STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Woods Nursing and Rehabilitation Center	33426 Old Salisbury Road Albemarle, NC 28002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on record reviews, and interviews with the police detective, pharmacy consultant, physician and staff, the facility failed to protect the residents' right to be free from misappropriation of multiple non-narcotic medications when Nurse #1 was found with a bag of prescribed medications during a traffic stop. This deficient practice affected 16 of 16 residents reviewed for misappropriation (Residents #2, #10, #31, #37, #60, #68, #78, #86, #88, #121, #122, #123, #124, #125, #126, and #127).The findings included: A review of the facility's policy entitled Abuse, Neglect, Misappropriation and Exploitation dated August 2019 read in part . The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.Misappropriation of resident property is defined as the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without consent. A review of sheriff's office incident sheet dated 9/4/25 read that on 9/4/25 at 3:08 PM, a traffic stop was conducted with Nurse #1 due to a vehicle registration infraction. Nurse #1's vehicle was searched due to the smell of marijuana and multiple prescription medications were found inside a bag and under the passenger seat. Nurse #1 stated that she got them from the facility she had worked at, put them in her pocket and forgot to return them. The report indicated that the facility was made aware of the findings and confirmed that Nurse #1 was a former employee that had been terminated. The prescription medications were placed into evidence pending further investigation and Nurse #1 was taken into custody. A phone interview occurred on 3/31/26 at 1:09 PM with the Police Detective. He stated that he oversaw the narcotics division and special operations and was present at the traffic stop of Nurse #1 on 9/4/25. He recalled during the search of her vehicle finding multiple packs of single medications as well as medication cards in multiple areas of her vehicle. He stated that Nurse #1 expressed to them that she was a nurse and had forgotten the medications were in her pocket, inadvertently taking them home at the end of her shift. The Police Detective confirmed there were no narcotic medications found in Nurse #1's possession. The facility was notified of the findings. He stated that the Administrator came to the police station the following day to take an inventory of what had been found in Nurse #1's possession. The interview further revealed the medications were kept as evidence and not released back to the facility. An initial allegation report was submitted to the State by the prior Administrator on 9/5/25. The report read that the facility initially became aware of the incident on 9/4/25 at 4:00 PM, alleging that Nurse #1 was detained during a traffic stop and was found with various medications belonging to facility residents. The facility investigation was initiated. Review of the facility investigation completed by the prior Administrator on 9/12/25 revealed that on 9/4/25, she was informed by the local law enforcement that Nurse #1 was stopped for a traffic violation and was observed with a zip lock bag of medications belonging to the facility. Nurse #1 was taken into custody and claimed the medications had been inadvertently taken home after being placed in her pocket. An inventory was taken of the medications in Nurse #1's possession on 9/5/25 with a total of 16 residents identified. Assessments associated with the medications in the nurse's possession were completed for all identified in-house residents with no adverse outcomes. The in-house identified residents' medication orders, Medication Administration Records (MARs) and progress notes were reviewed with no negative findings. Interviews were conducted with nursing staff and alert and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oriented residents with no concerns expressed regarding the nurses' practice of medication administration. Nurse #1 had worked at the facility from 9/17/24 to 1/25/25 and again from 7/15/25 to 8/25/25. Both times she had been terminated for poor attendance. Nurse #1's personnel file was reviewed, including pre-hire background screening and licensure verification with no significant findings. She had received training on the policy of misappropriation upon her employment on 9/17/24 and 7/15/25. The facility investigation determined that, while the nurse was found in possession of resident medications as documented by law enforcement, there was no evidence to indicate that residents missed any prescribed doses or that their care was compromised. MARs indicated that medications were administered in accordance with physician orders. However, the way the medications were removed from the facility and when could not be determined. The facility substantiated the police report findings but had no prior knowledge of any unauthorized removal of medications by the nurse before being notified by law enforcement. The facility notified all alert and oriented residents, Responsible Parties (RPs), Adult Protective Services and the Board of Nursing. The residents involved were reimbursed for the medications identified by law enforcement. The facility report detailed the medications in Nurse #1's possession as follows:Belonging to Resident #2: A multidose medication card with six Gabapentin (a medication used to treat nerve pain and seizures) 300 milligrams (mg) tablets. Belonging to Resident #10: A multidose medication card with three Gabapentin 400 mg tablets. Belonging to Resident #31: A single dose smart pack of one Carvedilol (a medication used to treat high blood pressure)12.5 mg tablet and a single dose smart pack of two and half Paroxetine (an antidepressant medication) 20 mg tablets.Belonging to Resident #37: A single dose smart pack of two Gabapentin 100mg tablets, a single dose smart pack of one Carbamazepine (a medication used to treat pain and seizures) 200 mg tablet, a single dose smart pack of one Meloxicam (a medication used to treat joint pain) 15 mg tablet and a single dose smart pack of one Xifaxin (an antibiotic) 550 mg tablet.Belonging to Resident #60: A multidose medication card with 14 Zofran (an antinausea medication) 4 mg tablets.Belonging to Resident #68: A multidose medication card with 10 Trazodone (an antidepressant) 50 mg tablets and a multidose medication card with one Trazodone 50 mg tablet. Belonging to Resident #78: A multidose medication card with 13 Simethicone (a medication used to treat gas) 125 mg tablets.Belonging to Resident #86: A single dose smart pack with one Gabapentin 300 mg tablet, a single dose smart pack with one Lisinopril (a medication used to treat high blood pressure) 20 mg tablet, a single dose smart pack with three Divalproex (a medication used to treat seizures and mood) 125 mg tablets, a single dose smart pack of one Vitamin B12 1000 micrograms (mcg) tablet, and a single dose smart pack of one Paliperidone (an antipsychotic medication) 6 mg tablet. Belonging to Resident #88: A multidose medication card with one Levaquin (an antibiotic) 500 mg, a multidose medication card with seven Prednisone 10 mg tablets, a multidose medication card with two Vitamin B12 1000 mcg tablets, and a multidose medication card with eight Gabapentin 300 mg tablets. Belonging to Resident #121: A multidose medication card with 16 Guaifenisin (a medication used to treat cough) 400 mg tablets. Belonging to Resident #122: A single dose smart pack of one Sertraline (an antidepressant) 0.25 mg tablet and one single dose smart pack of a Xarelto (a blood thinner) 10 mg tablet.Belonging to Resident #123: One multidose Albuterol inhaler (a medication used to treat wheezing) 108 mcg. Belonging to Resident #124: A multidose medication card with six Prilosec 20 mg tablets and one tube of Voltaren Gel. Belonging to Resident #125: A multidose medication card with two Gabapentin 300 mg tablets. Belonging to Resident #126: A multidose medication card with 16 Phenergan (an antinausea medication)12.5 mg tablets. Belonging to Resident #127: A multidose medication card with 16 Benzonate (a medication used to treat cough and congestion) 200 mg. Belonging to an unknown resident: One Albuterol inhaler 108 mcg. Belonging to an unknown resident: One Levalbuterol inhaler.Belonging to an unknown resident: A multidose medication card of seven oval shaped white tablets with the marking F on one side the 91 on the other. Per pharmacy verification the tablet was identified as Zofran. Multiple attempts to contact Nurse #1 from 3/31/26 to 4/2/26, were unsuccessful. A phone interview was conducted on 3/31/26 at 2:00 PM with (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the prior Administrator. She recalled being notified by the local law enforcement that Nurse #1 had been stopped for a traffic violation and was found to have multiple residents' medications that belonged to the facility. She stated that both she and the Director of Nursing (DON) went to the police station the following morning to take an inventory of what was found in Nurse #1's possession. There was a total of 16 residents that were identified and 3 medications that were unidentified. The Administrator stated that once the resident medications were identified, the physician, pharmacy, alert and oriented residents and responsible parties were notified. She stated that both she and the DON investigated how or when Nurse #1 misappropriated the medications but was difficult to determine as she worked at the facility two separate times and some of the residents she was not assigned to care for. It was thought that the discontinued medications may have still been on the medication cart or in the medication room waiting for pharmacy return. The prior Administrator stated that Nurse #1 had been terminated from the facility for poor attendance prior to the traffic stop. The interview further revealed all identified residents were reimbursed for the medications that had been misappropriated. The DON was interviewed on 4/1/26 at 10:44 AM and stated that she had been employed at the facility for approximately 3 weeks with the misappropriation incident occurred involving Nurse #1. She recalled it was difficult to determine when the medications had been removed from the facility as Nurse #1 had been employed twice at the facility. She stated that she and the prior Administrator went to the police station the day after being notified to take an inventory of the medications in Nurse #1's possession. The pharmacy was notified and assisted with when the medications had been dispensed and the reimbursement rate. An interview occurred with the Medical Director on 4/1/26 at 12:09 PM and stated that he had been notified of the incident in September 2025 and was aware of each resident that could have potentially been affected. He stated that he and his Nurse Practitioner (NP) assessed the residents' that were affected and found no negative effects. A phone interview was completed with the Pharmacy Consultant on 4/1/26 at 1:12 PM and verified she had been made aware of the misappropriation incident in September 2025. She stated the pharmacy assisted the Administrator to identify when the medications had been dispensed and the reimbursement rates for refund. The Pharmacy Consultant stated that she was at the facility monthly and completed a medication pass with a nurse as well as reviewed medication carts for expired medications. She stated that she would not have been able to determine from the medication cart audits if a medication had been discontinued or if a resident who no longer resided in the facility had medications on the medication carts. The Administrator was interviewed on 4/2/26 at 11:22 AM and stated that efforts were still ongoing to prevent misappropriation of resident medications. The facility provided a plan of correction that was not acceptable to the State Agency as the facility did not include a systemic approach to prevent future incidents of misappropriation of resident property.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and staff interviews, the facility failed to secure medications left on top of and in an unattended unlocked medication cart (400 hall medication cart) and failed to remove one (1) bottle of expired eye drops, label an Ozempic insulin pen with the name of the specific resident for whom it was prescribed and the date it was opened, and stored an unopened insulin pen in the medication cart (800 hall medication cart). This was for 2 of 3 medication carts observed for medication storage (400 hall and 800 hall medication cart). The findings included: 1. A continuous observation of an unattended medication cart on the 400 hall was made on 4/2/26 from 12:35 PM until 12:38 PM. The medication cart was observed to be unlocked (a red dot is visible on the lock mechanism when in the unlocked position), the narcotic medication drawer was pulled out and open, allowing the medications in the narcotic drawer to be exposed. In addition, a cup of crushed white pills and a small white bottle of medication containing a red liquid were observed on top of the medication cart. The medication cart was parked in the hallway between rooms [ROOM NUMBERS]. There were no observed residents, staff or visitors around the location of the medication cart. Nurse #2 walked up to the medication cart and stated she didn't mean to leave the narcotic drawer open, the medication cart unlocked or the medications on top of the cart. During an interview on 4/2/26 at 12:38 PM, Nurse #2 indicated she was assigned to the 400-hall medication cart and stated she had stepped into a resident's room and forgot to close the narcotic drawer, secure the medications on top of the medication cart as well as secure the medication cart. She verified that the medication left on top of the medication cart was a bottle of liquid Morphine (an opioid) and the crushed medications in the medication cup were Fluoxetine (an antidepressant) and Gabapentin (a non-narcotic medication used for pain). She added that medications should never be left unattended and the medication carts were to be locked when unattended. In an interview on 4/2/26 at 1:11 PM, the Director of Nursing (DON) stated that medications should not be left unattended on top of the medication carts and medication carts should be secured. She indicated that a resident could have come up and removed the medication from the cart and swallowed it. 2. On 4/1/26 at 10:16 AM an observation was conducted of the 800-hall medication cart in the presence of Medication Aide (MA) #2. The following medications were noted stored in the medication cart: One (1) Ozempic pen open in use and not labeled. One (1) Lantus Solostar pen not in use and not refrigerated as the label directed. One (1) bottle of latanoprost eye drops opened and dated 2/4/26 with an expiration date of 6 weeks after opening as the label directed. One (1) bottle of geritussin opened and undated. One (1) bottle of guaifenesin liquid opened and undated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One (1) bottle of milk of magnesia opened and undated. On 4/1/26 at 10:20 AM, MA #2 was interviewed and stated she was unaware the Ozempic pen was unlabeled. MA #2 explained the Lantus insulin pen should have been refrigerated since it was not in use, and the latanoprost eye drops should have been discarded 6 weeks after opening. MA #2 stated the stock medications of geritussin, guaifenesin, and milk of magnesia should have been labeled with the date they were opened. She was not sure why the medications were not labeled with resident identifier or dated. MA #2 removed the medications from the medication cart to be disposed. Unit Manager #1 was interviewed on 4/1/26 at 2:45 PM and stated staff assigned to the medication cart should have checked the labels of all medications for resident identifiers as well as open and expiration dates. UM #1 indicated all insulin pens should have been labeled with the resident's identifiers, as well as the open date, and refrigerated if not in use, and all expired medications should have been discarded. On 4/2/26 at 2:01 PM the Director of Nursing (DON) was interviewed and stated the Unit Managers had been auditing the medication carts weekly to make sure the medications were labeled and dated correctly as well as all expired medications were disposed of. She indicated the Lantus Solostar pen on the 800-hall medication cart must have been delivered during the night shift on 3/31/26 and placed on the cart instead of stored in the refrigerator as the label instructed. She further explained that all medication bottles and insulin pens should be labeled with resident identifiers and dates when opened. The DON stated the eye drops should have been discarded as the label directed 6 weeks after opening.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to ensure that residents were treated in a dignified and respectful manner. This was evidenced by staff arguing with a resident and using profanity in the resident's presence for 1 of 4 residents reviewed for dignity (Resident #7).Findings included:Resident #7 was admitted to the facility on [DATE] with diagnoses that included unspecified mood affective disorder and anxiety disorder.A quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that Residentˆ#7 was cognitively intact.Resident #7's active care plan, last reviewed on 3/2/26, indicated that he exhibits problematic behaviors related to ineffective coping, including verbal aggression and expressions of anger. These behaviors include use of profanity towards others, making threats toward staff, and making false accusations regarding his care. Interventions included avoid arguments with the resident.A review of the investigation report dated 3/23/26, completed by the Administrator, revealed that on 3/19/26, two nursing assistants (NA) #3 and NAˆ#8, were having a discussion in the hallway. Residentˆ#7 heard them from his bed and disagreed with the topic they were discussing. Residentˆ#7 yelled out to NAˆ#3 and NAˆ#8 and shared his opinion. NAˆ#8 responded, and a verbal exchange occurred between her and Residentˆ#7 from the hallway. During this exchange, both Residentˆ#7 and NAˆ#8 used profanity. Unit Manager (UM)ˆ#2 removed NA #8 from the hallway and spoke with Residentˆ#7 about the incident. Residentˆ#7 stated that he and NAˆ#8 had been arguing because she was talking about another staff member (NAˆ#6), and he felt what she said was untrue.During an interview conducted with Residentˆ#7 on 3/30/26 at 12:44 PM, he reported that on 3/19/26 NAˆ#8 and NAˆ#3, were in the hallway talking about NAˆ#6, who also worked in the facility. He said he told them to stop talking about NAˆ#6 because he felt NAˆ#6 did a good job. He explained that NA #8 was disrespectful and had no business arguing with him. He stated the exchange made him angry primarily because they were talking about NAˆ#6. During an interview on 4/1/26 at 8:17 PM, NAˆ#3 stated that she and NAˆ#8 were in the hallway talking about another employee. She stated that Residentˆ#7 heard them and began yelling and cursing, telling them to stop talking about the employee. NAˆ#3 explained that at this point, NAˆ#8 began arguing back with the resident. She stated that both Residentˆ#7 and NAˆ#8 used profanity during the verbal exchange.Attempts to speak with NAˆ#8 by phone on 4/1/26 and 4/2/26 were unsuccessful.During an interview conducted with the Director of Nursing (DON) on 4/2/26 at 11:16 AM, she explained that the verbal exchange between Residentˆ#7 and NAˆ#8 should not have occurred. The DON confirmed that NA #8 admitted to her that she used profanity in the hallway during the verbal exchange with Resident #7. She stated that NAˆ#8 should not have engaged or argued with Residentˆ#7 and should not have used profanity in the hallway. The DON stated she felt NAˆ#8 demonstrated poor customer service by arguing with Residentˆ#7 and using profanity in the hallway.An interview with the Administrator on 4/2/26 at 11:33 AM revealed that NAˆ#3 witnessed the verbal exchange between Residentˆ#7 and NAˆ#8. The Administrator stated that NAˆ#3 confirmed NAˆ#8 argued with Residentˆ#7 and used profanity while discussing NAˆ#6. The Administrator further stated that this interaction should not have occurred, as it was unprofessional and demonstrated poor customer service for a staff member to argue or use inappropriate language in front of residents. The Administrator confirmed that NAˆ#8 was terminated based on her admission that she argued with the resident and used profanity in the hallway, along with NAˆ#3's corroboration of the unprofessional communication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident and staff interviews, the facility failed to ensure a resident's call light system was placed within reach and accessible for 1 of 8 residents reviewed for accommodation of needs (Resident #7).The findings included:Resident #7 was admitted to the facility on [DATE] with diagnoses including quadriplegia, diabetes mellitus, stage 3 chronic kidney disease.A quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #7 was cognitively intact, had impaired function in both upper and lower extremities, and was dependent on staff for all activities of daily living (ADL).Review of the active care plan, last reviewed 3/2/26, identified the resident required staff assistance for all ADL due to quadriplegia and utilized a mouthˆblowing call system device to summon assistance. The care plan also indicated the resident exhibited problematic manner behaviors, including calling 911 when not receiving timely attention. Interventions included responding promptly to requests.Review of Resident #7's care guide (Kardex), last reviewed 3/2/26, confirmed the resident used a mouthˆblowing call device.On 3/30/26 at 12:44 PM, an observation and interview conducted with Resident #7 revealed he was lying in bed. His call device was observed out of reach, positioned too far away from his mouth for activation. The resident stated he did not know how long it had been out of reach and that although the device was normally placed correctly, there were times he had to yell out to staff in the hallway to reposition it. He stated he yelled for help if he needed something because he was unable to move independently to reach the device.During an interview on 3/30/26 at 12:52 PM NA #2 stated she was assigned to Resident #7 on 3/30/26 from 7:00 AM to 3:00 PM. She indicated she was unaware the resident's call device was out of reach. She explained the device must be close enough to the resident's mouth for him to blow into it to activate the call system and reported it may have been moved during ADL care. NA #2 stated she had been in his room within the last hour but could not recall if she checked the placement of his call device. She stated that the resident could yell out if needed something. NA #2 immediately repositioned the call device within Resident #7's reach. On 4/1/26 at 2:20 PM, Unit Manager #3 reported Resident #7 was quadriplegic, dependent on staff for all care, and required the mouthˆblowing call device to request assistance. She stated she was unaware of any issues with the device being out of reach and confirmed that it needed to be close enough to the resident's mouth for use.On 4/2/26 at 10:08 AM, another observation found the resident lying in bed watching television with the call device positioned above his head and out of reach. Resident #7 confirmed he could not access the device. He stated he would yell out or use his voiceˆactivated phone to call the facility if he required assistance. He believed the device may have been pushed away earlier that morning during care.Attempts to reach NA #6, who provided early morning care on 4/2/26, were unsuccessful.During an interview on 4/2/26 at 10:15 AM NA #5 stated she was assigned to Resident #7 on 4/2/26 from 7:00AM to 3:00 PM. NA #5 indicated she was last in the residents' room sometime between 7:30 AM and 8:30 AM and had not observed the call device out of reach. She also stated she had not moved the call device that morning.At 10:19 AM on 4/2/26, Nurse #2 reported the resident had requested she move the call device closer during her earlier medication pass. She stated she repositioned it appropriately and that this was the first time she had observed it out of reach but noted he could yell out to staff if needed.During an interview with the Director of Nursing on 4/2/26 at 2:14 PM, she stated Resident #7 was able to make his needs known by yelling out or using his voiceˆactivated cell phone. She reported she was unaware of any issues with the call device but confirmed her expectation was for the device to always be within the resident's reach.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to provide personal privacy during incontinence care when Nurse Aide (NA) #1 captured a picture of Resident #42 with her cellphone while in the room during care. Resident #42 was partially clothed and uncovered in the photo. This deficient practice affected 1 of 1 resident reviewed for privacy (Resident # 42).The findings included:Resident #42 was admitted to the facility on [DATE] with diagnoses including diabetes type II, congestive heart failure, and peripheral vascular disease with a right below the knee amputation (BKA). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #42 was cognitively intact, frequently incontinent, and dependent on assistance for activities of daily living (ADL).The Director of Nursing (DON) interview was conducted on 04/02/26 at 9:11 AM. The DON stated they received a call from an anonymous caller on 1/16/26 stating he had a screenshot of a resident from their facility that was taken by NA #1. The DON reported the photo was sent to her and at first, they could not identify the resident because you could not see the resident's face. The DON reported that you could see a person's backside, a leg amputation was noted, and part of a sweatshirt. The DON reported they narrowed it down by looking at only residents that had leg amputations, as well as the surroundings in the room. The DON reported they also spoke with NA #1 about their concerns. The DON reported NA #1 stated that she did recall a time when she was on her phone at the nurse's station and it was a Facetime call. The DON stated that NA#1 reported that she was putting the phone back in her pocket as she went into Resident #42's room and she assumes that the phone must have captured a view of Resident #42 before she got it put away. The DON reported that NA #1 reported not taking a picture of the resident but that her ex-boyfriend must have done a screenshot as she was putting the phone away. The DON reported that after she spoke with the anonymous caller about the concerns and received the picture from him, she requested that he delete the photo from his phone, and he agreed to do so. The DON reported that she asked NA #1 if she had the photo on her phone and she did not. The DON reported that it was the molding around the window that helped them to determine the time frame of the photo because the resident was in a different room during November and December 2025. The DON reported that NA #1 was terminated because she violated the cellphone policy. The DON reported that Resident #42 reported not recalling the incident happening. The DON felt NA #1 had taken the call on her cellphone but did not intend to invade Resident #42's privacy. The DON shared a photo of Resident #42 on 4/02/26 at 12:45 PM that was on her work cell phone. Resident #42 was lying on his right side facing the wall and window area receiving bowel incontinence care and had a right BKA. Resident #42's entire buttocks was uncovered and showing. Resident #42's genitals could not be seen in the photo. Resident #42 had feces behind his buttocks area on the bed. Resident #42 was wearing a striped, blue, yellow, and white long-sleeved shirt. Resident #42's face could not be seen in the photo, only the back of his head.An interview with NA #1 on 04/02/26 at 10:58 AM revealed that one evening she was working and continued to receive back-to-back calls on her cellphone from her ex-boyfriend. NA #1 reported that initially, she did not answer but while she was in Resident #42's room, the calls continued so she answered thinking it was an emergency call. NA #1 reported that she answered on Facetime with her earbuds in Resident #42's room. NA #1 reported that it was her boyfriend at the time, but it was not an emergency so she told him that she could not talk. NA #1 reported that later she found out that her phone had captured a picture of Resident #42's back side including his booty. NA #1 reported that she was not exactly sure how this happened, only that maybe it happened as she was locking her phone and putting it away in her pocket. NA #1 could not remember the name of the resident that was in the photo. NA #1 reported that the administrative staff spoke to her about it and initially suspended her during the investigation and then later terminated her employment because she had violated the cellphone policy. An interview with Resident #42 was conducted on 03/30/226 at 1:49 PM. Resident # (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42 stated he does not remember an incident where his picture was taken during incontinence care or working with NA #1. An additional interview with Resident #42 was conducted on 04/02/26 at 12:31 PM. Resident # 42 verbalized that if a picture was taken of him during incontinence care and his buttocks was showing it would not bother him. He stated, People are going to do what they are going to do anyways. I don't care. An Administrator interview was conducted on 04/01/26 at 3:37 PM. The Administrator reported that the facility received a call on 1/16/26 from an anonymous caller stating that NA #1 had taken a photo of a resident while providing incontinence care. The Administrator reported that in the photo the resident was partially clothed and they were unable to identify him because you could not see his face. The Administrator reported that you could only see part of the back of his head, part of his backside, part of his sweatshirt, and part of his bed including some surroundings in the room including a windowpane. The Administrator reported that they were able to eventually identify who it was based on the windowpane area and his sweatshirt. The Administrator reported that they determined that the photo must have been taken between November and December 2025 when Resident #42 was in a previous room that matched the windowpane. The Administrator reported when they spoke to NA #1, she reported that her phone must have accidentally captured a picture of the resident when she was in his room providing care. The Administrator indicated that at the time, NA #1 stated that she was dating a guy that kept calling her that evening and she only answered her phone to say that she could not talk because she was at work. NA #1 explained she had earbuds in at the nurse's station and when she answered the call it was on FaceTime, which is when the picture must have been captured. The Administrator reported that even though they did believe the incident to be accidental, the employee was still terminated due to violation of the electronic device policy. The Administrator stated staff should maintain privacy during incontinence care and not use their cellphones when providing any type of care to the residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and resident, staff, and Medical Director interviews, the facility failed to ensure oxygen was delivered at the prescribed rate. This deficient practice occurred for 1 of 4 residents reviewed for respiratory care (Resident #11).Findings included:Resident #11 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure and COPD (chronic obstructive pulmonary disease).The care plan dated 12/31/25 revealed Resident #11 had an intervention for oxygen therapy as ordered related to COPD.A review of the electronic medical record for Resident #11 revealed a physician order dated 1/22/26 for oxygen therapy at 3 liters per minute (LPM) via nasal cannula continuously to keep oxygen saturation levels above 90%.The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #11 was cognitively intact and was receiving oxygen therapy.An observation of Resident #11 was conducted on 3/30/26 at 2:20 PM. It was noted the oxygen concentrator was set at a flow rate of 2.5 LPM when viewed at eye level. Resident #11 was resting in bed and denied any shortness of breath, and she did not appear to be in respiratory distress.On 3/31/26 at 1:41 PM an observation was conducted of Resident #11's oxygen concentrator, and it was noted the oxygen concentrator was set at a flow rate of 2.5 LPM when viewed at eye level. Resident #11 was resting in bed and stated she was supposed to receive 3 LPM of oxygen therapy. She denied feeling short of breath, and she did not appear to be in respiratory distress.A review of the March 2026 medication administration record (MAR) revealed Medication Aide #1 had signed that Resident #11's oxygen concentrator was set at a flow rate of 3 LPM on 3/30/26 and 3/31/26.An observation and interview was conducted with Medication Aide (MA) #1 on 3/31/26 at 3:15 PM. MA #1 was accompanied to Resident #11's room to view the oxygen concentrator setting and immediately turned the oxygen concentrator flow rate to 0 LPM then adjusted the dial back and forth up the flow indicator field before stopping the dial stating that is how she would adjust the oxygen therapy flow level. MA #1 stood over the concentrator and stated, See, 3 liters. MA #1 was asked to view the oxygen therapy setting at eye level and agreed when viewed at eye level the flow level setting read 2.5 LPM. She then adjusted the oxygen therapy dial to 3 LPM when viewed at eye level. According to MA #1, she had assessed Resident #11's oxygen concentrator on both 3/30/26 and again on 3/31/26 while standing over the concentrator and documented the oxygen therapy flow rate was 3 LPM. MA #1 stated she evaluated Resident #11's oxygen concentrator flow rate as part of the medication pass, and if she had any problems with the oxygen therapy then she would notify the Unit Manager who was overseeing her work. On 3/31/26 at 3:31 PM Unit Manager (UM) #1 was interviewed. According to UM #1, she periodically checked the oxygen therapy concentrator flow rate settings when she entered a resident's room. However, she indicated she had not assessed Resident #11's oxygen therapy concentrator flow rate setting on 3/30/26 or 3/31/26.The Medical Director was interviewed on 4/1/26 at 12:16 PM and stated Resident #11 tended to get short of breath with activity, and it was his expectation that staff would follow orders as written for Resident #11 to receive oxygen therapy at 3 LPM.An interview was conducted with the Director of Nursing (DON) on 4/2/26 at 2:01 PM who stated Resident #11's oxygen therapy should have been delivered correctly at 3 LPM as ordered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41% for 2 of 3 residents observed for medication administration (Resident #129 and Resident #110).The findings includeda. Resident #129 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation and cardiomyopathy.A review of Resident #129's active physician's orders included a current order for March 2026 of metoprolol succinate 25 milligrams (mg) by mouth once daily. Hold for systolic blood pressure less than 110 or heart rate less than 60.On 4/1/26 at 9:00 AM Nurse #3 was observed as she obtained Resident #129's blood pressure and heart rate. Resident #129's blood pressure was noted as 110/64 and heart rate was 79. Nurse #3 stated she was going to hold Resident #129's metoprolol succinate since her systolic (top number) blood pressure was so close to the hold parameter ordered by the physician. Nurse #3 did not call the physician to obtain and order to hold the medication, and she did not give Resident #129 her ordered dose of metoprolol succinate.b. Resident #10 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease.A review of Resident #10's active physician's orders included a current order for March 2026 of fluticasone propionate 0.05 mg/actuation metered dose nasal spray, 2 sprays in both nostrils one time a day.On 4/1/26 at 9:12 AM Nurse #3 was observed as she handed Resident #10 the bottle of fluticasone nasal spray without any instructions on use. Resident #10 then rapidly administered 3 sprays of the medication back-to-back in the right nostril then repeated the 3 rapid sprays in the left nostril. Nurse #3 stood in front of Resident #10 and did not attempt to correct Resident #10's administration technique. The resident then handed the nasal spray back to Nurse #10 who exited the room. Nurse #3 was interviewed on 4/1/26 at 9:14 AM who stated Resident #10 preferred to administer her own nasal spray and liked to do it her own way. Nurse #3 stated she should have educated Resident #10 when she administered the medication incorrectly, but Resident #10 was in a hurry to go outside and did not like to wait around for education.Unit Manager (UM) #2 was interviewed on 4/1/26 at 2:55 PM and stated she expected Nurse #3 to administer the metoprolol succinate to Resident #129 according to the physician's order. She further stated Nurse #3 should have administered the fluticasone nasal spray herself instead of allowing Resident #10 perform the task. UM #2 stated Nurse #3 should have administered one spray per nostril and then repeated the same step for the second spray for correct administration of the ordered dosage.The Director of Nursing (DON) was interviewed on 4/2/26 at 2:01 PM and explained that Nurse #3 was using nursing discretion when she held the metoprolol succinate for Resident #129, and that Nurse #3 had contacted the physician to inform him she held it later that afternoon on 4/1/26. The DON further stated Nurse #3 should have administered the fluticasone nasal spray for Resident #10 according to the physician's order.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to post accurate daily staffing information as compared to the daily staffing schedules for licensed and unlicensed nursing staff for 19 out of 30 days (3/1/26, 3/2/26, 3/3/26, 3/4/26, 3/5/26, 3/6/26, 3/7/26, 3/8/26, 3/12/26, 3/13/26, 3/14/26, 3/17/26, 3/19/26, 3/20/26, 3/21/26, 3/24/26, 3/26/26, 3/27/26, and 3/28/26). The findings included: A review of the facility's daily posting for nursing staff for the past 30 days (3/1/26 to 3/30/26) as compared to the daily staffing schedule included an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 3/1/26 indicated that 12 Nurse Aides (NAs) worked from 7:00 AM to 3:00 PM, 5 Licensed Practical Nurses (LPNs) worked 11:00 PM to 7:00 AM and one Medication Aide (MA) worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/1/26 documented that 14 NAs worked 7:00 AM to 3:00 PM, 6 LPNs worked 11:00 PM to 7:00 AM and no MA worked 11:00 PM to 7:00 AM. b. The nursing schedule for 3/2/26 indicated that 4 Registered Nurses (RNs) worked 7:00 AM to 3:00 PM and 8 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/2/26 documented that 3 RNs worked 7:00 AM to 3:00 PM and 9 NAs worked 11:00 PM to 7:00 AM. c. The nursing schedule for 3/3/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 3/3/26 documented that 10 NAs worked from 7:00 AM to 3:00 PM. d. The nursing schedule for 3/4/26 indicated that 2 MAs worked 7:00 AM to 3:00 PM and 10 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/4/26 documented that 1 MA worked 7:00 AM to 3:00 PM and 8 NAs worked from 11:00 PM to 7:00 AM. e. The nursing schedule for 3/5/26 indicated that 8 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/5/26 documented that 10 NAs worked from 11:00 PM to 7:00 AM. f. The nursing schedule for 3/6/26 indicated that 10 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/6/26 documented that 11 NAs worked 11:00 PM to 7:00 AM. g. The nursing schedule for 3/7/26 indicated that 11 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/7/26 documented that 9 NAs worked from 11:00 PM to 7:00 AM. h. The nursing schedule for 3/8/26 indicated that 7 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/8/26 documented that 10 NAs worked 11:00 PM to 7:00 AM. i. The nursing schedule for 3/12/26 indicated that 2 MAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/12/26 documented that one MA worked from 11:00 PM to 7:00 AM. j. The nursing schedule for 3/13/26 indicated that 9 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/13/26 documented that 11 NAs worked 11:00 PM to 7:00 AM. k. The nursing schedule for 3/14/26 indicated that 5 LPNs worked from 7:00 AM to 3:00 PM and 8 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/14/26 documented that 6 LPNs worked 7:00 AM to 3:00 PM and 11 NAs worked 11:00 PM to 7:00 AM. l. The nursing schedule for 3/17/26 indicated that 6 LPNs worked 7:00 AM to 3:00 PM, 5 LPNs worked 11:00 PM to 7:00 AM and 7 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/17/26 documented that 5 LPNs worked 7:00 AM to 3:00 PM, 4 LPNs worked 11:00 PM to 7:00 AM and 9 NAs worked 11:00 PM to 7:00 AM. m. The nursing schedule for 3/19/26 indicated that 6 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/19/26 documented that 8 NAs worked from 11:00 PM to 7:00 AM. n. The nursing schedule for 3/20/26 indicated that 6 LPNs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 3/20/26 documented that 5 LPNs worked 7:00 AM to 3:00 PM. o. The nursing schedule for 3/21/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 3/21/26 documented that 11.4 NAs worked 7:00 AM to 3:00 PM. p. The nursing schedule for 3/24/26 indicated that 7 LPNs worked 7:00 AM to 3:00 PM and 10 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/24/26 documented that 6 LPNs worked from 7:00 AM to 3:00 PM and 8 NAs worked from 11:00 PM to 7:00 AM. q. The nursing schedule for 3/26/26 indicated that no RN worked and 6 LPNs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/26/26 documented that one RN and (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	4 LPNs worked 11:00 PM to 7:00 AM. r. The nursing schedule for 3/27/26 indicated that one MA 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 3/27/26 documented that no MA worked 11:00 PM to 7:00 AM. s. The nursing schedule for 3/28/26 indicated that 9 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/28/26 documented that 10 NAs worked from 11:00 PM to 7:00 AM. On 4/2/26 at 8:39 AM, an interview occurred with the Staffing Scheduler who stated that she managed the staffing schedule and daily postings. She reviewed the staffing schedules and daily postings and verified the number of staff working from 3/1/26 to 3/30/26 did not match. She stated that she failed to update the daily posted nurse staffing sheet when a staff member called out, was a no-show, or came in to cover a need. The Administrator was interviewed on 4/2/26 at 11:22 AM, and stated that the daily staff schedule posting, and the staffing schedule should match the number of staff worked on any given shift.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to ensure resident rooms were maintained in good repair for 7 of 19 resident rooms reviewed for clean, comfortable and homelike environment (Residents #3, # 8, #31, #37, #63, #65, and #72). The facility also failed to ensure the Packaged Terminal Air Conditioner (PTAC) unit (Resident #3) was kept clean for 1 of 19 resident rooms observed. This deficient practice affected 3 of 8 facility hallways. The findings included: 1 a. On 3/30/26 at 10:31 AM, observation of Resident #63's room revealed scattered areas of damage to the wall behind the head of the bed, with sheetrock exposed. b. On 3/30/26 at 10:44 AM, observation of Resident #31's room showed scattered areas of wall damage behind the head of the bed that extended to the left side of the room on the same wall, with exposed sheetrock. c. On 3/30/26 at 10:56 AM, observation of Resident #37's room revealed multiple scattered areas of wall damage on the left side of the bed, with sheetrock exposed. In an interview with the Maintenance Director on 4/2/26 at 12:30 PM, he stated he was aware that walls in resident rooms throughout the facility needed repair. He reported he was behind on room repairs and believed the damage was caused by movement of the bed. He stated his plan was to begin wall repairs the following week. During an interview with the Administrator on 4/2/26 at 11:22 AM, he stated it was important for resident rooms to be maintained in good repair and kept homelike. 2a. On 3/30/26 at 12:38 PM, an observation of Resident #65's room showed scrape marks on the wall to the left side at the head of the bed. The scrapes exposed white material with a chalk^like appearance. A subsequent observation completed on 4/1/26 at 12:42 PM revealed the wall in Resident #65's room continued to exhibit the same scrape marks as observed on 3/30/26. b. On 3/30/26 at 12:55 PM, observation of Resident #72's room revealed scrape marks on the wall at the head of the bed and along the full length of the wall along the left side of the bed. The scrapes exposed white wall material with a chalk^like appearance. A subsequent observation completed on 4/1/26 at 12:45 PM revealed the walls in Resident #72's room continued to exhibit the same scrape marks as observed on 3/30/26. An observation and interview were conducted with the Maintenance Director on 4/1/26 at 4:01 PM. He reported he had been in the position for one month and was the only staff member in the department. After observing the resident room walls, the Maintenance Director stated he had repaired the damaged areas in Resident #65 and Resident #72's rooms approximately one week prior to survey. He noted the beds in both rooms continued to be pushed against the walls, and he believed the raising and lowering of the beds caused the recurring scrape marks. According to the Maintenance Director, (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	he was seeking a more permanent solution to prevent continued wall damage. On 4/2/26 at 11:22 AM, the Administrator was interviewed and reported the Maintenance Director was behind on wall patching and repairs, noting scratches reappeared in rooms where repairs had been previously completed. The Administrator acknowledged resident rooms should be kept in good repair and homeˆlike and stated he would explore more permanent wall protection to prevent damage from beds and wheelchairs. 3a. On 3/30/26 at 10:30 AM, an observation of Resident #3's room revealed a large, scuffed area approximately 13 inches in size at the bottom corner of the wall between the closet and sink. The area had a thick application of patch but had not been sanded or painted. In addition, Resident #3's Packaged Terminal Air Conditioner (PTAC) unit revealed a large amount of grey dust particles to the left interior of the top vents. An observation and interview were conducted with the Maintenance Director on 4/1/26 at 10:15 AM. He observed the damaged wall at the bottom corner between the closet and sink of Resident #3's room and the large amount of grey dust particles to the left interior of the top vents of the PTAC unit. He indicated the wall was frequently damaged from the wheelchair and he had not finished repairing the area. He also indicated that he was responsible for cleaning the inside of the PTAC vents with the vacuum cleaner. The Maintenance Director stated that he tried to make a round in the facility every six months to clean the inside of the PTAC units but had gotten behind. He acknowledged Resident #3's wall and PTAC required attention and would be addressed. b. On 3/30/26 at 12:00 PM, an observation of Resident #8's room revealed multiple scattered areas of damage to the wall behind the head of the bed, exposing the sheetrock. In addition, the vinyl baseboard was coming away from the wall under the sink area, exposing the bare wall. An observation and interview were conducted with the Maintenance Director on 4/1/26 at 10:18 AM. He observed the area of exposed sheetrock behind the head of Resident #8's bed as well as the vinyl baseboard that was not attached to the wall under the sink. He indicated that he had gotten behind with room repairs and that movement of the bed had most likely caused damage to the wall. The Maintenance Director stated that he would like to find a more permanent fix to prevent damage to the walls where the head of the beds are located. He stated the areas required attention and would be addressed. The Administrator was interviewed on 4/2/26 at 11:22 AM and stated it was important for the residents' rooms to be in good repair and homelike.