STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Center	707 North Elm Street High Point, NC 27262

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to label and date food items stored for use in the reach-in refrigerator for 1 of 1 reach-in refrigerator and failed to use gloves when handling an unpeeled cucumber for 1 of 5 kitchen staff observed. These practices had the potential to affect food served to residents.Findings included:A.On 6/7/26 at 9:15 am the initial kitchen observation was completed with kitchen staff #1. The reach-in refrigerator had the following food items that were not in the original manufacturer's packaging and were not dated: Six applesauce cups no longer in the original package, One yellow pudding consistency food item in a large metal bowl with plastic wrap which was lying in the food and no longer covering. The food item appeared to be runny with water pooling on the edges, and Fourteen poured cups of thickened liquid were in plastic cups. On 6/7/26 at 10:45 am an interview was completed with the Dietary Manager (DM). The DM stated that all food items required an expired by date when placed in alternate packaging. B.On 6/9/26 at 12:32 pm an observation and interview were completed with kitchen staff #2. Kitchen staff #2 was observed holding 2 cucumbers with bare hands. Kitchen staff #2 was preparing to start cutting the cucumber over a bowl of already sliced cucumbers when asked about gloves and she stopped before slicing. Kitchen staff #2 stated she took her gloves off for something else and had not replaced her gloves to directly handle and prepare residents' food. Kitchen staff #2 further stated she was required to wear gloves when directly handling resident food items for preparation. On 6/9/26 at 12:38 pm an interview was completed with the Dietary Manager (DM). The DM was informed that kitchen staff #2 had not worn gloves when directly handling and preparing resident food. The DM stated staff were required to wear gloves when handling food. On 6/11/26 at 11:45 am the Administrator was interviewed. The Administrator was informed of the kitchen observation of the undated food items and a kitchen staff member not wearing gloves while handling/preparing food. The Administrator had no comment.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, staff and resident interviews, the facility failed to protect a resident's right to be free from misappropriation of property when a staff member (Nurse Aide #8) accepted a meal purchased by Resident #144 through an online food delivery service and failed to reimburse Resident #144 for the cost of the meal. The deficient practice was for 1 of 2 residents reviewed for misappropriate of resident property (Resident #144).Findings Included:Resident #144 was admitted to the facility on [DATE].Review of Resident #144's quarterly Minimum Data Set (MDS) Assessment indicated Resident #144 was cognitively intact.An initial allegation report dated 5/2/26 completed by the Administrator showed that Resident #144 made the Registered Nurse (RN) Weekend Supervisor aware on 5/2/26 that on 5/1/26, Nurse Aide #8 took his online food delivery service order and did not deliver it to him.A review of the 5-day investigation report dated 5/8/26 completed by the Administrator revealed that on 5/5/26 the Director of Nursing interviewed Resident #144 and he indicated that on 5/1/26 he felt pressured by Nurse Aide #8 to order the staff member food via an online food delivery service, but he did willingly order the food. Resident #144 was also reported to have stated Nurse Aide #8 agreed to pay him back in the amount of $26.19 however she did not pay him back on 5/1/26 and that he wanted his money returned. The report indicated that both local law enforcement and the county departement of social services were notified, however neither agency made an onsite visit nor filed charges.An interview was conducted with Resident #144 on 6/7/26 at 10:36 AM. Resident #144 indicated that the allegation was that he and Nurse Aide #8 were discussing lunch and that he agreed to buy Nurse Aide #8 lunch from an online food delivery service. He explained that although he felt pressured, he agreed and that Nurse Aide #8 was supposed to reimburse him that day but never did so he reported the incident the next day. Resident #144 further revealed that the Administrator refunded the full amount of money and felt that the complaint had been resolved.An attempt was made to interview Nurse Aide #8 by telephone however the phone number was no longer in service.An attempt was made to interview RN Weekend Supervisor, but attempts were unsuccessful.An interview was conducted with the Administrator 6/11/26 11:11 AM. The Administrator indicated he was contacted by the RN Weekend Supervisor on 5/2/26 and she reported that Resident #144 stated on 5/1/26 he had ordered from an online food delivery service and Nurse Aide #8 never gave it to him. The Administrator indicated that Nurse Aide #8 was identified and was immediately suspended pending an investigation. The Administrator indicated that both law enforcement and the department of social services were contacted but neither agency made an onsite visit and no charges were filed. The Administrator further revealed the RN Weekend Supervisor misunderstood Resident #144's initial allegation and when the Director of Nursing interviewed Resident #144 on 5/5/26 he stated he had felt pressured by Nurse Aide #8 to order her food via an online food delivery service but that he did consent to order the food. Resident #144 indicated that the staff member had agreed to pay him back $26.19, however she did not pay him back the money. The Administrator revealed that Nurse Aide #8 was interviewed, and she indicated that she and Resident #144 were discussing lunch and Resident #144 asked her what she wanted for lunch and that he placed the order via an online food delivery service on his phone and she would pay him back. The Administrator indicated that Nurse Aide #8 did not pay Resident #144 for the meal on 5/1/26 and was suspended on 5/2/26. The Administrator further revealed that upon completion of the investigation the facility did not substantiate the allegation of misappropriation of resident property because Resident #144 willingly ordered the staff member lunch. However, Nurse Aide #8 was terminated based on violating the facility policy which stated employees may not solicit, extend or accept gifts or gratuities from patients/residents, their families, visitors or referral sources. The Administrator indicated out of good faith the facility refunded Resident #144 $26.19 on 5/6/26. The Administrator indicated that facility staff should never solicit, extend or accept gifts or gratuities from residents.An interview was conducted with the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing on 6/11/26 at 11:51 AM and she indicated she interviewed Resident #144 on 5/5/26 and he indicated that he stated he had felt pressured by Nurse Aide #8 to order her food via an online food delivery service but that he did consent to willingly order the food. Resident #144 indicated that the staff member had agreed to pay him back $26.19, however she did not pay him back the money. The DON further revealed that Nurse Aide #8 should not have asked Resident #144 to order her food and that this was against facility policy.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to provide nail care for 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #68). The findings included:Resident #68 was admitted to the facility on [DATE] with diagnoses including essential hypertension, communication deficit, unspecified visual loss, and chronic pain syndrome.A care plan dated 6/5/2026 indicated Resident #68 had an ADL self-care performance deficit with a goal that read Resident #68 would maintain his current level of function. The care plan revealed the resident was dependent on the assistance of one staff with personal hygiene.The significant change Minimum Data Set (MDS) assessment completed 5/22/2026 documented Resident #68 as cognitively intact, without refusal of care behavior, and dependent on others for personal hygiene.Resident #68 was observed on 6/7/2026 at 10:39 AM. The free edge of Resident #68's fingernails on both hands were either jagged or broken, extended past his fingertips by what appeared to be more than 1/2 inch, or about the width of a pencil eraser. An interview conducted with Resident #68 on 6/7/2026 at 10:39 AM indicated his preference was to keep his fingernails short. He stated he has never had long nails, and he always kept his nails short. The resident stated long fingernails made him feel uncomfortable especially with his vision loss.A second observation on 6/8/2026 at 1:21 PM of Resident #68 revealed the free edge of Resident #68's fingernails on both hands were either jagged or broken, extended past his fingertips by what appeared to be more than 1/2 inch, or about the width of a pencil eraser. A second interview on 6/8/2026 at 1:21 PM with Resident #68 stated he had asked a Nurse Assistant (NA) at least three times to cut his nails. He was unable to recall who the NA was and the time. Resident #68 stated it made him feel frustrated because he was unable to do it himself anymore and he felt like the staff do not care and like he was forgotten. During this interview Resident #68 used his call light to request his fingernails to be cut. The Speech Language Pathologist (SLP) was the staff member who responded to the light and told the resident she would let his nurse know.A review of the shower log revealed Resident #68 was documented as a receiving shower on 6/8/2026. A follow-up interview with Resident #68 on 6/9/2026 at 10:02 AM revealed he had received a shower on 6/8/2026 but did not have nails cut.A third observation of Resident #68's fingernails on 6/9/2026 at 7:23 AM revealed them to be unchanged, and in the same condition as the observations from 6/7/2026 at 10:39 AM and 6/8/2026 at 1:21 PM. A third interview with Resident #68 was conducted on 6/9/2026 at 7:23 AM. Resident #68 shared that he asked the NA that came in his room the evening on 6/8/2026 and she stated, she did not have time to cut his fingernails. Resident #68 indicated the NA never gave her name. Resident #68 stated he was there because he needed help not because he wanted to be there and he was upset because he was unable to get the care he asked for. Resident #68 stated he didn't like having long nails. NA #1 was interviewed 6/9/2026 at 10:00 AM and accompanied to Resident #68's room to observe his fingernails. During the interview NA #1 confirmed she was assigned to Resident #68 on 6/9/2026. NA #1 stated that she performed nail care on shower days. She stated nail care included cleaning under the nails and cutting/trimming if needed. NA #1 stated if she observed a resident's nails long, she would cut them even if it was not their shower day. NA #1 observed Resident #68's nails and stated they were long. NA #1 stated it was not Resident #68's shower day but she assured Resident #68 she would give him a shower and provide the requested nail care that day. NA #1 was unaware of why nail care had not been provided to Resident #68. Unit Manager (UM) #1 was interviewed on 6/9/2026 at 10:08 AM and accompanied to Resident #68's room to observe his fingernails. She stated that nail care was performed when residents received showers or as needed. UM #1 observed Resident #68's nails and stated she was going to make sure Resident #68's nails were cut as soon as possible. She agreed Resident #68's nails were long. The Unit Manager was unable to explain why Residents #68 had not received nail care. A follow up interview with Resident #68 was conducted 6/9/2026 at 4:28 PM. Resident #68 had received a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower that day, and nail care was provided by NA #1. Resident #68 stated his nails were cut to the length he liked and felt comfortable with.An interview with Director of Nursing (DON) was conducted 6/9/2026 at 10:22 AM and she indicated that nail care was provided to residents on shower days or as needed. The DON stated she expected staff to provide nail care to residents on shower days and at any time it was requested. The DON was unable to explain why nail care had not been provided on shower days or when requested by Resident #68.The Administrator was interviewed on 6/11/2026 at 12:40 PM and stated he was unaware Resident #68 had not received nail care. He was unable to explain why the nail care had not been provided. The Administrator stated he expected staff to provide nail care with their routine care and if it was requested.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, resident representative, staff, Neurosurgery Staff Nurse, Wound Care Physician, and Medical Director interviews, the facility failed to follow up with the neurosurgeon's office regarding a follow up appointment to address resident's staples. The deficient practice affected 1 of 1 resident reviewed for quality of care (Resident #1).The findings included:A review of Resident #1's hospital Discharge summary dated [DATE], it was noted that the resident underwent a C4-T2 (4th cervical vertebra through 2nd thoracic vertebra) posterior fusion on 4/30/26. It was also noted that there were no follow-up visits scheduled for Neurosurgery or guidance provided regarding the 15 staples present in her surgical incision.Resident #1 was admitted to the facility on [DATE]. Her diagnoses included a non-displaced cervical fracture C6 and C7 (cervical spine in neck) acute 3-column fracture of C6 (a severe and unstable cervical spine injury in which all three structural columns of the vertebra are involved, and carries a high risk of spinal cord compromise), unspecified protein calorie malnutrition (a condition where the body lacks sufficient protein and calories to meet metabolic needs, leading to impaired body function and tissue loss), and history of feeding tube placement for nutritional support.An admission note dated 5/12/26 at 9:04PM written by Nurse #8 revealed Resident #1 had a surgical wound described as skin issue to the posterior neck, containing 18 staples. Under the skin section the note stated skin warm & dry, skin color within normal limits (WNL) and turgor (skin elasticity) was normal.An advanced skin check written by Nurse #8 on 5/12/26 at 9:24PM noted Resident #1's skin was warm and dry. It also stated skin color and turgor were WNL. The note also contained skin issue described as surgical wound that was present on admission located on the resident's posterior neck which contained 18 staples.Resident #1's telehealth admission note written by the telehealth physician dated 5/12/26 at 9:10PM contained no information regarding her surgical history or her surgical wound containing staples. That note did not contain a skin assessment. Review of Resident #1's post-emergency room and hospitalization note dated 5/13/26 at 7:23PM, written by the facility Nurse Practitioner stated that the resident's past surgical history included C4 to T2 posterior spinal fusion on 4/30/26 for acute 3-column fracture of C6, performed by Neurosurgery following mechanical fall with non-displaced cervical fractures at C6 and C7. The note also stated the visit was an acute visit as she was new to the skilled nursing facility service following recent hospitalization and spinal surgery. The nurse practitioner noted the resident was hospitalized from [DATE] until 5/12/26 after presenting to the emergency department with neck pain following a mechanical fall. Neurosurgery was consulted and she underwent C4 to T2 posterior fusion on 4/30/26. The nurse practitioner further noted that the resident was found to be clinically stable on the day of discharge from the hospital with no acute symptoms compared to prior and had follow-up appointments scheduled with ophthalmology, cardiology, and orthopedics. She noted under the integumentary(skin) portion of the note, that the resident's skin was warm and dry with no warmth or erythema.An advanced skilled nurse evaluation note dated 5/13/26 03:52AM written by Nurse #8 noted she had a skin issue described as posterior neck surgical wound which was present on admission, with 18 staples. The note did not contain any other information regarding the incision.A review of advanced skilled nurse evaluation, written by Nurse #9 which was dated 5/13/26 at 11:55AM revealed she noted the surgical wound described as skin issue to the posterior neck, containing 18 staples that were present on admission. No other information regarding her skin or the wound was noted.A review of Resident #1's telehealth provider visit dated 5/13/26 at 8:49PM, written by the telehealth physician contained no information regarding her surgical history or her surgical wounds containing staples. That note did not contain a skin assessment. An advanced skilled nurse evaluation note dated 5/14/2026 at11:32AM written by Nurse #10 noted she had the skin issue described as posterior neck surgical wound, which was present on admission, with 18 staples. That note did not contain any other information regarding the incision or a skin assessment.A review of an (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	advanced skilled nurse evaluation written by Nurse #8 on 5/14/26 at 11:32AM noted Resident #1 had a surgical wound described as skin issue to the posterior neck, containing 18 staples that were present on admission. That note did not contain a skin assessment or any other details regarding the resident's wound.Review of an encounter note written by the facility Nurse Practitioner, dated 5/15/25, revealed Resident #1 had a past surgical history of C4 to T2 posterior spinal fusion on 4/30/2026 for acute 3-column fracture of C6, performed by Neurosurgery following mechanical fall with non-displaced cervical fractures at C6 and C7. In the history of present illness, it noted the resident was a [AGE] year-old Caucasian female with a complex medical history including non-displaced fracture of 6th cervical vertebrae. Under Integumentary it was noted her skin was warm and dry, no warmth, no erythema (redness).An advanced skilled nurse assessment dated [DATE] at 11:03AM written by Nurse #9 noted Resident #1 had skin issue described as posterior neck surgical wound, which was present on admission, with 18 staples. No other skin assessment or description of the wound available with that note.A review of an advanced skilled nurse assessment dated [DATE] at 5:44PM written by Nurse #11stated Resident #1 had a skin issue described as posterior neck surgical wound which was present on admission, with 18 staples. That note did not contain any other information regarding the incision. A review of the admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact with no behaviors present. Resident #1 was dependent for toileting hygiene and showering, otherwise required supervision or set up assistance for all other ADLs and bed mobility. Resident #1 used a walker. She was noted to have a surgical incision. The resident was also coded for having a feeding tube from which she received 51% or more of her caloric intake through. Review of the care plan dated 5/31/26 Resident #1 had a focus listed for surgical wound management. The goals included the wound will be free of signs or symptoms of infection and would show signs of improvement. The intervention listed was to paint with betadine to posterior neck every day. She was also noted to be at risk for falls due to impaired mobility, recent hospitalization, and fracture of her cervical vertebra. The goal was to have no falls. Interventions included to provide education for safe techniques, educate the resident regarding the use of the call light, and provide verbal cues for safety and sequencing when needed.During an interview with Resident #1's son and daughter-in-law on 6/8/26 at 2:30PM, they stated that they were concerned that the resident had no follow up appointment scheduled to see the Neurosurgeon and no plan to remove the staples from the resident's surgical incision. Her daughter-in-law stated that the Neurosurgeon was very involved and she was sure he would want to see the resident. She further stated that she would think the staples would be very uncomfortable. The resident stated they had been in there so long she hardly noticed them anymore. The daughter-in-law pointed out that the resident was ?not a complainer'.An interview was obtained with the Wound Care Physician and Wound Care Nurse on 6/9/26 at 2:00PM. The Wound Care Physician stated he was not worried about Resident #1's surgical incision because he had seen it and everything looked great. He further explained the wound edges were approximated there were no signs or symptoms of infection. The Wound Care Physician stated the staples were fine, and could stay there for 6 months. Surveyor clarified with Wound Care Physician that he would recommend Resident #1's staples stay in for 6 months? He stated, not necessarily, that would not be the normal practice. He stated Resident #1's staples could be in a couple weeks up to a couple months. He stated it would just depend on when the Neurosurgeon wanted them out, but they weren't hurting anything. The Wound Care Physician stated he could take them out on a follow up visit, but that the Neurosurgeon may want to be the want that wanted to remove them. The Wound Care Nurse stated it would have been the responsibility of the admitting nurse to find out when the staples needed to be removed and if there was no guidance from the discharge paperwork from the hospital, it would have been their responsibility to follow up with the Neurosurgeon. The Wound Care Physician stated the Neurosurgeon needed to be contacted to find out if he wanted to see the resident or when he wanted them removed, but from an infection standpoint the wound looked good. He further stated that from a comfort standpoint, the staples may (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be uncomfortable.During an interview with the Director of Nursing (DON) on 6/9/26 at 2:20PM, she revealed that she was not sure when the staples in Resident #1's neck were supposed to be removed as there was not a scheduled follow up made for the resident to see the Neurosurgeon. She stated if there was no follow up appointment listed on the resident's discharge summary from the hospital, then she expected the facility staff including the admitting nurse, other staff nurses, providers, and herself to have caught that and called the Neurosurgeon's office to get an appointment made. She further explained from her nursing opinion, staples would not normally be left in longer than 14 days. She stated she would make sure she got ahold of the Neurosurgeon's office immediately. An interview with the DON on 6/9/26 at 4:15PM revealed the scheduler was able to call the Neurosurgeon's office and was told to leave Resident 1's staples in place and they wanted to see her in their office. The DON stated the appointment was scheduled for the next day (9/10/26 at 8:40AM).A telephone interview was conducted on 6/10/26 at 2:40PM with Nurse #10 revealed she was not aware that Resident #1 did not have a follow-up appointment with Neurosurgery scheduled. She stated she would have made scheduling aware if she realized, but that task was usually taken care of upon admission to the facility. She stated she was not aware that the resident's staples had been in since 5/4/26. An interview with the Neurosurgery Office Nurse was conducted on 6/10/26 at12:27PM revealed that they generally remove staples 2 weeks post-op (after operation). She stated she would have expected that information to be stated on the residents' hospital discharge paperwork, but if it wasn't she would have expected the facility to reach out to their office to ask. She stated there was no record of the facility contacting them regarding Resident #1 until 6/9/26.During an interview on 6/10/26 at 2:00PM with the Medical Director, she stated that removal of surgical wound staples could vary depending on the surgeon. She further explained that surgeons often prefer to remove their own patient's staples. She stated generally, they are removed after 14 days. She stated her expectation would have been that facility staff would have reached out to the surgeon's office to get guidance on the staple removal within 14 days of her admission to the facility. An interview was obtained with Nurse #9 on 6/10/26 at 2:40PM that revealed she was not aware that Resident #1 had no follow up appointment scheduled with her Neurosurgeon. She stated that was usually taken care of right away when the residents are admitted to the facility. She stated she did not admit the resident so she was not aware of what the discharge paperwork from the hospital would have included. She stated was not aware the staples had been present in her neck since 5/4/26.An observation and interview were completed on 6/10/26 at 3:00PM with Resident #1. The surgical incision no longer had staples present and there was no drainage, swelling, or redness noted. The resident stated the first 2 staples hurt when being removed but she could hardly feel the rest being removed.An attempt for an interview with Nurse #8 (who admitted Resident #1 to the facility who was no longer employed at the facility) was made on 6/10/26 at 3:15PM. No return phone call was received. On 6/10/26 at 3:53PM a request for information was sent to the Neurosurgeon via fax. There has been no reply as of 6/19/26.An interview was conducted on 6/11/26 at 8:19AM with the Medical Records and Transportation staff member. She stated when a resident was admitted to the facility, her process was to look at all paperwork, but she primarily focused on the after-visit notes, appointment paperwork, and discharge summary. She further explained anytime there was an appointment noted on the paperwork she would have immediately made the arrangements for that appointment. She stated sometimes the paperwork may not contain a specific appointment date but may have included follow up with surgeon and she would then call them and make the appointment herself. She stated Resident #1's paperwork did not say that she had staples and she had not seen the resident personally, so she did not know that she needed an appointment to address staples. She stated she was not medical so she relies on the nurses to tell her if there was a particular appointment she would need to make in that situation. She stated as soon as she was told by the DON (on 6/9/26) to make an appointment for Resident #1, she immediately called the Neurosurgery office and was able to get her in for an appointment right away the next day. She revealed she asked the Neurosurgery office staff why Resident #1 did not have any follow-up appointments scheduled and was told because nobody at the facility made one.

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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 observation, record review, resident and staff interviews, the facility failed to provide personal care in a safe manner when Resident # 44 was left unattended in shower room with the side rails on shower stretcher left in down position. Resident #44 rolled off the right side of shower stretcher and required transfer to the hospital for medical evaluation. This was for 1 of 4 residents reviewed for accidents (Resident #44).Findings included: Resident #44 was admitted to the facility on [DATE]. The residents' diagnoses included Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness of one side of the body) following Cerebral infarction (ischemic stroke) affecting left non-dominant side, and contractures of left wrist and hand. A quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #44 was cognitively intact and had range of motion impairment on one side of his upper and lower extremities. The MDS also indicated Resident #44 was dependent rolling left and right.Resident #44's care plan dated on 12/10/25 revealed a focus area of risk for falls: Impaired mobility, cognitive loss, history of Stroke with left Hemiplegia. Interventions included provide verbal cues for safety and sequencing. An additional focus that was included was Resident #44 requires assistance with Activities of Daily Living (ADL), bathing, personal hygiene due to impaired balance due to history of Stroke with left Hemiplegia. Intervention included Resident #44 prefers showers on scheduled bathing days with the use of shower bed/stretcher for shower and provide dependent assist of one for personal hygiene and bath.An interview with Resident #44 on 6/9/2026 at 2:15 PM was completed. Resident #44 stated that he had a fall in the shower room and ended up on the floor lying on his back. Resident #44 was unable to recall the date of his accident and stated it was a couple of months ago. Resident #44 stated the Nurse Aide (NA) that was giving him his shower left the shower room to go get a towel. He stated he was left unattended in the shower room. Resident #44 stated he felt like he was slipping and when he tried sliding to the left towards the wall, he fell off the right side of shower stretcher on to the floor. Resident #44 was unsure how long he was on the floor but stated he thought it was less than two minutes. Resident #44 stated he remembered being in pain and uncomfortable. Resident #44 could not recall what pain level he reported at the time of the accident. Resident #44 stated he had pain in his head, hip and neck. He could not recall if he hit his head on anything. Resident #44 stated that it was usually just one staff member that gave him a shower. Resident #44 revealed that the rails were down on the shower stretcher when the NA left and normally when he receives a shower the rails are up. Resident #44 was unsure why the shower stretcher rails were down and was unable to recall the name of the NA providing the care. Nurse #1 was interviewed 6/9/2026 at 4:13 PM and stated she was working the day the accident occurred. She stated she had gone to lunch and when she returned, she was informed by Nurse #6 that Resident #44 was on the floor of the shower room. Nurse #1 stated she and Nurse #6 completed skin check, pain assessment, change in condition and fall risk evaluation. Nurse #1 stated she completed the transfer form and sent it to hospital with Resident #44. Nurse #1 stated they used a mechanical lift to assist with getting Resident #44 off the shower floor and back stretcher and to transfer from shower stretcher back to bed. Nurse #1 stated she notified the Physician and orders were completed for Resident #44 to be transferred to the emergency room (ER) for further evaluation. Nurse #1 stated there were no findings and Resident #44 was transported back to the facility. She stated that Resident #44 was compliant with care and does not have a history of attempting to get up and walk without assistance. Observation on 6/9/2026 at 4:20 PM of the shower room and shower stretcher was completed with interview with Nurse #1. The shower stretcher was up against the wall to the left of the door. The Shower stretcher was approximately 3 feet in height. Nurse #1 stated Resident #44 was lying to the right of the shower stretcher on the floor approximately 2 feet from the shower stretcher. Nurse #1 stated Resident #44 was found lying on his (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back.Attempted phone contact was made on 6/9/2026 at 6:20 PM with NA #9. NA #9 was providing care to Resident #44 at the time of accident. NA#9 refused interview and is no longer an employee at the facility. Nurse #6 was interviewed on 6/10/2026 at 11:30 AM. Nurse #6 has been working at the facility for 14 years. She stated she recalled working with Resident #44 on the day of the accident. Nurse #6 stated she was the weekend supervisor that weekend. She stated that NA#9 that gave Resident #44 a shower notified her that Resident #44 was on the floor. She stated that when she went to the shower room Resident #44 was lying on his back and stated that he was trying to roll over and fell off the shower stretcher. Nurse #6 stated the rails on the shower stretcher should have been up but had been left down. Nurse #6 stated she and Nurse #1 completed assessments on Resident #44 and notified the Physician. After talking with physician, they got Resident #44 ready for transportation to the ER. Nurse #6 stated immediate training was provided to staff for safe resident handling, how to use a shower stretcher, with demonstrations provided and neglect. Nurse #6 stated that administrative staff had all come into facility that day. She stated that the Administrator and DON were the ones providing the training. Nurse #6 stated she assisted with the skin checks on the residents who were not alert and oriented. She stated there were no findings with the skin assessments completed on cognitively impaired residents. A review of the incident report dated 1/17/2026 at 11:04 AM was completed. The incident report was completed by Nurse #1 and revealed that Resident #44 received assistance with bathing by Nursing Assistant(NA) #9. NA #9 stated she left the shower room, leaving Resident #44 unattended, to get a towel. NA #9 stated as she re-entered the shower room, she observed resident #44 on the floor. Resident #44 was complaining of pain in his head, hip and neck. Nurse #1 contacted on-call provider and orders were received for Resident #44 to be sent to the local hospital for further evaluation. Resident #44 was transported to local hospital. A review of an emergency department report dated 1/17/2026 revealed Resident #44 was transported for evaluation following an unwitnessed fall at the facility. Resident #44 was alert and oriented and complained about head, hip and neck pain. Extensive imaging studies were performed to evaluate Resident #44 for any fractures. Two Computed Tomography (CT) scans revealed no cervical concerns and no concerns with swelling with the prevertebral soft tissue. All these imaging studies were negative. Resident #44 was transported back to the facility on 1/17/2026 with no new orders. The Social Worker was interviewed on 6/10/2026 at 11:40 AM and stated she was not at the facility at the time of the accident but did come to facility to assist with the interviews with the alert and oriented residents. Interviews were completed with residents that had a Brief Interview for Mental Status (BIMS) for 12 or higher. The Social Worker stated there were no findings with the interviews conducted. She stated she could not recall the details of the accident. An interview with the Physician was conducted 6/10/2026 at 1:47 PM. She stated she remembered being notified of the fall and giving orders to have Resident #44 transported to the ER for further evaluation. The Physician stated she recalled Resident #44 was evaluated and there were no injuries and Resident #44 was transported back to the facility. She stated the staff were trained, the equipment was working properly, and she felt this was an isolated accident that unfortunately occurred. There were no new orders from this accident. An interview with the Maintenance Director was conducted 6/11/2026 at 10:22 AM. The Maintenance Director confirmed that there was nothing wrong with the shower stretcher. He stated all shower stretchers and chairs were evaluated on the day of the accident and all were in working order. He stated the shower stretcher and chairs are checked monthly. The Maintenance Director stated the accident was not due to the equipment, the shower stretcher being used at the time of the accident was in working order and the side rails were working.An interview with the DON was completed on 6/11/2026 12:02 PM and she stated she was called and notified of the accident. She stated she came to the facility immediately to begin working in the report and training with the staff. She stated the training that was provided was safe resident handling, how to use a shower stretcher with completed demonstrations and resident neglect. The DON stated she did not think NA #9 left Resident #44 unattended thinking Resident #44 would fall. The DON was unsure (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why NA #9 did not raise the rails on the shower stretcher. The DON confirmed that staff were trained to not leave residents in shower rooms unattended.Observation of a shower stretcher like the one used at time of accident was completed 6/11/2026 at 1:59 PM. The shower stretcher had workable side rails that would rise and lower, the wheels would lock in place and also included safety pins to secure the position of the side rails when raised. The facility implemented the following Corrective Action Plan with a compliance date of 1/17/2026. 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 01/17/2026, resident #1 received assistance with bathing by Certified Nursing Assistant #1 (AS). Resident #1 was care planned dependence of 1 staff member for bathing. Certified Nursing Assistant #1 stated she entered the shower room with resident #1 to give him a shower via a shower bed. Certified Nursing Assistant #1 assisted resident #1 with shaving and bathing. Certified Nursing Assistant #1 stated she left the shower room, leaving resident #1 unattended, to get linen. Certified Nursing Assistant #1 stated as she re-entered the shower room, she observed resident #1 on the floor. Certified Nursing Assistant #1 immediately notified the nurse. Nurse #1 assessed resident #1 and noted bleeding on his right third and fourth toe. Resident #1 noted his pain as a 5 to his hip, head and neck. Vital signs were obtained by Nurse #1 and noted as within resident #1 baseline. Nurse #1 contacted on-call provider on 01/17/2026 at 11:00AM and ordered resident #1 to be sent to the local hospital for further evaluation. Nurse #1 contacted resident #1 responsible party on 01/17/2026 at 11:15AM. Resident #1 was transported to the local hospital. The Administrator notified the facility Medical Director of resident #1 fall. An interview with Resident # 1 was conducted by the Registered Nurse Weekend Supervisor. Residents # 1 stated he was laying on the shower stretcher. Resident #1 stated he was attempting to turn on his left side and fell onto the floor from the shower stretcher. An x-ray of resident #1 pelvis was obtained at the local hospital on [DATE]. The x-ray results indicated no acute fracture or dislocation. Computed Tomography (CT) of resident #1 head and spine was obtained at the local hospital on [DATE]. The CT results did not indicate a fracture or intracranial abnormality. Resident #1 returned to the facility on [DATE] with no new orders. On 01/17/2026, the Administrator submitted an initial allegation report to the North Carolina Division of Health Service Regulation, local police department, and local adult protective services. On 01/17/2026, root cause analysis identified Certified Nursing Assistant #1 did not ensure resident safety by providing supervision during resident #1 shower leading to the fall. On 01/18/2026, the Administrator submitted a five-day allegation report and investigation summary to the North Carolina Division of Health Service Regulation. Certified Nursing Assistant #1 was placed on administrative leave on 01/17/2026 pending investigation. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?The Director of Nursing and / or designee completed care plan reviews to identify residents in the facility that require assistance with bathing by 01/18/2026. Resident #1 care plan and Kardex was updated to reflect assistance required by 01/18/2026.By 01/17/2026, The Director of Nursing / designee conducted an audit of all falls in the last 60 days to ensure no falls with injury occurred during resident bathing. No concerns noted during the audit. On 01/17/2026, the Administrator and Assistant Administrator conducted a 90 day look back utilizing an audit tool of resident grievances / incidents and accident logs to ensure no concerns were identified related to resident transfers while utilizing a mechanical lift as well as no resident concerns related to staff not providing supervision while bathing while using a shower bed / in a shower room. No concerns were identified. The Maintenance Director conducted an audit of all facility shower chairs and shower stretchers to ensure all shower chairs and shower stretchers are equipped with safety mechanisms per manufacturers instructions on 01/17/2026. No issues identified. On 01/17/2026, the Social Worker conducted interviews with alert and oriented residents that scored a 13 or higher on the Brief Interview of Mental Status (BIMS) evaluation to ensure residents that require a mechanical lift for transfers with 2 staff assistance and residents that require assistance with bathing have staff present in the shower room. No issues identified. 3. What measures will be put into place or systemic changes made to ensure that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the deficient practice will not occur? On 01/17/2026, the Director of Nursing and / or designee-initiated re-education to licensed nurses and certified nursing assistants on the facility's safe resident handling program to include level of staff assistance required during resident bathing, where to locate individual resident assistance required on care plan and to remain in the shower room during the resident's shower. Licensed Nurses and Certified Nursing Assistants provided return demonstration for utilization of shower chairs and stretchers and completed Safe Resident Handling: Learner Assessment post test. Any nurse and / or certified nursing assistant that did not receive education on 1/17/26 was identified and will receive education and conduct a return demonstration for utilization of shower chairs and stretchers and complete Safe Resident Handling: Learner Assessment post test prior to their next scheduled shift by the Director of Nursing and or Unit Manager Beginning on 1/18/26, The Director of Nursing / Nursing Supervisor will conduct random quality monitoring of 5 nursing staff member observations during resident showers to ensure staff members are providing the required assistance indicated on the resident care plan and that the staff member(s) remain in the shower room during the residents shower, that shower equipment is fully operational on 1st and 2nd shifts, 3x per week for 4 weeks, then 2x per week for 4 weeks, then 1x per week for 4 weeks.Beginning on 1/18/26, The Administrator / Designee will conduct random quality monitoring of all shower chairs and shower stretchers to ensure safety equipment (safety belts and foot rests for shower chairs and safety pins for shower stretchers) are properly installed and in working condition 3x per week for 4 weeks, then 2x per week for 4 weeks, then 1x per week for 4 weeks. An in-prompt QAPI meeting was on 01/17/2026 by the Administrator and Assistant Administrator to discuss the plan of correction and corrective measures for the deficient practice.All newly hired Licensed Nurses and Certified Nursing Assistants to include newly hired Agency Licensed Nurses and Agency Certified Nursing Assistants will be educated during new hire orientation on the facility's safe resident handling program to include level of staff assistance required during resident bathing, where to locate individual resident assistance required on care plan and to remain in the shower room during the resident's shower and the facility's abuse prohibition policy with an emphasis on neglect and who to report to and timeframes of reporting by the Director of Nursing and / or Nursing Supervisor. 4. How will the facility monitor its corrective actions to ensure the deficient practice will not recur?The results of the quality monitoring will be brought to the monthly Quality Assurance meeting to ensure compliance of resident safety x 3 months. The improvement-monitoring schedule will be modified based on the findings of monitoring. The results of the quality monitoring will be reviewed at the monthly QAPI meeting for 3 months to sustain substantial compliance. Allegation of Compliance Date: 01/19/2026 The Corrective Action plan was validated by reviewing the completed audit of all shower/bathing equipment. Observations of shower stretchers and chairs were completed. A review of staff training and staff interviews were completed confirming the education provided for the safe handling program. A review of the monthly quality monitoring documentation was completed. The correction date of 1/19/2026 was validated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to secure a bottle of prescription eye drops that was left unattended on top of the second-floor medication cart for 1 of 5 medication carts reviewed for medication storage (second floor medication cart).The findings included:A continuous observation was conducted on 6/9/26 from 9:15 AM to 9:18 AM. During that time, the second-floor medication cart parked outside of room [ROOM NUMBER], contained a bottle of prescription eye drops (timolol, used to reduce high pressure in the eye) that were sitting on top of the cart. The cart was unattended and an observation of the hallway revealed the nurse for this cart (Nurse #7) was not present in the hallway. Also, at 9:15 AM Unit Manager #1 walked past the medication cart but did not acknowledge or remove the prescription eye drops. There were 2 residents observed sitting in the hallway in the vicinity of the medication cart during the observation. On 6/9/26 at 9:19 AM Nurse #7 returned to the medication cart and stated she would not normally leave medications on top of the cart. She stated another resident was going to be leaving for an appointment, so she went to his room to give him his medications before he left. Nurse #7 stated she should have put the medication (eye drops) back inside the medication cart.During an interview on 6/9/26 at 9:20 AM with Unit Manager #1, she revealed she did not notice the prescription eye drops sitting on the medication cart when she walked by or she would have removed it. Unit Manager #1 stated the expectation would be that the nurse put the medication back in the medication cart before leaving the medication cart. An interview was conducted on 6/9/26 at 9:36 AM with the Director of Nursing (DON). She stated she would expect the nurse to complete the medication pass first, but if she had to leave her medication cart, she would expect the nurse to put the medication in the cart before leaving the cart.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and resident and staff interviews, the facility failed to provide food that was palatable in taste and temperature. The deficient practice affected 3 of 3 residents reviewed for food (Resident #14, #83, and #139). Findings included:1a. On 6/7/26 at 9:10 am during the initial kitchen observation, there were two carts of breakfast trays returned to the kitchen for washing. Several of the plates had what appeared to be French toast that was dark brown with shriveled edges that was not eaten or had bites taken. The toast felt hard when touched.On 6/7/26 at 9:12 am kitchen staff #1 was interviewed. She stated the carts were breakfast trays returned from this morning. She had no comment regarding the French toast that was not eaten and returned on the tray nor its consistency. On 6/7/26 at 9:15 am the cook was interviewed. The cook stated she prepared the breakfast which included French toast and had no comment about the toast. Resident #14 was admitted to the facility on [DATE]. Resident #14's quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact.The diet order for Resident #14 was regular, liberalized.On 6/7/26 at 9:30 am an interview and observation were completed with Resident #14. The resident stated her breakfast tray was delivered at approximately 8:45 am and her French toast was burnt, and she could not eat it. The toast was observed to be dark brown and dry in appearance. The resident stated the food frequently does not taste good. The food can be cold, dry and overcooked. On 6/8/26 at 10:00 am an interview was conducted with Resident #14. The resident stated she had sausage this morning that was overcooked and hard. The resident could not cut the outer edge of the sausage with the knife and could not eat it. The resident further commented that the sausage was frequently burned, and she had informed the nursing assistant when the trays were picked up after breakfast.b. Resident #83 was admitted to the facility on [DATE].Resident #83's quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact.The diet order dated 4/29/26 for Resident #83 was regular, liberalized.On 6/7/26 at 9:40 am an interview was completed with Resident #83. The resident stated the food was frequently overdone, dry, sometimes cold, and doesn't taste good. The resident commented she does not want the alternate, she wants her food cooked appropriately. The resident further commented that just this morning the French toast was badly burned and not edible and the breakfast sausage was consistently burned, dry, and hard.c. Resident #139 was admitted to the facility on [DATE].The quarterly Minimum Data Set, dated [DATE] for Resident #139 documented that he was cognitively intact.The diet order dated 3/18/26 for Resident #139 was regular, liberalized.On 6/7/26 at 10:06 am Resident #139 was interviewed. He stated the food was horrible and often not edible. Resident #139 had around 300 pictures of food in his phone that had been served at the facility. The most current picture was the breakfast served on this day 6/7/2026, which was French toast and cereal. The toast in the picture was observed to be dark in color and very flat and shriveled in the center. The resident stated he was unable to cut the toast and did not eat it.On 6/7/2026 at 1:36 pm Resident #139 was interviewed. He did not eat the facility lunch provided; he obtained a sandwich from outside the facility. The facility does have ham sandwich as an alternate, but the resident does not like their ham.On 6/8/2026 at 8:59 am Resident #139 was observed to be eating cereal at this time. The resident had two sausage patties on his plate for breakfast. He picked up one of two circular sausage patties and started shaking it. The sausage patty appeared firm like rubber and had shriveled edges. The resident attempted to cut a sausage patty with a fork and was unable to. The sausage patty had dark brown edges that appeared about 1 inch and then lighter brown towards the center. On 6/9/2026 at 10:30 am Resident #139 was observed to be sleeping in his room. The breakfast tray was observed sitting on the bed table. The eggs and cereal appeared to have been mostly eaten. The sausage patties remained, had the same overcooked appearance and were left uneaten. On 6/7/26 at 10:45 am an interview was completed with the Dietary Manager (DM). The DM was informed of the residents' food concerns including cold and overcooked food. The DM stated he (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had not observed the French toast and the cook was new. He was unaware that the residents had reported food palatability concerns regarding flavor, temperature, and overcooked food.On 6/09/26 at 1:16 pm a lunch test tray with the DM was completed. The test lunch tray was the last one to be delivered. The lunch included potato wedges, sloppy joe sandwich on a bun, salad with cheese shreds, and a dessert. The sloppy joe was of good texture and taste and warm enough to enjoy. The salad appeared wilted. The potato and dessert appeared tasteful. The DM was interviewed and commented that hot food affected the cold food's temperature after being plated and placed into the closed transport tray cart. The rise in temperature during transport in the closed cart was seen with ice cream also which started to melt by the time it reached the resident. On 6/11/26 at 11:45 am the Administrator was interviewed. The Administrator was informed of the residents' food concerns and the observations of food provided. The Administrator had no comment.