STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345160	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis Health Care Center	1011 Porters Neck Road Wilmington, NC 28411

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, record review and interviews with staff, Nurse Practitioner and Responsible Party (RP), the facility failed to protect the residents' right to be free of resident-to-resident physical abuse for 2 of 2 residents (Resident #110 and Resident #14) reviewed for abuse. Resident #110 (a female resident with severe cognitive impairment) had a history of following Resident #14 (a male resident with cognitive impairment) around the facility, getting close to him, and entering his room at night. Staff reported Resident #14 would get irritated and try to get away from Resident #110. On 6/5/26 Resident #110 was observed poking Resident #14 in the face with her finger and yelling. Resident #14 grabbed Resident #110's wrist, followed by Resident #110 grabbing Resident #14's left arm digging in her nails, and Resident #14 hitting Resident #110 on her face. Resident #14 had scattered bruising and a small skin tear to the arm and Resident #110 had reddened areas to her face following the 6/5/26 altercation. Two days later on 6/7/26, Nurse #6 heard Resident #14 yelling from his (Resident #14's) room and when the nurse entered the resident's room she saw Resident #110 on the ground with Resident #14 standing over her. Resident #14 was holding Resident #110 by the hair with one hand causing Resident #110's upper body and head to be elevated off the ground as Resident #14 was kicking Resident #110 in the face. Resident #110 was sent to the emergency department for evaluation, was identified with no acute findings, and returned to the facility. A reasonable person expects to be safe from abuse in their home environment. The altercation that occurred on 6/7/26 would have resulted in trauma, fear, and severe anxiety for Resident #110. Immediate Jeopardy began on 6/7/26 when Resident #14 was holding Resident # 110 by the hair and kicking Resident #110 in the face. The immediate jeopardy was removed on 6/19/26 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.Findings included:Resident #14 and Resident #110 resided in the facility's special care unit (a secure unit designed for residents with dementia or other cognitive impairments at risk of wandering and/or elopement). The residents' rooms were across from each other in the special care unit.Resident #14 was admitted on [DATE] with a diagnosis of dementia with agitation.Review of Resident #14's annual Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had impaired short- and long-term memory impairment, was usually able to make self-understood and understand others, rejected care 1 to 3 days during the look back period, was independent with transfers and ambulation with no assistive device and received antipsychotic and antidepressant medications. Resident weighed 166 pounds and was 72 inches tall. A review of Resident #14's care plan revealed a behavioral problem initiated on 3/26/25 and updated on 4/3/26 which indicated that the resident had a behavioral problem related to delusions, cognitive impairment and dementia. Interventions indicated to respect Resident #14's need for privacy and space, avoid unnecessary touching of the resident, provide 1 to 1 supervision as needed for behaviors and 15-minute checks as needed for safety. A review of a progress note written by the Psychiatric Nurse Practitioner dated (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/5/26 at 5:09 PM indicated that Resident #14 was hard of hearing, had impaired speech, mumbled and smiled at times and was primarily non-communicative. The note indicated that Resident #14 had moderate dementia with restlessness and agitation with a history of violent outbursts.Resident #110 was admitted to the facility on [DATE] with diagnoses which included dementia, anxiety, restlessness, agitation and bipolar disorder. A physician order in Resident #110's electronic health record dated 11/23/25 written by the Nurse Practitioner indicated trazadone 50 mg at bedtime daily. (Trazadone is an antidepressant used to manage restlessness and anxiety and is used as a sleep aid).A pharmacy recommendation dated 2/6/26 indicated that Resident #110 received trazadone 50 milligrams (mg) at bedtime. The recommendation stated to consider dose reduction if appropriate. The recommendation was signed in agreement by the Nurse Practitioner on 2/17/26 with a new order written to decrease trazadone to 25 mg at bedtime. A physician order in Resident #110's electronic health record dated 2/17/26 written by the Nurse Practitioner indicated to discontinue trazadone 50 mg at bedtime and start trazadone 25 mg at bedtime daily. An NP progress note dated 2/24/26 indicated that Resident #110 was evaluated due to staff reports of increased anxiety and insomnia since trazadone was decreased due to pharmacy recommendation for gradual dose reduction. The note indicated that staff requested intervention and that Resident #110 had failed the dose reduction. A physician order in Resident #110's electronic health record dated 2/24/26 written by the Nurse Practitioner indicated trazadone 25 mg at bedtime daily. (same dose as the resident was receiving).A nursing progress note written by Nurse #3 on 3/2/26 at 6:54 PM revealed that Resident #110 was sitting in a reclining chair watching television when the nurse was alerted by staff that Resident (110) had pushed another resident, which caused the other resident to fall. Resident #110 was unable to answer why she pushed the other resident and appears irritated or annoyed by writer's question. Resident #110 is marginally verbal at baseline and seldom completes intelligible sentences.Review of Resident #110's electronic health record revealed a Nurse Practitioner progress note dated 3/3/26 at 5:16 PM that indicated that the resident was evaluated due to agitation with recent agitation toward another resident. Review of Resident #110's care plan last updated on 3/3/26 indicated a problem of behavioral symptoms with restlessness, anxiety, agitation. The care plan indicated that Resident #110 packs her belongings in anticipation of leaving the facility, has a history of exit seeking behaviors, refusing medications, wandering and requiring 1 to 1 supervision. Interventions included to notify and collaborate with the psychiatric service and staff will observe and re-direct as able.A review of Resident #110's annual Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident had a severe cognitive impairment, was sometimes able to make herself understood and sometimes understood others. Resident #110 exhibited physical behaviors directed towards others including hitting, kicking, pushing, scratching or grabbing others for 1 to 3 days in the review look back period. Resident #110 exhibited verbal behaviors including threatening, screaming and cursing and other behavioral symptoms including pacing and rummaging in the past 1 to 3 days. Resident #110 ambulated independently and weighed 138 pounds and was 64 inches tall.A review of Resident #110's physician orders revealed an order dated 3/5/26 to obtain a psychiatric service consult.A nursing progress note dated 3/23/26 at 2:25 AM indicated that Resident #110 was found in Resident #14's room. Staff redirected Resident #110 back to her own room. A nursing progress note dated 3/31/26 at 10:24 PM indicated that Resident #110 was found sleeping in Resident #14's bed. Resident #110 became very agitated and combative swinging her arms trying to hit the nurse and NA who redirected her back to her room. Resident #110 eventually returned to her room. NA had to sit outside Resident #110's room to keep her from going back into Resident #14's room.A nursing progress note dated 4/4/26 at 6:24 AM revealed that Resident #110 was seen wandering throughout the shift.A review of Resident #110's electronic health record revealed a Psychotherapy Comprehensive Clinical assessment dated [DATE] which indicated that an assessment was completed for services due to history of agitation, aggressive behaviors and wandering at night. The recommendation indicated that psychotherapy talk therapy was not appropriate due to Resident #110's severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#110 and Resident #14 occurred. NA #2 stated that after the incident on 6/5/26, neither Resident #14 or Resident #110 had a sitter and there were no interventions implemented that she was aware of. NA #2 indicated that following the incident on 6/5/26, she was instructed by the Clinical Coordinator to keep an eye on Resident #14 and Resident #110. A Physician progress note dated 6/7/26 at 9:55 PM indicated that Resident #110 was seen for a telemedicine visit due to a physical altercation with another resident. Resident #110 has a history of dementia and bipolar disorder. Resident #110 went to a male resident's room (Resident #14) and would not leave his room after being told by him to leave. Resident #14 likely pushed Resident #110 down to the floor. When the staff heard the altercation, they found Resident #14 was pulling Resident #110's hair, kicking her in the face and staff noted that the resident had a raised area to the back of her head. Resident #110 exhibited some discomfort. It seemed that Resident #110 had similar behavior in the past where she chased the male resident (Resident #14) and did not leave him alone. Resident #14 gets upset and aggressive. The assessment and plan indicated Resident #110 had a head strike with the floor and Resident #14 hit her in the face and pulled her hair. Resident #110 to be transferred to the emergency department for evaluation and monitoring.A nursing progress note in Resident #110's electronic health record written by Nurse #6 dated 6/7/26 at 11:34 PM indicated that the nurse was passing medications earlier in the evening when she heard arguing coming from a male resident's room. The nurse quickly went into the room where the arguing was heard. The nurse noticed Resident #110 lying on Resident #14's floor. Resident #14 was standing over Resident #110, holding her by her hair and kicking her in the face. The nurse attempted to separate the residents but was unable to so she called for the Nurse Aide (NA) to help. The NA and nurse separated the residents and was able to get Resident #110 to her room. Resident #110 had a notable knot on the back of her head. The on-call provider was notified, and Resident #110 was sent to the emergency department for evaluation. A nursing progress note in Resident #14's electronic health record written by Nurse #6 dated 6/7/26 at 11:53 PM indicated that the nurse observed Resident #14 standing over Resident #110 and was holding onto her hair while kicking her in the face. Resident #14 and #110 were quickly separated by the nurse and the NA. Resident #14 observed with scratches to the right hand. No other injuries were observed. Staff will continue to monitor. An interview was conducted via phone on 6/17/26 at 4:10 PM with Nurse #6, the nurse that was assigned to Resident #110 and Resident #14 on 6/7/26 from 7:00 PM to 7:00 AM on 6/8/26. Nurse # 6 stated that Resident #110 was always following Resident #14 around and was obsessed with him. Resident #110 was demonstrating agitation and would frequently enter Resident #14's room at night. Resident #14 would get irritated and try to get away from Resident #110. Nurse #6 stated that she heard Resident #14 yelling on 6/7/26 when she was down the hall administering medications. Nurse #6 stated that she entered the room to see Resident #14 standing over Resident #110 who was on the floor with her upper body and head elevated. Resident #14 was holding Resident #110 by the hair with one hand and kicking Resident #110 in the face with his foot. Nurse #6 stated that she called the NA for assistance to separate the residents. Resident #110 was scratching Resident #14 on his arms. Nurse #6 stated that both residents had behaviors and had a history of aggressive behavior and she and the NA tried to keep an eye on them.An interview was conducted via phone with NA #3 on 6/17/26 at 1:50 PM. NA #3 stated that she worked from 7:00 PM to 7:00 AM and was assigned to Resident #110 and Resident #14 frequently. NA #3 stated that Resident #110 had been increasingly agitated and aggressive with a change in her behavior for the past several months. NA #3 stated that Resident#110 had become increasingly agitated and aggressive with other residents, would get upset with other residents and slam doors. NA #3 reported that there had been prior warning signs involving Resident #110 and Resident #14, noting a history of verbal altercations and incidents in which Resident #110 wandered into Resident #14's room at night and was found in his bed. NA #3 stated that she and the other staff had expressed concerns to the nurses and had reported the concern that something bad was going to happen between Resident #110 and Resident #14. NA # 3 stated that she was told by the nurses that they would investigate it. NA #3 stated that (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #14 typically kept his door closed at night and Resident #110 frequently went into his room and would agitate him. NA #3 explained that Resident #14 was highly protective of his personal space and belongings, and as a result, was unable to share a room with another resident. NA #3 stated that there may have been other incidents between the residents that happened behind closed doors. NA #3 stated there were other nights that she witnessed Resident #110 upset coming out of Resident #14's room. On the night of 6/7/25, NA #3 stated that she was in another resident's room providing personal care when she heard the nurse yelling for help. NA #3 stated when she entered the room, she grabbed Resident #14 and tried to calm him down. NA #3 stated that Resident #14's level of aggression was 100. NA #3 stated that Resident #14 was agitated for several hours after the incident with Resident #110 and was swinging at staff. NA #3 stated that Resident #14 was at the nurse's station after the incident for several hours and then went to his room and went to sleep.An emergency department encounter note dated 6/8/26 at 12:20 AM indicated that Resident #110's chief complaint was assault victim. The note indicated that Resident #110 presented after an assault by another resident. Resident #110 was kicked in the head resulting in a head injury. Resident #110 was evaluated for possible head injury and pelvic fracture. A CT (Computed Tomography) scan was completed with no acute findings. An exam revealed no evidence of a pelvic fracture and Resident #110 was discharged back to the facility on 6/8/26 with instructions to monitor for new symptoms or changes in condition.A Nurse Practitioner progress note dated 6/9/26 at 9:44 AM indicated that X rays were completed to the left wrist for pain. Results of the x ray were negative. Resident #110's left wrist is still swollen and tender today. Resident #110 had 2 altercations over the weekend, one episode when she went into another resident's room and required an emergency room visit for a possible head injury. Resident #110 has a bruise to her wrist as well as a lump to the back left side of the head. Emergency department workup was negative. Resident #110's wrist is still painful.An interview with the Nurse Practitioner on 6/19/26 at 9:00 AM revealed that Resident #110 wandered frequently, often went into other residents' rooms and plundered in their belongings. The NP stated that the psychiatry recommendations should have been addressed by the provider. If the medication had been increased according to the psychiatric recommendation, it would have been expected to aid in her sleep and prevent wandering and plundering in other resident rooms at night. The NP stated that there was potential for Resident #110 to sustain further injuries during the altercation with Resident #14 on 6/7/26. The NP stated that there was a likelihood that Resident #14 could have caused serious bodily harm to Resident #110 if the staff had not intervened when they did. Resident #14 had an increased adrenaline response during the assault, and something could have been triggered in him that caused such a violent response.An interview with Clinical Coordinator #3 was conducted on 6/17/26 at 10:15 AM. Clinical Coordinator #3 stated that Resident #110 had episodes of wandering and that sometimes she (Resident #110) got along with Resident #14 and sometimes she didn't, but they were frequently together during the daytime. Clinical Coordinator #3 stated that she didn't know if Resident #14 reminded Resident 110 of someone she used to know, or why she (Resident #110) always tried to be around Resident #14. Clinical Coordinator #3 stated Resident #14 would become aggravated with Resident #110 always wanting to be around him. Clinical Coordinator #3 stated that on the morning of 6/8/26 she was informed of the incident that occurred on 6/7/26 between Resident #14 and Resident #110. Clinical Coordinator #3 stated that she was informed that Resident #14 was observed pulling Resident #110's hair and kicking the resident. Resident #110 was sent to the emergency department for evaluation and returned in the early morning. Clinical Coordinator #3 stated that on 6/8/26, Resident #110 appeared upset throughout the day but was unable to express why. Clinical Coordinator #3 stated that Resident #110 was moved to another area of the facility later in the day on 6/8/26. Clinical Coordinator #3 stated that there was no additional monitoring or interventions implemented, and a plan of correction was not initiated following this incident. An interview with Nurse #3 on 6/17/26 at 3:40 PM indicated that Resident #14 had episodes of angry outbursts. Nurse #3 stated that Resident #110 was obsessed with Resident #14 and would follow him around. Resident #110 would (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	management services to send Resident #110 to hospital for evaluation. Nurse then called Resident #110's daughter, Director of Nursing and Nursing Supervisor. Nurse assessed Resident #14 for injury who had scratches on his right hand. Nurse notified on call provider who did not give any new orders. Nurse notified Resident #110's daughter, Director of Nursing and Nursing Supervisor. One on one caregiver was initiated for Resident #14 on 6/7/2026 at 11:53 PM. On 6/7, after the incident was reported, the nurse notified the DON. The DON directed staff to separate the residents, contact law enforcement, and place Resident #14 on 1:1 supervision.Following the incident, the Nurse Supervisor educated the nurses on duty regarding the facility's policy and procedures for resident-to-resident altercations.On 6/18, the DON provided education to the nurse leadership team on the facility's incident reporting policy and procedures related to resident-to-resident altercations, including resident safety interventions, notification requirements, and documentation expectations.Nursing Supervisor reported event to Police Deputy [NAME] at 9:53 PM on 6/7/2026. [NAME]'s department came to the facility and spoke to Nursing Supervisor about incident. [NAME]'s department completed police report.Resident #110 was transported to emergency department and assessed for head trauma, wrist pain and assault. Resident #110 had x-ray completed for left wrist and CT of spine with no abnormalities. Resident #110 was offered Tylenol but refused administration. Neurology assessment was completed for Resident #110 with no abnormalities. Resident #110 discharged back facility on 6/8/2026 at approximately 1 AM. Resident #110 remained in the facility.Resident #110 was moved to another room in a separate wing on 6/8/2026. Resident #110's daughter was notified and agreeable. Resident #110's physician evaluated resident on 6/8/2026 and ordered Olanzapine to treat Resident #110 for bipolar disorder with behavioral disturbances. Resident #14 was evaluated by physician on 6/8/2026 who ordered increased Zyprexa and continue one to one staff supervision.Residents were assessed by the Clinical Coordinator for injury of unknown origin with a skin audit on 6/18/2026. No injuries were noted on any residents. Each resident has a weekly body audit completed by the nurse which would show any deficient practice. This body audit is reviewed at weekly Interdisciplinary Team meetings. The Interdisciplinary team consists of Compliance Administrator, Director of Nursing, Nursing Home Administrator, Assisted Living Administrator, Clinical Coordinators and the Staff Educator/Infection Control Nurse.Resident's behavior monitoring logs were reviewed by Director of Nursing on 6/18/2026 which did not identify any significant behavior changes that required intervention. Behavior monitoring logs are completed each shift by staff nurse. These logs will be reviewed at weekly Interdisciplinary Team meetings. The Interdisciplinary team consists of Compliance Administrator, Director of Nursing, Nursing Home Administrator, Clinical Coordinators and the Staff Educator/Infection Control Nurse. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 6/5/2026, the facility utilized an internal investigation guide to respond to the incident. This was in error, as the facility should have utilized the Reportable Event Checklist, which includes required interventions such as separating residents involved in an altercation and implementing 1:1 supervision of the aggressor when an injury has occurred.On 6/18/2026, the facility implemented the Reportable Event Checklist and nursing leadership provided education to all nurses and nurse's assistants regarding its use and the required interventions outlined within the process. The Reportable Event Checklist has been posted at each nurses' station to ensure staff have immediate access to the procedure and can consistently implement the required actions during future reportable events.The Nursing Leadership team meets weekly to review status changes of any resident. This process was implemented on 11/1/2025, nurses and nurse's assistants were reeducated by Leadership on 6/18/2026. This review includes the following: I. Resident Risk AssessmentUpon admission, quarterly, annually, and with any significant change in condition, the interdisciplinary team will assess residents for risk factors including: Cognitive impairment or dementia History of aggression, assaultive behavior, or threatening behavior Wandering or intrusive behaviors Delusions, paranoia, or psychosis Behavioral symptoms associated with mental illness (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	History of resident-to-resident altercations Communication deficits Exit-seeking behaviorsResidents i[TRUNCATED]

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and Nurse Practitioner interviews, the facility failed to ensure two cognitively impaired residents were free from the use of physical restraints. A staff member applied gait belts around the residents' abdomen and secured the belts to the back frames of their wheelchairs, restricting their freedom of movement and preventing them from independently rising from the chairs. The residents were unable to remove the belts on their own. There was no physician's order, assessment, care plan or clinical justification for restraint use. This deficient practice occurred for 2 of 2 residents (Resident #3 and Resident #95) reviewed for restraint use. A reasonable person would have felt fear, loss of autonomy, helplessness, and a loss of dignity when physically restrained in a wheelchair without the ability to remove the device or move freely.Findings included:Resident #3 was admitted to the facility on [DATE] with diagnoses including dementia and generalized anxiety. Resident #3's care plan revised 12/19/25 revealed no plan of care regarding the use of restraints. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #3 had moderately impaired cognition. The assessment revealed no physical or verbal behaviors directed toward others. No restraints were noted on the assessment. Resident #95 was admitted to the facility on [DATE] with diagnoses including dementia. Resident #95's care plan revised 3/1/26 revealed no plan of care regarding the use of restraints. The MDS annual assessment dated [DATE] revealed Resident #95 had severe cognitive impairment. The assessment revealed no physical or verbal behaviors directed toward others. No restraints were noted on the assessment. A 5-day investigation report submitted to the State Agency revealed: the date of the incident was 3/17/26, the facility became aware 4/22/26 at 5:15 PM. An employee reported that two residents (Resident #3 and Resident #95) had their rights violated by having gait belts around them and their wheelchairs. Resident #3 and Resident #95 were able to self-propel in their wheelchairs independently. There were no injuries reported. During an investigation it was discovered that the assigned nurse (Nurse #24) was aware of the gait belts around the residents, however Nurse #24 denied ever having knowledge of this. Nurse Aide #1 (the assigned nurse aide) reported that she informed Nurse #24 that gait belts were in place. Nurse Aide #1 was told that the Clinical Coordinator (#2) placed the gait belts on the residents. The Activity Assistant also questioned Nurse Aide #1 and Nurse #24. Later Nurse #24 messaged the Activity Assistant asking her not to say anything to anyone and that she had removed the gait belts from the residents. The Clinical Coordinator (#2) and Nurse #24 were both terminated on 4/23/2026.Review of Resident #3 and Resident #95's electronic medical records from 3/17/26 through 6/16/26 revealed no documentation of the incident, no physical assessments, or monitoring following the incident, and no physician's order in place indicating a medical symptom for the use of restraints. During an interview on 6/16/26 at 1:40 PM, the Activities Director stated that during a St. Patrick's Day (3/17/26) activity in the locked unit, she overheard Activity Assistant #1 and Nurse #24 arguing about the gait belts being on the residents. The Activity Director stated she observed Resident #3 and Resident #95 wearing gait belts secured around their abdomens and strapped around the back of their wheelchairs. She stated she reported the concern to the Administrator, and the Director of Nursing but could not recall if she went to them the day of the incident or the following day. During an interview on 6/16/26 at 2:00 PM, Activity Assistant #1 stated she was no longer the Activity Assistant and now currently worked in Housekeeping. She stated on St Patrick's Day (3/17/26) during an activity she observed gait belts around Resident #3 and Resident #95 that were around their abdomen and strapped to the back of their wheelchairs. She indicated both residents were cognitively impaired. Resident #95 kept pulling at her shirt during that time as if something was bothering her. She questioned Nurse Aide #1 who stated she did not know why the belts were on the residents and Nurse Aide #1 stated to her that the Clinical Coordinator (#2) put the (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	gait belts on them. The Activity Assistant stated she reported the gait belts to Nurse #24 who told her, You let me worry about my own house. The Activity Assistant stated Nurse #24 later sent her a text message asking her not to say anything about the gait belts to anyone and that she had removed them from the residents. The Activity Assistant stated she reported this immediately to the Activity Director who reported it to the Administrator. She stated Resident #3 and Resident #95 remained with the gait belts on them during the activity which lasted approximately 30-45 minutes, and she did not know how long the gait belts had been on the residents prior to her entering the locked unit or how long they were on after she left the unit. The Activity Assistant stated she never heard anything else about the incident so a few weeks later she asked Human Resources what the outcome of the incident was, and an investigation was started. During a phone interview on 6/16/26 at 2:30 PM, Nurse Aide #1 stated that the Clinical Coordinator (#2) placed gait belts on Resident #3 and Resident #95 while they were in the dining room. Nurse Aide #1 stated after lunch she observed the gait belts wrapped around the residents and strapped to the back of their wheelchairs. She asked Nurse #24 about the gait belts and why they were being used because she had never seen the gait belts used like that before. Nurse Aide #1 stated Nurse #24 looked at the belts but did not take any action. Nurse Aide #1 stated the gait belts were on the residents for at least an hour before Nurse #24 removed them. Nurse Aide #1 stated she denied seeing gait belts on Resident #3 and Resident #95 following the incident because it was the Clinical Coordinator (#2) who put the gait belts on the residents and indicated she feared retaliation from the Clinical Coordinator and Nurse #24. During observations on 6/15/26 at 12:00 PM Resident #3 and Resident #95 were observed sitting in the dining area of the locked unit. There were no signs of distress. During an interview on 6/16/26 at 3:30 PM, the Director of Nursing (DON) stated she was alerted of the incident with the gait belts on Resident #3 and Resident #95 by the Activity Assistant following the incident. She and the Administrator went to the locked unit but did not observe gait belts on the residents at that time. The DON stated she questioned the Clinical Coordinator (#2) and Nurse #24 and both denied using the gait belts on the residents. The DON stated she assessed both residents for skin issues at that time with no injuries found but did not document her assessments. The DON stated Human Resources received additional information a few weeks later when the Activity Assistant provided a copy of the text message that was sent to her by Nurse #24 asking her not to say anything about the gait belts being used on the residents. The DON questioned Nurse Aide #1 again and she confirmed the device used was a gait belt. She stated the Clinical Coordinator and Nurse #24 continued to deny involvement and were suspended and later terminated. During an interview on 6/16/26 at 3:50 PM, the Administrator stated following the incident she was informed by the Activity Director that her activity staff observed the two residents (Resident #3 and Resident #95) in their wheelchairs with gait belts around the abdominal area and attached to the back of their wheelchair. The Administrator and the Director of Nursing went to the locked unit to ask about the gait belts. She spoke with the Clinical Coordinator (#2), the assigned nurse (Nurse #24), and the assigned nurse aide (Nurse Aide#1) , and all three denied the allegation, and at that time the residents did not have the gait belts on them. The Administrator stated that based on those denials, no further investigation was completed at that time. On 4/15/26, the Activity Assistant contacted Human Resources to ask about the outcome of the initial investigation, which prompted further review. The Activity Assistant then provided a text message from Nurse #24 asking her not to say anything about the gait belts and that she had removed them. The Administrator stated that additional interviews were conducted, and staff reported that the Clinical Coordinator (#2) had placed the gait belts on the residents. Following the investigation, both the Clinical Coordinator (#2) and Nurse #24 were suspended and then terminated. Multiple attempts to contact the Clinical Coordinator (#2) and Nurse #24 during the investigation from 6/16/26 through 6/19/26 were unsuccessful.During a phone interview on 6/17/26 at 3:00 PM Resident #95's Responsible Party stated (Resident #95) had severe dementia, poor safety awareness, and would not have wanted to be restrained.During a phone interview on 6/17/26 at 3:15 PM Resident #3's (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Responsible Party stated (Resident #3) had severe dementia and would have been angry and scared if restrained.During an interview on 6/19/26 at 9:00 AM the Nurse Practitioner stated she was aware of the incident with the gait belts regarding Resident #3 and Resident #95. She indicated both residents remained at their baseline and there had been no reported change in condition following the incident from the use of the gait belts.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review, and staff and resident interviews, the facility failed to communicate the efforts to address and resolve concerns that were reported during Resident Council Meetings for 6 of 8 months of Resident Council Meeting minutes reviewed (October 2025, November 2025, December 2025, January 2026, February 2026, March 2026, April 2026, May 2026).Finding included:a. The Resident Council Minutes dated 10/23/25 indicated in the notes section of the form that the following concerns were voiced: the laundry was not being put away after being washed and the food was cold. Staff in attendance at the meeting were the Activities Director, Activities Assistant, Administrator, Director of Nursing (DON), Dietitian, Environmental Services Supervisor (EVS), and Food Services Director. b The Resident Council Minutes dated 11/20/25 did not indicate that a response was provided to the council regarding the concerns that were voiced on 10/23/25 or any follow-up that the facility completed. Staff in attendance were the Activities Assistant, Administrator, Dietitian, EVS, and Food Services Director. Cold food was listed as a concern again. c. The Resident Council Minutes dated 12/18/25 did not indicate that a response was provided to the council regarding the food being cold. Cold food was listed as a concern again. Staff in attendance were the Activities Assistants, Administrator, Dietitian, and EVS. d. The Resident Council Minutes dated 1/15/26 did not indicate that a response was provided to the council regarding the concerns that were voiced on 12/18/25 or any follow-up that the facility completed. The following concerns were listed cold food, and the use of plastic silverware and plates, and having to ask for desserts, and employees were on their cell phones and wearing ear buds during resident care. Staff in attendance were the Activities Director and the Activities Assistants. A Grievance Report dated 1/16/26 was filed by the Resident Council regarding the use of plastic silver ware and paper plates for meals. The Corrective Action Taken was the Dining Director ordered more silverware on 1/17/26 and it was signed by the Administrator on 1/19/26. e. The Resident Council Minutes dated 2/19/26 did not indicate that a response was provided to the council regarding cold food and employees being on their cell phones and wearing ear buds during resident care. Staff in attendance were the Activities Director and the Activities Assistant. Ongoing concerns were regarding cold food and residents not receiving assistance with eating such as cutting food and opening containers. f. The Resident Council Minutes dated 3/19/26 through 3/23/26 (individual meetings were held during resident infection quarantine) did not indicate a response was provided to the council regarding the concerns that were voiced on 2/19/26 or follow-up the facility completed. There were ongoing complaints regarding the laundry not being returned timely, folded and put away, not getting help opening foods, having to ask for desserts and salads. Staff in attendance were listed as the Activities Director and the Activities Assistants. g. The Resident Council Minutes dated 4/28/26 did not indicate that a response was provided to the council regarding the concerns that were voiced on 3/19-3/23/26 or any follow-up that the facility completed. The following concerns were listed receiving plastic ware and paper plates for meals, cold food, and staff being on their cell phone during resident care activities. Staff in attendance were the Activities Director and the Activities Assistants. A Grievance Form was filed on 4/29/26 by the Resident Council regarding cold food and having to ask for dessert. The Response was Dining Director was to review concerns and address with dining staff. It was reviewed and signed by the Administrator on 6/8/26 due to ongoing issues at Resident Council. A Grievance Form was filed on 4/29/26 by the Resident Council regarding staff talking on their phones during patient care and other concerns. The Corrective Action Taken was Review of dining concerns with dining staff. Repeat concerns from Resident Council. Call bell reports review call bell reports daily and it was signed by the Administrator on 6/8/26. There was no mention of staff being on phones during resident care. h. The Resident Council Minutes dated 5/26/26 did not indicate that a response was provided regarding the cold food and staff being on cell phones during resident care. The following concerns were listed: staff on their phone when providing resident care, and cold food. Staff in attendance were the Activities Director (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the Activities Assistants. A Grievance Form was filed on 5/28/26 by the Resident Council regarding dietary and cold food. The Corrective Action Taken: Review of issues given to dining team Director and it was signed by the Administrator on 6/8/26. A Grievance Form dated 5/28/26 was filed by the Resident Council regarding staff being on the phone during care and having to ask for dessert during meals. The Corrective Action Taken: was reviewed findings discussed with Clinical Staff. Staff reeducated on resident requests and Clinical Coordinators to follow up with meal and it was signed by the Administrator on 6/8/26. An interview was conducted with Resident #75 on 6/16/26 at 9:14 AM. Resident #75 stated that the Resident Council met monthly and the Activities Director and Activities Assistants recorded the concerns that were expressed. Resident #75 indicated that nothing was done about the concerns that were expressed during the meetings. Resident #75 stated she attended all the Resident Council meetings and she was getting frustrated with the lack of follow-up because she felt administration did not address the concerns of the council. She stated the council was not provided with a resolution to their concerns each month, especially the ones regarding the laundry and cold food. During an interview with the Resident Council on 6/16/26 at 1:30 PM the residents stated Resident Council meetings were held regularly but their concerns were not addressed. The residents stated they felt like no one listened to them. The residents stated they were told the issues were being reviewed, when they expressed their concerns, but nothing was ever done, and this made them feel like they did not make any difference. An interview was conducted with the Activities Director on 6/16/26 at 2:31 PM. The Activities Director stated she was responsible for documenting the grievances and concerns that were voiced during the Resident Council Meeting. She stated that the process was for her to give a copy to the Social Worker and the Administrator. An interview with the Social Worker was completed on 6/16/26 at 2:46 PM. The Social Worker stated she was the Grievance Coordinator and was responsible for recording the grievances in the logbook and keeping the logbook with the forms. The Social Worker stated that she reviewed each grievance and then gave them to the Department Director responsible for the concern. She stated that she knew there were ongoing concerns with the food being cold and plastic silverware and paper plates. An interview with the Administrator on 6/18/26 at 2:10 PM revealed that the process for addressing the Resident Council grievances was that The Activities Director records the grievances and gives a copy to the Social Worker and to her. She stated the Social Worker was responsible for making sure the grievance was distributed to the proper department director and then they were supposed to address the grievance. The Administrator indicated that both she and the Social Worker were responsible for ensuring the concerns were addressed. She stated that there were some issues that were not addressed appropriately. The Administrator confirmed there were multiple grievances filed by the Resident Council regarding cold food and the use of plastic silverware and paper plates. She stated that she had ordered more silverware but that it still didn't seem to solve the problem. The Administrator indicated that the process that they had in place to address the Resident Council grievances was not working well. She stated that they should address the grievances and provide a resolution at next month's meeting.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, the Pharmacy Quality Assurance Representative, Pharmacy Nurse Consultant and Nurse Practitioner interviews, the facility failed to protect resident's right to be free from misappropriation of narcotic pain medications (oxycodone). This deficient practice occurred for 2 of 2 residents reviewed for misappropriation of controlled medications (Resident #125 and Resident #87). Findings included: a.) Resident # 125 was admitted to the facility on [DATE] with diagnoses including lower lumbar radiculopathy (any pinched nerve root in the lower back). A physician's order for Resident #125 dated 3/3/26 revealed oxycodone 10 milligram (mg) tablets, to give one tablet by mouth three times a day for lumbago/sciatic pain, (a specific presentation of lower lumbar radiculopathy) with a start date of 3/3/26 and an end date of 4/1/26. A packing slip and delivery receipt from the dispensing pharmacy revealed on 3/3/26 that a total of 90 oxycodone 10 mg tablets (3 cards of 30 tablets each) were delivered for Resident #125. The delivery receipt was signed as received by Nurse #13. During a phone interview on 6/18/26 at 12:50 PM the dispensing Pharmacy's Quality Assurance Representative confirmed the delivery of 3 cards with 30 tablets each (90 tablets) of oxycodone 10 mgs on 3/3/26 for Resident #125. She confirmed no medication was returned to the pharmacy. During a phone interview on 6/18/26 at 3:03 PM Nurse #13 who signed the delivery receipt on 3/3/26 stated she was made aware there were missing oxycodone tablets for Resident #125. Nurse #13 stated that if she signed for 90 tablets of oxycodone 10 mg tablets for Resident #125 on 3/3/26, then that amount was received.The facility's investigation report dated 3/23/26 revealed Nurse #9 attempted to reorder oxycodone 10 milligram tablets for Resident #125 on 3/23/26. The pharmacy denied the refill and stated Resident #125 had 90 tablets dispensed on 3/3/26 and should have 30 oxycodone tablets remaining from the 3/3/26 delivery. Nurse #9 immediately notified the Director of Nursing (DON). An investigation was initiated and all medication carts in the facility were searched. The Administrator, Medical Director, and pharmacy were notified. The DON counted all narcotics on the medication carts, and card counts matched the narcotic count sheets. All staff were interviewed, with the exception of one nurse who did not respond after multiple attempts. State agencies, the police, and the Drug Enforcement Agency (DEA) were notified. The investigation identified multiple discrepancies during narcotic counts, including mathematical counting errors, lack of staff visually confirming counted narcotics, and missing signatures on end^of^shift count sheets. Education was provided to all nurses on proper narcotic count procedures. A new form was implemented for signing in and removing narcotics from the count. The facility determined Resident #125 did not miss any scheduled doses. Review of the Medication Administration Record (MAR) from 3/3/26 through 4/1/26 revealed Resident #125 received oxycodone 10 mg three times daily, as documented by nurse signatures. During an interview on 6/17/26 at 4:30 PM, Nurse #9 confirmed that she called the pharmacy on 3/23/26 to refill Resident #125's oxycodone 10 mg tablets. The pharmacy denied the refill because oxycodone should have remained from the 3/3/26 delivery. She stated that 30 tablets were unaccounted for and were never found During an interview on 6/19/26 at 9:10 AM, the Nurse Practitioner stated she monitored narcotic refill requests and reviewed order histories if requests appeared early. She reported that at the time, Resident #125's medications were being adjusted but the resident had no complaints of unrelieved pain during that time. b.)Resident # 87 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome. A physician's order dated 11/30/25 for Resident #87 which remained active at the time of review, revealed oxycodone 15 milligrams (mg) take one tablet by mouth every four hours for chronic pain. A packing slip and delivery receipt from the dispensing pharmacy revealed that on 3/4/26 a total of 180 oxycodone 15 mg tablets (6 cards of 30 tablets each) were delivered to the facility for Resident #87. The delivery receipt was signed off as received by Nurse #10. During a phone interview on 6/18/26 at 12:50 PM the dispensing Pharmacy's Quality Assurance Representative confirmed that 6 cards with (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	30 tablets per card of oxycodone 15 mgs were delivered to the facility on 3/4/26 for Resident #87. She confirmed no medication was returned to the pharmacy. During an interview on 6/18/26 at 4:00 PM the Director of Nursing (DON) stated only 4 of the 6 declining count sheets for the 3/4/26 delivery were located. The DON stated two cards (60 tablets) along with the corresponding declining count sheets were missing from the medication cart for Resident #87 and were never found. During a phone interview on 6/19/26 at 1:40 PM Nurse #10 who signed the delivery receipt on 3/4/26 stated she was aware there were missing oxycodone tablets for Resident #87. She stated that at the time of delivery, the process required nurses to initiate a declining count sheet for each card of 30 tablets. A new sheet was started after each card was completed. She indicated the facility later updated the process to number each sheet (e.g., 1 of 6) to improve tracking. Nurse #10 stated that if she signed for 180 tablets on 3/4/26, then that amount was received.A pharmacy packing slip and delivery receipt dated 3/23/26 documented another delivery of 180 oxycodone 15 mg tablets (6 cards of 30 tablets each) for Resident #87. The signature on the receipt was illegible. During a phone interview on 6/18/26 at 12:50 PM the dispensing Pharmacy's Quality Assurance Representative confirmed that 6 cards with 30 tablets per card of oxycodone 15 mgs was delivered to the facility on 3/23/26 for Resident #87. She confirmed no medication was returned to the pharmacy. The facility's investigation report dated 4/8/26 revealed only 3 of the 6 declining count sheets for the 3/23/26 delivery were accounted for. Three cards (90 tablets) were missing from the medication cart for Resident #87. Review of the Medication Administration Record (MAR) from 11/30/25 through 6/18/26 revealed Resident #87 received oxycodone 15 mgs every 4 hours, as documented by nurse signatures. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #87 was cognitively intact and received opioid medications. During an interview on 6/19/26 at 8:15 AM Resident #87 reported she consistently received her pain medication, and her pain was well controlled.During an interview on 6/18/26 at 12:00 PM the Director of Nursing (DON) stated on 3/23/26 Nurse #9 reported to her that Resident #125 had missing oxycodone. She stated all medication carts were checked, and staff were interviewed and they determined 30 oxycodone 10 mg tablets were unaccounted for and were never found. She stated the resident was notified and also the Medical Director, pharmacy, the police, Drug Enforcement Agency (DEA), and the state agencies. The DON stated on 4/8/26 Nurse #12 reported missing oxycodone cards for Resident #87 after the pharmacy declined a refill request due to it being too soon. The DON stated an investigation determined that several declining count sheets and medication cards were missing. Resident #87 was assessed and confirmed she had not missed any medication doses. The DON stated oxycodone was kept in the pyxis (in house medication dispenser) so oxycodone was available for the residents during that time. The DON stated all medication carts were checked, staff were interviewed, and staff drug screens were completed except for one nurse who refused testing and was no longer employed. The DON reported they found discrepancies on the endˆofˆshift narcotic count sheets and implemented new procedures requiring nurses to log all delivered narcotic cards in a notebook, numbering each card (1 through 6), numbering the declining count sheets accordingly, and verifying empty cards with signatures from both outgoing and incoming nurses. The DON stated they had not identified any concerns with controlled medications until this occurred with Resident #125. The DON indicated she conducted periodic cart audits and the pharmacy conducted random cart audits and the missing medication cards were not identified during the audits. During an interview on 6/19/26 at 8:15 AM, Nurse #12 stated she routinely worked on the hall where Resident #87 resided. She stated that during the morning shift count (on 4/8/26), Nurse #11 questioned whether Resident #87 should have had more oxycodone 15 mg medication cards on the cart than were present, even though the total number of narcotic cards on the cart matched the narcotic count sheet. Nurse #12 contacted the pharmacy to request a refill, and the pharmacy informed her it was too soon for a refill for Resident #87. Nurse #12 reported this to the Director of Nursing, and an investigation was started. She stated that medication cards containing oxycodone 15 mg tablets, along with the associated declining count sheets, were missing. Nurse #12 reported the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing medication cards were never located. During a phone interview on 6/19/26 at 3:00 PM Nurse #11 stated she returned from being off work from 4/2/26 through 4/7/26 and noted that Resident #87 had only one oxycodone card remaining, and she had four cards before leaving. Nurse #11 calculated Resident #87 should have used only one card during her time off work. She stated Nurse #12 reported this to the DON and an investigation was done and staff had to have urine drug screens. Nurse #11 stated the missing medication cards, and count sheets were never located. During a phone interview on 6/18/26 at 4:00 PM the Pharmacy Nurse Consultant stated she conducted random medication cart audits during her visits to the facility. She stated she would review a random selection of medications, but it was not her process to conduct a full narcotic count of each controlled medication during her audits. During an interview on 6/19/26 at 9:10 AM the Nurse Practitioner stated there had been no concerns brought to her regarding Resident #87's oxycodone until the missing medication issue was discovered. She stated Resident #87 has had no complaints of unrelieved pain. During an interview on 6/19/26 at 4:00 PM the Administrator stated the DON conducted an investigation after missing oxycodone was identified for Resident #125 on 3/23/26 and then again on 4/8/26 for Resident #87. The medications were reported to the state agencies and the DEA. The Administrator reported that the missing oxycodone was never found. The facility did not provide a fully implemented corrective action plan therefore, corrective actions could not be validated.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Nurse Practitioner interviews the facility failed to implement its abuse policy and procedures in the areas of reporting to the Administrator, reporting to the regulatory agency, law enforcement and Department of Social Services Adult Protective Services and provide protection for: 1.) An injury of unknown origin in a cognitively impaired resident (Resident #14) who sustained fractures of the left radius and ulna without any documented or reported fall, and was not reported to the Administrator. 2.) Two (2) separate incidents of resident-to-resident abuse between Resident #14 and Resident #110 in a special care unit that resulted in injuries to both residents and a hospital evaluation for Resident #110. None of these 3 incidents were reported to the North Carolina Division of Health Service Regulation or Adult Protective Services (APS as required), and 3.) failed to thoroughly investigate a reported incident of resident abuse involving improper restraint use at the time of the initial allegation. The staff member continued to work with the affected residents from 3/17/26 until termination on 4/22/26 with no protective measures in place during this period to ensure resident safety. This failure occurred with 4 of 4 residents reviewed for injuries of unknown origin, abuse, and improper restraint use (Resident #14, Resident #110, Resident #3 and Resident #95). Findings included: The facility's abuse policy revised in 2026 stated that all alleged incidents of resident abuse, including an injury of unknown source which is defined as an injury that the source was not observed or could not be explained, shall be promptly reported to the Administrator and investigated by the Administrator or designee. Should a resident be observed or accused of abusing another resident, the facility will remove the resident from the situation and develop a plan of care to protect the resident and prevent recurrence. All allegations related to abuse or neglect shall be reported to the appropriate state agency, law enforcement and the Department of Social Services Adult Protective Services within 24 hours or as soon as practicable. The Administrator or designee will report the investigation findings of allegations of abuse including injuries of unknown origin within 5 working days of the allegation of abuse to the Division of Health Service Regulation. The investigation report will include the name of the resident or residents, names of witnesses, and the corrective actions and protection that was implemented. 1).Resident #14 was admitted to the facility in a special care unit on 3/13/24 with a diagnosis of dementia with agitation. Review of Resident #14's annual Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had impaired short- and long-term memory impairment, had impaired communication, rejected care 1 to 3 days during the look back period, was independent with transfers and ambulation and received antipsychotic and antidepressant medications. A review of Resident #14's electronic health record from 3/25/26 through 3/31/26 revealed no reported falls or injury with no pain or swelling to the left hand and wrist observed. Review of a skin audit dated 3/28/26 indicated that Resident #14 had no new skin issues and no open areas on the skin were noted. Review of a nursing progress note dated 4/1/26 at 10:54 AM written by Nurse #8 indicated Resident (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#14 had new left hand and wrist edema (swelling) extending to the forearm. Pain and tenderness as well as generalized purplish discoloration were observed over the resident's left hand, index finger, thumb and wrist. Unknown source of the injury. Resident #14's Responsible Party was in the facility and was updated. The provider was notified and an order was received to obtain an x ray. The resident cannot verbalize what occurred. An interview with Nurse Aide (NA) #2 on 6/18/26 at 3:00 PM indicated that she was assigned to Resident #14 from 7:00 AM to 7:00 PM on 4/1/26. NA #2 stated that on 4/1/26, Resident #14's left arm and hand appeared significantly swollen and painful. NA #2 stated she did not know what the cause was. NA #2 reported that Resident#14 had not experienced any falls in the week prior to the Xˆray being obtained which indicated he had an acute fractured wrist. An interview with NA #1 on 6/18/26 at 3:10 PM revealed that on 4/1/26 from 7:00 AM to 7:00 PM she was assigned to the area that Resident #14 resided in. NA #1 indicated that Resident #14 had swelling and pain in his left arm and hand on 4/1/26. NA #1 stated that she did not know what the cause of the injury was and was unaware of the resident having had any falls. NA #1 stated that Resident #14 had dementia with behaviors, was ambulatory and could have had an unwitnessed fall. NA #1 stated that Resident #14 liked his privacy and preferred to have his door closed at night. An x ray report in Resident #14's electronic health record dated 4/2/26 at 10:12 AM indicated a result of acute fractures of the left radius and ulna (the long bones in the forearm). A nursing progress note dated 4/2/26 at 3:46 PM written by Nurse #7 indicated that Resident #14's left hand and wrist swelling was first observed on the previous day, at which time an x-ray was ordered. The mobile x-ray was completed today. X-ray results were received and revealed acute fractures of the left hand involving the radius and ulna. The physician was immediately updated with these findings and provided a new order to send the resident to the emergency department for further evaluation and management. A review of an emergency department visit note dated 4/2/26 indicated that Resident #14 was diagnosed with a closed left wrist fracture with no falls or injuries reported. Resident #14 presented to the emergency department with swelling of the left hand and forearm with fractures identified and the recommendation was for the resident to follow up with an orthopedic doctor. An interview was conducted with the Administrator on 6/18/26 at 12:25 PM. The Administrator stated that she had no information regarding Resident #14's injury of unknown origin and she had no incident report regarding this. The Administrator stated that a facility initial allegation report was not submitted to the North Carolina Division of Health Service Regulation, Law enforcement was not notified and Resident #14's injury was not investigated. The Administrator stated that she was not aware of the reporting and investigation requirements for an injury of unknown origin. The Administrator acknowledged that she was the abuse coordinator for the facility and stated that she expected that reports of abuse including injuries of unknown origin would be reported timely and that the appropriate authorities would be informed. The Administrator stated that she was not aware that she was required to notify Adult Protective Services of incidents of alleged abuse. An interview was conducted with the Director of Nursing (DON) on 6/18/26 at 2:00 PM. The DON stated that she reviewed Resident #14's electronic health record and noted that the resident had an injury of unknown origin documented on 4/1/26. The DON stated that she advised the nursing staff to obtain an order for an x ray. The DON stated that she did not submit an initial allegation report to the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	North Carolina Division of Health Service Regulation, did not inform law enforcement or other agencies and did not complete an investigation of Resident #14's injury of unknown origin. The DON stated that she was new to the position and was not aware of the requirements. Attempts were made on 6/17/26 at 11:11 AM, 6/18/26 at 8:42 AM, and 6/19/26 at 10:05 AM to interview Clinical Coordinator #2. Voicemail and text messages were sent with no return call received. Clinical Coordinator #2 was the coordinator at the time of this incident but is no longer employed at the facility. An interview with the Nurse Practitioner on 6/19/26 at 9:00 AM revealed that any incident of unknown origin or changes in condition should be reported and investigated as soon as possible. The NP stated that a delay in the treatment of an injury could cause further complications and increased pain. 2)a. Resident #110 was admitted to the facility in a special care unit on 2/29/24 with diagnoses which included dementia, anxiety, restlessness and agitation. A review of Resident #110's quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident had a severe cognitive impairment, exhibited wandering, verbal symptoms and other behavioral symptoms 1 to 3 days in the review period and received an antidepressant. A nursing progress note dated 6/5/26 at 2:30 PM written by Clinical Coordinator #3 indicated that Resident #110 was observed poking Resident #14 in the face with her pointer finger yelling. While staff attempted redirection, Resident #14 grabbed resident #110's wrist. Resident #14 let go of Resident #110's wrist. While Resident #110 was being redirected by staff, the resident turned and grabbed Resident #14's left arm digging in her nails. Resident #110 then attempted to bite Resident #14 and bit staff while staff were intervening. Resident #110 still had a hold of Resident #14's left arm when Resident #14 hit her in the face. Resident #110 let go of Resident #14's arm and the staff were able to redirect her to another room. Resident #110 had reddened areas on the right side of her face. A review of an Initial Allegation Report provided by the facility revealed that the report was prepared by the Administrator. The Report indicated that the facility became aware of an incident on 6/5/26 at 12:00 AM with the allegation details listed as an altercation between Resident #110 and Resident #14 in which Resident #14 sustained bruising to the left arm and a skin tear and Resident #110 had a reddened area to the right side of the face. Law enforcement was notified at 1:30 PM on 6/5/26. There was no evidence that the Initial Allegation Report was received by the North Carolina Division of Health Service Regulation and the Department of Social Services Adult Protective Services was not notified. A review of an Investigation Report completed by Clinical Coordinator #3 on 6/9/26 indicated that Resident #110 and Resident #14 were involved in an altercation on 6/5/26. The summary of the facility investigation indicated that Resident #110 and Resident #14 were cognitively impaired and required redirection. Corrective action indicated that staff were present to redirect the residents when needed. The Investigation Report indicated that the County Department of Social Services Adult Protective Services (APS) was not notified. There was no evidence that the Investigation Report was sent or received by the North Carolina Division of Health Service Regulation and the Department of Social Services APS was notified. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 6/17/26 at 12:30 PM revealed that she was in the position since April 2025 and had never verified that Initial Allegation Reports or Investigation Reports were received by the North Carolina Division of Health Service Regulation. The Administrator stated that the reports were sent via an electronic fax system and she had not verified that the reports went through the system. The Administrator further indicated that she had never notified the Department of Social Services APS of allegations of abuse and was not aware of this requirement. 2)b. A nursing progress note written by Nurse #6 dated 6/7/26 at 11:34 PM indicated that the nurse was passing medications earlier in the evening when she heard arguing coming from a male resident's room. The nurse quickly went into the room where the arguing was heard. The nurse noticed Resident #110 lying on Resident #14's floor. Resident #14 was standing over Resident #110, holding her by her hair and kicking her in the face. The nurse attempted to separate the residents but was unable to so she called for the Nurse Aide (NA) to help. The NA and nurse separated the residents and was able to get Resident #110 to her room. Resident #110 had a notable knot on the back of her head. The on-call provider was notified, and Resident #110 was sent to the emergency department for evaluation. A review of a facility Initial Allegation Report revealed a report which indicated an incident occurred on 6/7/26 between Resident #110 and Resident #14. The Report indicated Resident #110 entered Resident #14's room. The nurse heard yelling and witnessed Resident #14 holding Resident #110's hair and kicking her in the head. Resident #110 sustained a moderate sized raised area to the back of her head and Resident #14 sustained scratches to the right hand. Law enforcement was notified at 9:53 PM on 6/7/26. A review of an Investigation Report dated 6/12/26 completed by Clinical Coordinator #3 indicated that an incident occurred on 6/7/26 between Resident #110 and Resident #14. The Investigation Report indicated that the nurse witnessed Resident #14 holding Resident #110's hair and kicking her in the head. The incident resulted in physical injury or harm. The report indicated that Resident #110 and Resident #14 were unable to get along and Resident #110 was moved to another area. The Investigation Report indicated that the County Department of Social Services Adult Protective Services (APS) was not notified. An interview with Clinical Coordinator #3 was conducted on 6/17/26 at 10:15 AM. Clinical Coordinator #3 stated that she was new to the position and was not familiar with how to complete the investigation reports for abuse and was not aware that it was required to report incidents of abuse to the County Department of Social Services APS. An interview with the Administrator on 6/18/26 at 12:30 PM revealed that there was no investigation completed regarding the incident between Resident #110 and Resident #14 that occurred on 6/7/26. The Administrator stated she had no further information regarding the incident. The Administrator acknowledged that the facility policy indicated that an investigation of all incidents of abuse was to be completed. The Administrator stated that she had never notified the Department of Social Services APS of allegations of abuse and was not aware of this requirement. 3.) Resident #3 was admitted to the facility on [DATE] with diagnoses including dementia and generalized anxiety. Resident #95 was admitted to the facility on [DATE] with diagnoses including dementia. A 5-day investigation report submitted to the State Agency revealed: the date of the incident was (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/17/26, the facility became aware 4/22/26 at 5:15 PM, and the investigation end date 4/27/26. An employee reported that two residents (Resident #3 and Resident #95) had their rights violated by having gait belts around them and their wheelchairs. Resident #3 and Resident #95 were able to self-propel in their wheelchairs independently. There were no injuries reported. During an investigation it was discovered that the assigned nurse (Nurse #24) was aware of the gait belts around the residents, however Nurse #24 denied ever having knowledge of this. Nurse Aide #1 (the assigned nurse aide) reported that she informed Nurse #24 that gait belts were in place. Nurse Aide #1 was told that the Clinical Coordinator (#2) placed the gait belts on the residents. The Activity Assistant also questioned Nurse Aide #1 and Nurse #24. Later Nurse #24 messaged the Activity Assistant asking her not to say anything to anyone and that she had removed the gait belts from the residents. The Clinical Coordinator (#2) and Nurse #24 were both terminated on 4/22/2026. A handwritten facility investigation report with a timeline of the events revealed the following: On 3/18/26 the Activity Director reported to the Administrator and Director of Nursing (DON) that activity staff saw two residents in wheelchairs with gait belts on them. The Administrator and DON went to the unit and questioned Clinical Coordinator #2, who denied that gait belts had been used. Nurse #24 was also questioned and stated that she had heard about it. Both denied knowledge of the gait belts. On 4/15/26 the Activity Assistant went to Human Resources to get an update on the incident with the gait belts. The Administrator and DON spoke with Human Resources and reported that nothing was found. On 4/17/26 new information was received from the Activity Assistant that she reported the gait belts to Nurse #24. Nurse Aide #1 now states that she saw the gait belts and questioned Nurse #24. A text message was sent by Nurse #24 to the Activity Assistant saying that she had removed the gait belts and not to say anything. The Activity Assistant reported that Clinical Coordinator #2 stopped speaking to her. On 4/22/26 the reports were submitted to administration. Clinical Coordinator #2 and Nurse #24 were terminated. Review of the employee timecard revealed that Clinical Coordinator #2 continued to work his regular full^time schedule, Monday through Friday from 8:30 AM to 5:00 PM, from 3/17/26 until his termination on 4/22/26, and no protective measures were implemented by the facility to prevent potential further abuse during this time. During an interview on 6/16/26 at 1:40 PM, the Activities Director stated she observed Resident #3 and Resident #95 wearing gait belts secured around their abdomens and strapped around the back of their wheelchairs on the day of the incident (3/17/26). She stated she reported the concern to the Administrator, and the Director of Nursing but could not recall if she went to them the day of the incident or the following day. During an interview on 6/16/26 at 2:00 PM, Activity Assistant #1 stated she was no longer the Activity Assistant and now currently worked in Housekeeping. She stated on St Patrick's Day (3/17/26) during an activity she observed gait belts around Resident #3 and Resident #95 that were around their abdomen and strapped to the back of their wheelchairs. The Activity Assistant stated she reported this immediately to the Activity Director who reported it to the Administrator. The (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activity Assistant stated she never heard anything else about the incident so a few weeks later she asked Human Resources what the outcome of the incident was, and an investigation was started. During a phone interview on 6/16/26 at 2:30 PM, Nurse Aide #1 stated on the day of the incident (3/17/26) she observed the gait belts wrapped around the residents and strapped to the back of their wheelchairs. Nurse Aide #1 stated she denied seeing gait belts on Resident #3 and Resident #95 following the incident because it was the Clinical Coordinator (#2) who put the gait belts on the residents and indicated she feared retaliation from the Clinical Coordinator and Nurse #24, and she was scared to say anything. During an interview on 6/16/26 at 3:30 PM, the Director of Nursing (DON) stated she was alerted of the incident with the gait belts on Resident #3 and Resident #95 by the Activity Assistant following the incident on 3/17/26. She and the Administrator went to the locked unit but did not observe gait belts on the residents at that time. The DON stated she questioned the Clinical Coordinator (#2) and Nurse #24 and both denied using the gait belts on the residents. The DON stated she assessed both residents for skin issues at that time with no injuries found but did not document her assessments. During an interview on 6/16/26 at 3:50 PM, the Administrator stated she did not initiate a full investigation on 3/17/26 because the staff involved denied the allegations, and as a result, the facility's abuse investigation protocols were not implemented. She acknowledged that a thorough investigation was not initiated until 4/15/26 and the required reporting to the State Agency until 4/22/26.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Psychiatric Nurse Practitioner interview, and staff interviews, the facility failed to permit a resident to return to the facility after being transferred to the hospital for a psychiatric evaluation due to aggressive behaviors toward other residents for 1 of 2 residents reviewed for hospitalization (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE] with cumulative diagnoses that included generalized anxiety, Alzheimer's disease, dementia with behavioral disturbance, restlessness and agitation, recurrent moderate major depressive disorder, disorientation and insomnia.An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had severely impaired cognition. No mood issues were identified. Other behavioral symptoms not directed toward others and wandering occurred on 1 to 3 days and the resident was noted with no change in behavior or other symptoms compared to a prior assessment. The resident had functional impairment with range of motion in one upper and one lower extremity, used a walker and a wheelchair, and required supervision for all activities of daily living. He had received antidepressant medication during the assessment look back period.A progress note written on 11/24/25 at 5:36 PM by Nurse #3 documented Resident #1 was found in another resident's room, room [ROOM NUMBER]. Another staff member told Nurse #3 that she saw Resident #1 shake the resident in Bed 2 to wake her. Nurse #3 did not observe this. Both residents were assessed and there were no injuries to either one. Nurse #3 was able to redirect Resident #1 away from room [ROOM NUMBER].An interview was conducted with Nurse Aide (NA) #1 on 06/18/26 at 4:55 PM. She stated she was familiar with Resident #1 and had cared for him during his stay. She stated that Resident #1 always thought his room was in a different location (room [ROOM NUMBER]). NA #1 recalled that on 11/24/25 Resident #1 was seen by herself shaking the resident who resided in Bed 2 trying to wake her so she would move out of what he thought was his bed. Resident #1 often had to be redirected back to his own room. NA #1 stated Resident #1 had never struck a staff member or another resident.Review of the care plan updated on 11/24/25 for Resident #1 documented he had behaviors directed toward others. He often wandered hallways, disrobed and urinated/defecated in his room, packed up his belongings and entered other resident's rooms. The goal for Resident #1 was to not exhibit socially inappropriate or disruptive behavior. Interventions included: one to one (1:1) supervision (created 11/24/25); avoidance of over-stimulation, maintain a calm environment and approach to the resident; provide activities and a daily schedule that resembles the resident's prior lifestyle, and when resident begins to become socially inappropriate or disruptive, provide comfort measures for basic needs such as pain, hunger, toileting, too hot or cold, etc. A progress note written on 12/10/25 at 2:31 AM by Nurse #6 documented Resident #1 hit his roommate with a laminated piece of paper witnessed by staff. Nurse #6 was able to redirect Resident #1. Nurse #6 documented she had administered an as needed (PRN) dose of lorazepam (a benzodiazepine) 0.5 milligrams (mg) to Resident #1 for agitation and the medication was effective. There were no injuries identified upon assessment. Resident was on 1:1 observation.Attempts to contact Nurse #6 by phone on 06/19/26 at 8:58 AM and 1:30 PM were unsuccessful.An interview was conducted with Nurse #3 on 06/17/25 at 3:55 PM via telephone. He stated he cared for Resident #1 and remembered him. He indicated the resident was hard to care for because Resident #1 always felt his room was in a different location (room [ROOM NUMBER]) that was occupied by another resident and it was difficult to redirect him when he went into that room. He explained that the different interventions used to manage the resident's behaviors were medication administration, 1:1 sitter, verbal redirection, and pain assessments. He stated the family was aware of the resident's behaviors because he had been in constant contact with the family.A psychiatry note by Psychiatric Nurse Practitioner #2 on 12/11/25 recommended that Resident #1 be sent to the hospital for a full psychological evaluation. It was her (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hope that once the evaluation was completed staff could appropriately manage and maintain Resident #1's behaviors with adjusted medications and repeated nonpharmacological interventions.An interview was conducted with the Psychiatric Nurse Practitioner #2 on 06/23/26 at 10:01 AM. She explained Resident #1 was newer to her when she saw him on 12/11/25 and she had planned on doing an in depth assessment on him when he returned to the facility after a psychiatric evaluation at the hospital to assess his medications. She noted that when she interviewed Resident #1 via telehealth on 12/11/25 that he was sweet as pie. She indicated that Resident #1 was agitated at times by his roommate's constant humming and had previously suggested that he be moved to another room but understood that room availability was a barrier.Nurse #3 documented on 12/12/2025 at 2:32 PM that Resident #1 departed the facility via EMS (Emergency Medical Services) and was enroute to the hospital for a psychiatric evaluation for acute episodic behaviors.In an additional in person interview with Nurse #3 on 06/19/26 at 11:50 AM he stated he was caring for Resident #1 on 12/12/25 when he was sent to the hospital for evaluation. He explained that on 12/12/25 Resident #1 had not had any behaviors out of the ordinary and had not required PRN lorazepam. Nurse #3 stated he was sure that if the resident had behaviors that were out of the ordinary on the day he was discharged he would have administered the PRN lorazepam.Review of the hospital emergency room records dated 12/12/2025 revealed Resident #1 was assessed by the psychiatric team who documented they did not feel the patient needed a psychiatric admission, but rather a medicine admission. In the emergency room Resident #1 was assessed as resting comfortably, answered to his name, and denied any complaints. He was pleasantly confused and followed commands. He did not know where he was or what year it was. The resident was admitted to the hospital on [DATE] for a medical admission with psychiatric consultation. The listed diagnosis was dementia with behavioral disturbance.Review of the hospital discharge record dated 12/15/25 revealed a Case Manager at the hospital documented that on 12/15/25 the facility was contacted and advised by Clinical Coordinator #2 that the facility was unable to accept Resident #1 back to the facility due to his aggressive behaviors. The Case Manager documented that Resident #1 was not exhibiting aggressive behavior at the hospital. The family chose to have Resident #1 discharged from the hospital to a community Hospice House.Three attempts to contact the hospital Case Manager by phone were made on 06/19/26 with no success. Voicemail messages were left on each attempt with no response.During an interview with Psychiatric Nurse Practitioner #2 on 06/23/26 at 10:01 AM she stated she was very surprised when she learned Resident #1 had been denied admission back to the facility as it was never her intention when he was sent to the hospital for a psychiatric evaluation.During an interview with NA #1 on 6/18/26 at 4:55 PM she stated Resident #1 was difficult to care for, but she considered his behaviors to be the same at discharge as they were when he was admitted .An interview was conducted with the Administrator on 06/17/26 at 4:00 PM. She stated Clinical Coordinator #2 handled Resident #1's discharge in coordination with herself and Director of Nursing (DON) #2 . She reported that it was decided by all 3 of them that Resident #1 would not be accepted back to the facility because they felt other residents were unsafe due to Resident #1's behaviors. The Administrator stated she was under the impression that the hospital had called to return Resident #1 to the facility, and Clinical Coordinator #2 refused his readmission because Resident #1 had thrown a laminated paper at his roommate.In a follow up interview on 06/19/26 at 3:00 PM the Administrator retracted her previous statement that she was involved in the decision to deny Resident #1 readmission and clarified that she was not involved in the decision to deny Resident #1 readmission. She explained that she was informed by Clinical Coordinator #2 that he refused to take Resident #1 back for readmission. Multiple attempts were made to contact Clinical Coordinator #2 by phone during the survey with no success. He was no longer employed by the facility.An interview was conducted with the DON #1 on 06/19/26 at 11:30 AM. DON #1 stated she was not involved with any decisions that were made regarding Resident #1's care. She stated she knew nothing about the situation and that Clinical Coordinator #2 had made the decision not to readmit Resident #1.A phone interview was conducted with a former DON, DON #2, on (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/18/26 at 1:24 PM. She indicated she was not an employee at the facility on 12/12/25 when Resident #1 was transferred to the hospital for psychiatric evaluation. She stated she had separated from employment at the facility in October 2025. An interview was conducted with NA #2 on 06/18/26 at 5:20 PM. She stated she had had taken care of Resident #1 during his stay at the facility. She was aware that Resident #1 always felt his room was in a different location that was occupied by another resident and it was difficult to redirect him when he went into that room. He often had to be redirected out of the room because he was confused. NA #2 explained that it was often difficult to redirect Resident #1, but she would let him cool down and when reapproached he could then be redirected. She had known Resident #1 was frustrated with his roommate humming all the time and he would ask his roommate to stop. She thought his behaviors remained the same throughout his stay. She stated he wasn't really difficult to care for and felt his behaviors were ordinary for a resident with dementia.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and Nurse Practitioner (NP) interviews, and record review, the facility failed to ensure a safe environment free of accident hazards for 1 of 5 residents reviewed for accidents (Resident #25), when a can of WD-40 (a penetrating oil used to lubricate metal surfaces and highly flammable) was observed in Resident #25's room in an area easily accessible to other cognitively impaired residents, creating the potential for accidental ingestion, misuse, or exposure. This deficient practice had the potential to affect all residents on the unit.Findings included:Resident #25 was admitted to the facility on [DATE] with bilateral below the knee (BKA) amputations.Resident #25's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and used an electric wheelchair for mobility.The label on the can of WD-40 read in part to keep the product out of reach of children. The contents are, flammable and to keep it away from heat, sparks, flames, etc. It further read that it was a breathing hazard and to use only in well-ventilated area and that deliberate or direct inhalation of vapor or mist may be harmful or fatal.An observation and interview with Resident #25 were completed on 6/17/2026 at 2:04 PM. Resident #25 was observed in the first bed of a semi-private room. A 2.75 ounce (oz) can of WD-40 was observed on top of his dresser on the left side of the doorway entrance. Resident #25 stated that he used the WD-40 on his electric wheelchair as needed. He further stated that he had ordered the WD-40 and had it delivered to the facility. Resident #25 indicated he was unaware he was not supposed to have WD-40 in his room. He stated he had not considered that other residents were able to access it.An interview with Clinical Coordinator was completed on 6/17/26 at 2:06 PM. Clinical Coordinator #3 indicated she was the nurse working on the unit that day. She stated she was not sure if Resident #25 was supposed to have WD-40 in his room. She further stated she was going to remove it and check with the Director of Nursing (DON) regarding facility policy. Clinical Coordinator #3 stated that there were several cognitively impaired residents on the unit that wandered in and out of rooms and sometimes they took other residents' belongings. She stated it could be dangerous if a cognitively impaired resident sprayed themselves or other residents with it. An interview with the Social Worker (SW)was conducted on 6/18/26 at 11:23 AM. The SW stated that residents were not allowed to keep dangerous products in their rooms where other residents could access it. She further stated there were several residents on that unit that wandered in other residents' rooms and could accidentally misuse it and harm themselves or others.An interview with Nurse Aide (NA) #4 was completed on 6/18/26 at 11:29 AM. NA #4 stated she had not noticed the WD-40 in Resident #25's room. She further stated there was a new resident on the unit that frequently wandered in other residents' rooms and they would have to redirect her attention out of the room.An interview with NA #5 was completed on 6/18/26 at 11:35 AM. NA #5 stated there were usually two NAs and one nurse on the unit. She indicated there were several residents that frequently wandered in other residents' rooms. She stated she didn't know Resident #25 was keeping WD-40 in his room.An interview with Nurse #5 was completed on 6/18/26 at 11:37 AM. Nurse #5 stated she had worked at the facility for approximately a year and floated or worked wherever she was needed. She indicated Resident #25 should not have WD-40 in his room because it could be dangerous for other residents.An interview with the Administrator was completed on 6/18/26 at 2:00 PM. The Administrator stated that WD-40 should not be kept in a resident's room because there were residents that wander on that unit and they could get a hold of it. She indicated that it was dangerous for other residents if they were accidentally exposed to it.An interview with the Director of Nursing (DON) was completed on 6/18/26 at 2:15 PM. The DON stated that WD-40 was not to be kept in residents' rooms because it was a hazardous substance. She indicated that it could be harmful if a cognitively impaired resident got a hold of it and was accidentally exposed.An interview with the Nurse Practitioner (NP) #2 was conducted on 6/19/26 at 9:32 AM. The NP stated that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25 was not supposed to have WD-40 in his room. She further stated that it was aerosol petroleum product that could be dangerous if inhaled or ingested. NP #2 indicated an accidental exposure could cause aspiration or chemical pneumonia or other serious issues.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Nurse Practitioner and Psychiatric Nurse Practitioner, the facility failed to address a psychiatric Nurse Practitioner recommendation to increase the medication trazadone (an antidepressant used to manage restlessness and anxiety and is used as a sleep aid) for a resident (Resident # 110) diagnosed with dementia who had a known pattern of wandering behaviors and nighttime sleep disturbance. This deficient practice was for 1 of 1 resident (Resident # 110) sampled for dementia care.Findings included:Resident #110 was admitted on [DATE] with diagnoses which included dementia, anxiety, restlessness, and agitation.A physician order in Resident #110's electronic health record dated 11/23/25 written by the Nurse Practitioner indicated trazadone 50 mg at bedtime daily. A pharmacy recommendation dated 2/6/26 indicated that Resident #110 received trazadone 50 milligrams (mg) at bedtime. The recommendation stated to consider dose reduction if appropriate. The recommendation was signed in agreement by the Nurse Practitioner on 2/17/26 with a new order written to decrease trazadone to 25 mg at bedtime. A Nurse Practitioner (NP) progress note dated 2/17/26 indicated that Resident #110 was evaluated regarding a pharmacy review and recommendation for a gradual dose reduction of trazadone from 50 mg to 25 mg.A physician order in Resident #110's electronic health record dated 2/17/26 written by the Nurse Practitioner indicated to discontinue trazadone 50 mg at bedtime and start trazadone 25 mg at bedtime daily. An NP progress note dated 2/24/26 indicated that Resident #110 was evaluated due to a pharmacy recommendation for a gradual dose reduction of trazadone. Staff reported increased anxiety and insomnia since trazadone was decreased. The note indicated that staff requested intervention and that Resident #110 had failed the dose reduction. A physician order in Resident #110's electronic health record dated 2/24/26 written by the Nurse Practitioner indicated trazadone 25 mg at bedtime daily. (same dose as the resident was receiving).A review of Resident #110's electronic health record revealed no new order dated 2/24/26 to increase trazadone to 50 mg. A review of Resident #110's electronic Medication Administration Record (MAR) for February 2026 indicated that from 2/1/26 through 2/16/26 the resident received trazadone 50 mg daily at bedtime. The MAR indicated from 2/17/26 through 2/28/26 Resident #110 received 25 mg trazadone daily at bedtime. A nursing progress note written by Nurse #3 on 3/2/26 at 6:54 PM revealed that Resident #110 was sitting in reclining chair watching television when the nurse was alerted by staff that resident had pushed another resident, which caused the other resident to fall. Review of Resident #110's electronic health record revealed a Nurse Practitioner (NP) progress note dated 3/3/26 at 5:16 PM that indicated that the resident was evaluated due to agitation with a recent incident of agitation toward another resident. The assessment and plan indicated to consult with the psychiatric service for possible increase in trazadone. Review of Resident #110's care plan last reviewed on 3/3/26 indicated a problem of behavioral symptoms with restlessness, anxiety, agitation. Resident #110 packs belongings in anticipation of leaving facility, has a history of exit seeking behaviors, refusing medications, wandering and requiring 1:1. Interventions included to notify and collaborate with the psychiatric service for behavioral review and recommendations as indicated and staff will observe and re-direct as able; attempt to engage in activities or phone call with family to encourage acceptance of placement. A review of Resident #110's physician orders revealed an order dated 3/5/26 to obtain a psychiatric service consult.A review of Resident #110's electronic Medication Administration Record (MAR) for March 2026 revealed the resident received trazadone 25 mg daily at bedtime daily from March 1, 2026 through March 31, 2026.A nursing progress note dated 3/16/26 at 6:30 AM indicated that Resident #110 was seen wandering throughout the shift. A nursing progress note dated 3/23/26 at 2:25 AM indicated that Resident #110 was in Resident #14's room. Resident #110 was redirected to her room. A nursing progress note dated 3/31/26 at 6:24 AM revealed that Resident #110 was found in (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14's bed. Resident #110 became very agitated and combative swinging her arms at the nurse and Nurse Aide. Eventually Resident #110 was redirected back to her room. Nurse Aide had to sit outside Resident #110's room to keep her from going back into Resident #14's room.A nursing progress note dated 4/4/26 at 6:24 AM revealed that Resident #110 was seen wandering throughout the shift. Staff attempted to redirect Resident #110. Review of Resident #110's electronic health record revealed a Psychotherapy Comprehensive Clinical assessment dated [DATE] which indicated that an assessment was completed for services due to the resident's history of agitation, aggressive behaviors and wandering at night. The assessment indicated that Resident #110 presented with guarded and suspicious behavior with agitation. The assessment highlighted Resident #110's significant cognitive and behavioral challenges suggesting a need for further interventions. Resident #110 became agitated with peers, easily frustrated and angry and staff reported a history of violent behavior. The assessment indicated that psychotherapy talk therapy was not appropriate due to Resident #110's severe cognitive impairment. Medication management services were indicated to address psychotropic medications.A review of Resident #110's electronic health record revealed a pharmacy evaluation for April 2026 which indicated no new recommendations and no information regarding the behaviors of wandering at night and agitation documented in the nursing progress notes. A Psychiatric Initial Visit note dated 4/22/26 indicated that an initial visit was completed with Resident #110. The plan indicated to monitor and document the side effects of medications, mood changes, and changes in behavior with no current medication changes recommended. A review of Resident #110's electronic MAR for April 2026 revealed that the resident received trazadone 25 mg nightly from 4/1/26 through 4/30/26. A nursing progress note dated 5/2/26 at 6:00 AM indicated that Resident #110 was seen wandering throughout the night. Plan of care was continued. No new interventions were implemented. A Psychiatry Follow Up note dated 5/19/26 indicated the recommendation was to increase Resident #110's trazodone to 50mg or 75mg nightly for sleep and restlessness. A review of Resident #110's electronic health revealed there was no order dated 5/19/26 to increase trazadone from 25 mg to 50 mg or 75 mg.A review of Resident #110's electronic MAR for May 2026 revealed that the resident received trazadone 25 mg nightly from 5/1/26 through 5/31/26.A review of Resident #110's electronic MAR for June 2026 revealed that the resident received trazadone 25 mg nightly from 6/1/26 through 6/16/26. Resident #110 received 50 mg trazadone starting on 6/17/26.A review of Resident #110's quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident had a severe cognitive impairment, exhibited wandering, verbal symptoms and other behavioral symptoms 1 to 3 days in the review period and received an antidepressant.An interview with Clinical Coordinator #3 on 6/18/26 at 2:50 PM revealed that she began her role in May, 2026. In this position, she serves as the nursing manager responsible for overseeing patient care coordination for the special care unit where Resident #110 resided. She stated the Director of Nursing received the psychiatry recommendations and either presented them to the provider for orders or delegated that task to the staff nurse assigned to the resident. Clinical Coordinator #3 stated that she was unaware there was a recommendation from psychiatry to increase Resident #110's trazadone to 50 mg or 75 mg. An interview with Nurse Practitioner (NP) on 6/19/26 at 9:00 AM revealed Resident #110 exhibited behaviors including wandering frequently, often entering other residents' rooms and plundering in their belongings. The NP revealed on 2/24/26, Resident #110's dose of trazadone should have been increased back to the previous dose of 50 mg at bedtime. The NP stated it was her error and that she thought Resident #110's trazadone was discontinued completely on 2/17/26. The NP stated the psychiatry recommendations should have been addressed. The NP indicated she was unaware of the process for how psychiatric recommendations were handled in the facility. If the medication had been increased according to the psychiatric recommendation, it would have been expected to aid in her sleep and prevent wandering and plundering in other resident rooms at night. An interview was conducted with the Psychiatric Nurse Practitioner (NP) via telephone on 6/19/26 at 5:00 PM. The Psychiatric NP explained that trazodone (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is an antidepressant commonly used to assist with sleep. She stated that she had recommended increasing Resident #110's dose of trazadone to help address nighttime sleep disturbances and wandering behaviors. The Psychiatric NP further indicated that the dosage adjustment should have been implemented and that a breakdown occurred in the process of carrying out the recommendations she documented.An interview with the Director of Nursing (DON) on 6/17/26 at 1:10 PM revealed the facility's established process was that the clinical coordinator received recommendations from the psychiatric service via email, print the recommendations, and provide them to the staff nurse to submit to the provider for review, approval, and new orders if in agreement. The DON stated that she did not recall whether the Clinical Coordinator received the psychiatric recommendation written on 5/19/26 which recommended to increase Resident #110's trazadone. The DON stated that the psychiatry recommendation for Resident #110 to increase the trazadone was missed and was not addressed and assumed it was due to human error.

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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. Based on observations, record review, and staff interviews, the facility failed to record the opened date on an insulin pen and discard an expired bottle of an ophthalmic solution (eye drops), according to the manufacturer's guidelines, and discard an expired bottle of a proton pump inhibitor (a medication that decreases the amount of acid produced in the stomach). This was observed on 1 of 3 medication carts (200 hall medication cart) reviewed for medication storage. Findings Included: Review of the manufacturer's guidelines for Insulin Glargine (Lantus) pens instructed to discard 28 days after opening. Review of the manufacturer's guidelines for Polyvinyl 1.4 % ophthalmic solution instructed to discard 90 days after opening. An observation of the 200-hall medication cart on 6/17/26 at 10:30 AM along with Nurse #10 revealed the following: - One Insulin Glargine (Lantus) pen with no opened date and the insulin pen had been used, - One bottle of Polyvinyl 1.4 % ophthalmic solution with an open date of 3/4/26, - One bottle (house stock) of Omeprazole (proton pump inhibitor) opened and used with a manufacturer's expiration date on the bottle of April 2026. During an interview on 6/17/26 at 10:30 AM Nurse #10 stated that the nurses were required to check medication carts for expired medications and to record the date insulin pens were opened. She stated she had not administered Lantus, the eye drops, or omeprazole that morning and therefore had not noticed the expiration dates. During an interview on 6/19/26 at 4:00 PM the Administrator indicated all nurses were responsible for checking medication carts for expired medications and insulin pens should be checked daily and opened dates recorded. She stated the expired medications on the 200-hall cart should have been discarded and an open date labeled on the Lantus pen.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews, the facility failed to implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when two staff members (Nurse #9 and NA #7) were observed providing direct care activities to Resident #42 who had a Stage IV pressure ulcer on her sacrum and Nurse #9 was observed not changing her gloves and hand sanitizing prior to going from a dirty area to a clean area during wound care. This occurred for 2 of 3 staff members observed for infection control practices. Findings included: The Infection Control Policy dated 11/2/25 revealed Enhanced Barrier Precautions referred to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms by requiring the use of gown and gloves during high contact resident care activities. During an observation on 6/17/26 at 10:11 AM Resident #42 was observed lying in bed. There was no Enhanced Barrier Precaution sign observed on the door of Resident #42's room and there was no Personal Protective Equipment (PPE) on the door or the outside of the room. Nurse #9 and Nurse Aide #7 were observed washing their hands and applying gloves and they did not apply gowns. Nurse Aide #7 assisted Resident #42 to roll over on her right side to expose her sacral area. Nurse #9 then removed the dirty sacral dressing. Nurse #9 was not observed removing her dirty gloves and hand sanitizing prior to cleaning the wound with Normal Saline and applying calcium alginate with silver and covering with a dry self-adhesive dressing. An interview with Nurse #9 was completed on 6/17/26 at 10:19 AM. Nurse #9 stated she was provided education by the facility regarding EBP. She indicated she should have been wearing a gown and gloves during Resident #42's dressing change. She stated she was not aware that the EBP was not posted outside the door. Nurse #9 explained she was just real nervous because she was being observed and just forgot to apply the PPE gown. She stated she just forgot to change her gloves and sanitize her hands after removing the dirty dressing and applying the clean dressing. Nurse #9 indicated she usually carried an extra pair of gloves with her supplies, but she was just nervous and forgot.An interview was completed with the Director of Nursing (DON) on 6/17/26 at 10:25 AM. The DON stated she was the interim Infection Control Preventionist (ICP) since the ICP resigned in May. She indicated she was the staff member responsible for initiating EBP by placing a sign and PPE supplies outside the identified resident's door. The DON explained she was aware of Resident #42's Stage IV pressure ulcer and she just missed putting the supplies out and the sign for EBP. The DON confirmed that Nurse #9 should have changed her gloves and sanitized her hands and applied clean gloves prior to applying the clean dressing.An interview was conducted with NA #7 on 6/17/26 at 12:47 PM. NA #7 stated she was aware of EBP, but there was never a sign or PPE outside Resident #42's room. She stated she should have been wearing a gown and gloves when assisting with wound care for Resident #42.An interview was completed with the Administrator on 6/18/26 at 2:05 PM. The Administrator stated she expected the nursing staff to follow EBP when providing direct patient care for residents, including wound care.