounts of events from the residents and the witness statements taken from staff it had been determined during the investigation that the resident-to-resident abuse was substantiated by the facility. An interview was conducted with Nurse #11 on 2/26/26 at 6:13PM. Nurse #11 indicated she was agency staff and vaguely remembered the incident that occurred with Resident #86 and Resident #54. She recalled Resident #86 utilized a wheelchair for ambulation and Resident #54 was able to walk independently. Nurse #11 did not recall Resident #86 having a 1:1 but did have a NA (name unknown) beside him while Resident #86 was at the nursing station. She recalled Resident #54 approach Resident #86, and Resident #86 was saying, leave me alone. Resident #54 reached out to Resident #86, and Resident #86 stood up from this wheelchair and hit Resident #54. From the nursing station she noticed Resident #54 leaning down toward Resident #86 before he was hit. Nurse #11 stated she could not tell if Resident #86 was hit with an open hand or his fist. Nurse #11 revealed she was not the assigned nurse for the residents but witnessed the incident because it occurred in front of the nursing station.Interview with NA #12 on 2/26/26 at 6:35PM revealed she recalled providing Resident #86 1:1 supervision on 12/24/25. She recalled Resident #54 coming off the 200 hallway towards the nursing station. NA #12 stated Resident #54 was about 5 steps from Resident #86 who was seated in his wheelchair within arm's reach of her. She stated she didn't think anything would happen when Resident #54 approached close to Resident #86 as she assumed Resident #54 was just coming over to speak. NA #12 indicated she could not remember what Resident #54 was saying but he leaned close to Resident #86 and Resident #86 hit him in the face with an open hand. Resident #54 was not directly in Resident #86 face, but he was very close. She stated Resident #86 hit Resident #54 so quickly she did not have time to prevent the altercation. NA #12 indicated she becomes aware she's assigned 1:1 when she arrives to shift and reviews the assignment sheet. She stated she had not received any instructions regarding Resident #86's triggers or what to avoid.An interview and observation was conducted with NA #9 in Resident #86's room on 2/27/26 at 8:10AM. NA #9 revealed she was assigned the task of 1:1 supervision for (continued on next page)

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	345143	A. Building B. Wing	03/13/2026

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Siler City Center	900 W Dolphin Street Siler City, NC 27344

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #86. She further stated she was as needed (PRN) staff but worked with Resident #86 often. She further revealed she was usually assigned to conduct 1:1 with the resident weekly, completing 16-hour shift with Resident #86. NA #9 revealed the facility had not told her why she was providing Resident #86 with 1:1 supervision. She had overheard a nurse (name not known) verbalizing there was an incident but not the details of the incident. NA #9 further revealed she was only instructed to tell a nurse if Resident #86 was upset and to get them if she needed assistance. Resident #86 was described as very social and he occasionally becomes upset but was easily calmed. NA #9 stated she was not aware of triggers that led to previous resident-to-resident altercations. An interview was conducted with the DON on 2/27/26 at 10:41PM. The DON stated interventions were put into place following 12/24/25 the incident with Resident #86 and Resident #54. The interventions included continued 1:1 supervision with Resident #86, re-education on abuse, resident rooms were reassigned and psych evaluation were completed. The DON stated she was unaware if NAs assigned to provide Resident #86 with 1:1 supervision staff were educated about potential triggers. Interview with the Assistant Director of Nursing (ADON) on 2/27/26 at 10:53AM revealed staff were told when providing 1:1 supervision, they were to stay with the assigned resident at all times. Staff further ensure residents on 1:1 were not being aggressive with other residents. When staff were assigned 1:1 supervision, staff were told triggers. The ADON indicated Resident #86 triggers were if anyone was messing with his personal items or got into his personal space. The ADON could not recall any formal in-service being conducted regarding Resident #86's triggers to resident-to-resident aggression. Interview with the Administrator on 2/27/26 at 11:49AM revealed on 12/24/25 Resident #86 hit Resident #54 in the face while Resident #86 was receiving 1:1 supervision and the incident took place at the nursing station. He described Resident #54 as very friendly and hard of hearing. He revealed he believed Resident #54 leaned in to hear what Resident #86 was saying when Resident #86 was startled and hit Resident #54. He stated both Residents were residing on the same hall and as an intervention, Resident #54 was assigned to another hall. He further revealed staff received education on de-escalation and dementia training. He stated he would expect NAs to be told about what may trigger a resident to display aggressive behaviors prior to providing 1:1 supervision. He further stated he would have to get with the nurse educator to identify if triggers were discussed. He indicated 1:1 supervision failed on 12/24/25 because the movements of Resident #86 were swift and happened in a matter of seconds. The NA assigned to provide 1:1 was present and within arm's reach of the Resident #86 when the incident occurred. To his understanding Resident #54, Resident #86 and staff were talking at the nursing station and Resident #54 leaned in close to Resident #86.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, the facility failed to complete an accurate Minimum Data Set (MDS) assessment in the area of skin conditions for 1 of 11 residents who MDS assessments were reviewed (Resident #5).The findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses of left patella fracture, atrial fibrillation (A-fib), congestive heart failure (CHF), hypothyroidism, and Alzheimer's disease. An admission progress note written on 10/08/25 at 2:46 PM by Nurse #8 stated Resident #5 had arrived at the facility via ambulance on a stretcher. She noted that Resident #5 had a dark spot to her coccyx, an open area to her spine, and redness to her left knee. A review of Resident #5's care plan dated 10/09/25 revealed she was found to be at risk for skin breakdown. The goal dated 10/9/25 stated Resident #5 would not show any signs of skin breakdown for 90 days. The interventions also dated 10/9/25 included to pat (do not rub) skin when drying, observe skin for signs and symptoms of skin breakdown including redness, cracking, blistering, decreased sensation, and skin that does not blanch easily, provide preventative skin care (lotions, barrier creams as ordered), apply barrier cream with each cleansing, observe skin conditions daily with activities of daily living (ADL) care and to report abnormalities and the resident's skin was to be checked weekly by a licensed nurse. There were no care plans or interventions included for Resident #5 for or directly speaking to the open area noted to her spine or the dark spot on her coccyx observed on admission. Resident #5's admission Minimum Data Set (MDS) dated [DATE] revealed she was severely cognitively impaired and required extensive assistance with activities of daily living, bed mobility, and transfers. The MDS noted that she was at risk for developing pressure ulcers/injuries but stated she did not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing or device. That MDS stated Resident #5 had no pressure ulcers or skin issues. Under ?Other ulcers, wounds, and skin problems' the MDS indicated none were present. The MDS did not indicate that Resident #5 was to have a pressure relieving device in her chair or have her participate in a reposition/turning program or be part of a nutrition and hydration program for skin.

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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 observations, record review and resident, staff and Physician interviews, the facility failed to secure medications stored at the bedside for 1 of 1 resident reviewed for medication storage (Resident #7).The findings included:Resident #7 was admitted to the facility on [DATE]. A review of Resident #7's physician's orders dated 6/25/2025 revealed an order that stated, Resident may not administer his own meds. A review of Physician's order dated 6/25/25 for Resident #7 revealed that staff were to monitor swallowing during medication pass and to document if resident coughed, complained of pain, or demonstrated difficulty when swallowing meds.An observation and interview were conducted on 2/24/26 at 2:50PM with Resident #7 in his room. It was observed that he had a medication cup containing 7 pills sitting on his bedside table. Observation of the hallway outside of resident's room revealed the nurse for this hallway (Nurse #2) was no longer passing medications on the hallway. Resident #7 said he would take his medications in the cup, when they let me out of this place. An interview was then conducted on 2/24/26 at 2:55PM, in Resident #7's room with Nurse #2 (nurse assigned to the 100 hallway). She stated the medication cup contained different medications and named them. Nurse #2 indicated they were Resident #7's lunch meds (medications) which she gave him at approximately 1:30PM. Nurse #2 stated, 'He usually takes them.' Nurse #2 then asked Resident #7 if he would take the medication and resident refused stating, I will take them when I get up outta here and he did not take the medication. Nurse took the med cup with her out of the resident's room and walked back to the staff breakroom. In a continued interview and observation on 2/24/26 at 2:58pm, outside of Resident's room, Nurse #2 explained she would typically administer Resident #7's medications to him, by just handing them to him to take and he would take them. She went on to say that in this case, he told her he would take them so she trusted that he would do that. Nurse #2 stated this was a lapse in her judgement and she should not have left them in there because he didn't take them. She said she was aware that he was not supposed to have his medications left at bedside as well as the order to monitor swallowing during medication pass and document if Resident #7 coughed, complained of pain, or demonstrated difficulty when swallowing medications. An interview was conducted on 2/26/2026 at 2:45PM with the Physician. He stated that he couldn't really speak to Resident #7 having his own meds at his bedside. The Physician did not recall initially that Resident #7 had an order that stated he was not permitted to administer his own medications, but stated, Then he probably shouldn't. He indicated he did not feel like the pills in the cup would hurt Resident #7 to have them on his bedside table, but that he did know he was resistive to care at times. He said he did expect all physicians' orders to be followed by staff, but he can't always control what the staff did. An interview with the Director of Nursing (DON), conducted on 2/27/2026 at 1:14PM revealed that there was only one resident in the facility during the time of survey who had an order to administer their own medications. All other residents had orders that they may not self-administer medications. The DON stated that Nurse #2 should have stayed and watched Resident #7 take his medications and should not have left them at the bedside. Interview with the Administrator on 2/27/2026 at 1:23PM revealed that he was not aware that medications were left at the bedside of Resident #7. The Administrator stated he was not familiar with the resident, and he did not feel he could speak about the situation.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and staff interviews, the facility failed to keep the area around the trash compactor free from accumulated trash and debris for 1 of 1 trash compactor observed. This failure had the potential to attract pests and rodents.The findings included:An observation of the dumpster area occurred on 2/23/26 at 10:23 am with the Dietary Manager (DM). The observation revealed the facility had one trash compactor located in a fenced area behind the kitchen entrance. Directly in front of the trash compactor was a cement platform with a grassy area to the left side and back of the trash compactor. On the left side of the trash compactor in the grassy area there were four plastic bottles, six disposable cups, four disposable gloves, and seven straws.The DM was interviewed on 2/23/26 at 10:24 am. The DM explained the cement platform was cleaned weekly by a member of the kitchen staff but the trash and debris on the left side and back of the trash compactor did not get picked up. The DM stated she was not sure why the area was not attended to and commented that all departments in the facility used the same trash compactor.During an interview with the Administrator on 2/27/26 at 10:22am, the Administrator stated he did not know why the trash compactor area had not been cleaned and explained he would want the area cleaned of any debris.