STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345180	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Pines Retirement Community	1000 Wesley Pines Road Lumberton, NC 28358

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, Nurse Practitioner, and staff interviews the facility failed to notify the Physician when nursing staff were not following a physician order for daily administration of one capsule of Linzess (a medication for long-lasting or chronic constipation from unknown reasons) and were administering 3 capsules of Linzess twice weekly per the resident's request for 1 of 1 resident reviewed (Resident #19). Findings included: Resident #19 was admitted to the facility on [DATE]. Diagnoses included chronic idiopathic (unknown reason) constipation, and gastroparesis (food and liquid remaining in body for prolonged period of time). The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #19 was cognitively intact. An observation was conducted on 01/27/26 at 1:30 PM of Resident #19's room. It was observed there was a medication cup filled with 3 capsules sitting on her bed whilst she sat in her wheelchair to the right of the bed. An interview was conducted with Resident #19 on 01/27/26 at 1:30 PM. Resident #19 was alert and oriented and reported that the three capsules in the medication cup was her Linzess and they were for her to take to help move her bowels due to her rectal paralysis. A Physician's order written on 04/16/25 revealed Linzess 290 micrograms (mcg) one capsule by mouth daily on Sunday, Monday, Tuesday, Wednesday, Thursday, and Friday and Linzess 290 mcg one capsule by mouth daily on Saturday. Review of the Medication Administration Record from 01/01/26 through 01/28/26 revealed the Linzess 290 mcg one capsule was being signed off as administered daily between 7:00 AM and 11:00 AM on Sunday, Monday, Tuesday, Wednesday, Thursday and Friday as evidenced by nursing initials. A follow up interview was conducted with Resident #19 on 01/28/26 at 3:50 PM. Resident #19 revealed she did not take the Linzess capsule daily. Resident #19 explained that the nursing staff put the daily capsule in an empty medication bottle which was on her bedside table and that there was one capsule of Linzess in the bottle now. She stated on Tuesdays and Fridays, the nursing staff would take the 3 tablets out of that bottle and place them in a medication cup and leave them in her room for her to take at 4:50 PM. An interview was conducted with Nurse #1 on 01/28/26 at 4:05 PM. Nurse #1 stated she was aware that Resident #19 was requesting that the nursing staff (including herself) put the Linzess capsule in an empty bottle kept on her bedside table daily. Nurse #1 stated Resident #19 expressed that she wanted to take 3 capsules of her Linzess on Tuesdays and Fridays instead of one capsule daily. Nurse #1 stated Resident #19 was insistent on taking her Linzess this way and that was why it was administered it that way. Nurse #1 stated she should have notified the Physician or Nurse Practitioner that Resident #19 was refusing the ordered dose of one capsule daily of the Linzess and wanted to take 3 capsules twice weekly instead. Nurse #1 stated she should have notified the provider instead of honoring Resident #19's request. An interview was conducted with Medication Aide #1 on 01/29/26 at 7:30 AM. Medication Aide (MA) #1 stated she placed the Linzess capsule in a bottle that was kept on Resident #19's bedside table whenever she worked. MA #1 stated if she was assigned to Resident #19 (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on Tuesdays and Fridays, she would remove the capsules from the bottle that they were stored in and put them in a medication cup in the morning for Resident #19. MA #1 reported that on Tuesday 01/27/26 she put the 3 tablets from the bottle in the medication cup for resident #19. MA #1 stated she never questioned the physician order and should have because it was not being given as written. MA #1 added she would not have been responsible notifying the Physician or Nurse Practitioner because the nurses were responsible for notifying them. An interview with Medication Aide #2 on 01/29/26 at 8:40 AM revealed she had worked for the facility for 4 years and since she has been here, she has been leaving the Linzess capsule in an empty bottle on her bedside table. MA #2 stated Resident #19 liked to take all 3 capsules together and that was how she requested it. MA #2 stated she should have notified the Director of Nursing about the way this medication was being administered because the way Resident #19 was taking it was not how the order was written. MA #2 stated she would not have notified the Physician or Nurse Practitioner because the nurses were responsible for notifying them. An interview with Nurse #4 on 01/29/26 at 8:40 AM stated she had been working at the facility on and off for several years and Resident #19 had been taking the 3 capsules of Linzess every Tuesday and Friday for as long as she could remember. Nurse #4 stated Resident #19 was very adamant about the way she wanted to take her medications. Nurse #4 stated she knew that administering 3 capsules twice weekly instead of one capsule daily as ordered was wrong and she should have notified the Physician or Nurse Practitioner that Resident #19 refused to take the Linzess daily and wanted to take it twice weekly. An interview was conducted with the Director of Nursing (DON) on 01/28/26 at 4:30 PM. The DON revealed she had no knowledge that the nurses and medications aides were leaving the Linzess capsule in an empty bottle in Resident #19's room instead of administering the medication daily as ordered nor did she have any knowledge that Resident #19 was taking 3 capsules twice weekly. She stated had she known Resident #19 was refusing to take the medication as ordered, she would have consulted the Nurse Practitioner to see if the order could be revised to meet the residents' needs. The DON stated she expected the nurses to notify the Physician or Nurse Practitioner if a resident was consistently refusing to take a medication as ordered. An interview was conducted with the Nurse Practitioner on 01/29/26 at 10:15 AM. The Nurse Practitioner stated she was made aware by the DON on 01/28/26 that Resident #19 was taking 870 mcg of Linzess twice per week instead of 290 mcg daily as ordered. The Nurse Practitioner stated she had no knowledge that Resident #19 was taking the medication this way. The Nurse Practitioner stated the biggest risk of taking this high of a dose of Linzess twice per week was dehydration and that had she been made aware of Resident #19's request and how the nurses were administering Resident #19 this medication, she would have intervened much sooner and revised the bowel regimen with another type of laxative that would have been safer and stronger for her. The Nurse Practitioner stated she would have expected the nursing staff to have notified her of the refusal of the daily dose of Linzess, and added, that it was not up to the nursing staff to administer the medication the way Resident #19 requested instead of how it was ordered.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, resident, Consulting Pharmacist and Nurse Practitioner interviews, the facility failed to follow a physician's order as written to administer Linzess (a medication for chronic constipation) daily for 1 of 1 resident reviewed (Resident #19). The nursing staff were dispensing the medication into a bottle on Resident #19's bedside table labeled with a different medication name and then Resident #19 was taking the 3 capsules of the medication on Tuesdays and Fridays. (Resident #19 was not assessed to be able to self-administer medications). Findings included: Resident #19 was admitted to the facility on [DATE]. Diagnoses included paraplegia, contractures to right and left elbow/hand wrist, chronic idiopathic (unknown reason) constipation, and gastroparesis (food and liquid remaining in body for prolonged period of time). Review of the self-administer medication assessment written on 02/10/23 revealed Resident #19 was assessed to self-administer medication and it was determined that she was not able to self-administer medication. This assessment was updated and last reviewed on 01/07/25. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #19 was cognitively intact, demonstrated no behaviors during this assessment and was frequently incontinent of bowel and bladder. She was coded as having range of motion impairments to upper and lower extremities. Resident #19's care plan dated 12/03/25 revealed refusal of medications and care at times per resident's choice/routine. History of refusing medications. Resident was aware of the importance of complying with physician orders, however, had a routine that she followed which caused her to refuse medications and care at times. Resident was at risk for constipation related to impaired mobility. Resident had stated that she usually wanted a laxative once a week even if bowel movement has happened in 3 days and would only take laxatives as she desired. An observation was conducted on 01/27/26 at 1:30 PM of Resident #19's room. It was observed there was a medication cup filled with 3 capsules sitting on her bed whilst she sat in her wheelchair to the right of the bed. Resident #19 was noted to have bilateral hand and wrist contractures. An interview was conducted with Resident #19 on 01/27/26 at 1:30 PM. Resident #19 was alert and oriented and reported that the capsules in the medication cup were for her to take to help move her bowels due to her rectal paralysis. Resident #19 explained that the nursing staff left the cup at the bedside on Tuesday and Friday mornings for her to take at 4:50 PM on these days. Resident #19 was asked how she took the medications and she demonstrated (using her head since she was not able to her hands) bending her head toward the medication cup on the bed, picking up the medication cup with her mouth, and emptying the pills into her mouth without the use of her hands. Resident #19 stated she took 3 capsules of Linzess (a medication for adults with long-lasting or chronic constipation from unknown reasons) on Tuesdays and Fridays at 4:50 PM and then at 1:30 AM on Wednesday and Saturday the night nurse administered her Magnesium Citrate (a supplement and laxative to help with constipation). Resident #19 explained that Tuesday and Friday were her hydrate days and she drank a lot of water on these days to help loosen her stools. She stated she had been doing this bowel regimen for years and it had been the best way for her to evacuate her bowels due to her rectal paralysis. Physician's orders written on 04/16/25 revealed the following: Linzess 290 micrograms (mcg) one capsule by mouth daily on Sunday, Monday, Tuesday, Wednesday, Thursday, and Friday. Linzess 290 mcg one capsule one capsule by mouth daily on Saturday. Magnesium Citrate Solution give 10 ounces by mouth 2 times a week with 8 ounces of water for constipation. A Physician's order written on 05/23/25 revealed the following order: Simethicone 180 milligrams take 2 capsules by mouth every 4 hours as needed for gas and bloating. Review of the Medication Administration Record from 01/01/26 through 01/28/26 revealed the Linzess medication was being signed off as (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered daily between 7:00 AM and 11:00 AM on Sunday, Monday, Tuesday, Wednesday, Thursday and Friday as evidenced by nurse initials and the Linzess medication was also being signed off as administered daily on Saturday as evidenced by nursing initials. Review of the Medication Administration Record from 01/01/26 through 01/28/26 revealed the Magnesium Citrate Solution 10 ounces by mouth was being administered on Wednesdays and Saturdays at 1:30 AM as evidenced by nurse initials. Review of the Medication Administration Record from 01/01/26 through 01/28/26 revealed the Simethicone medication had been given as needed as evidenced by nurse initials and time of administration. An interview was conducted with Nurse #1 on 01/28/26 at 3:40 PM. Nurse #1 reported she and Medication Aide (MA) #1 worked together to administer medications on this unit. She stated she was responsible for dispensing the medications in a medication cup and Medication Aide #1 would administer the medications to the residents. Nurse #1 stated she pulled the Linzess capsule for Resident #19 on 01/27/26 for MA #1 to administer. Nurse #1 stated she was not aware that Resident #19 did not take the Linzess from MA #1 and MA #1 never told Nurse #1 that Resident #19 did not take the medication or that she left the medication at her bedside. Nurse #1 stated Resident #19 did not have an order that she could self-administer medications due to her bilateral hand contractures. Nurse #1 stated she would have expected MA #1 to let her know that Resident #19 did not take the Linzess from the MA #1 at that time and that she left the medication at her bedside. A follow up interview was conducted with Resident #19 on 01/28/26 at 3:50 PM. Resident #19 revealed she did not take the Linzess capsule daily. Resident #19 explained that the nursing staff put the daily capsule in an empty medication bottle which was on her bedside table and that there was one capsule of Linzess in the bottle now. She stated on Tuesdays and Fridays, the nursing staff would take the 3 tablets out of that bottle and place them in a medication cup and leave for her to take at 4:50 PM. Resident #19 stated each Tuesday and Friday were her hydrate (drink a lot of water) days and she would drink water all day long because the medication worked by drawing fluid into the intestines to make stools softer and easier to pass. Resident #19 stated she took the medications at 4:50 PM because she wanted to hydrate all day and take it closer to the time she received her Magnesium Citrate. Resident #19 stated she had been doing this regimen for years and it was recommended by her Gastroenterologist (GI) doctor. During this interview, the Director of Nursing (DON) entered the room to discuss the administration of the Linzess medication with Resident #19. Resident #19 explained to the Director of Nursing how she took her Linzess. The Director of Nursing opened the medication bottle with the pink cap located on her bedside table and it was labeled Simethicone and there was one capsule of the Linzess medication in this bottle. The DON stated to Resident #19 that it was a huge no, no to have pills left in another pill container and that the nurses and medication aides should be making sure she took the medication as ordered and while in their presence. The DON stated to Resident #19 that she understood Resident #19 had a certain bowel regimen she wanted to follow that had been working but she (the DON) would have to check with the Nurse Practitioner to see if she could change the current order to take the Linzess 3 capsules on Tuesday and 3 capsules on Friday. Review of Resident #19's medical record revealed there was no order from Resident #19's Gastroenterologist (GI) Physician to take 3 Linzess capsules twice per week. A follow up interview was conducted with Nurse #1 on 01/28/26 at 4:05 PM. Nurse #1 stated she was aware that Resident #19 was requesting that the nursing staff (including herself) put the Linzess capsule in an empty bottle kept on her bedside table. Nurse #1 stated she should not have left the Linzess capsule in the empty Simethicone bottle at any point and neither should have Medication Aide #1 and when Resident #19 expressed that she wanted to take her Linzess capsules on Tuesdays and Fridays instead of daily, she should have explained the policy to Resident #19 and followed the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician order as written. Nurse #1 stated she had been placing the daily Linzess capsule in the bottle for a while and added she could not remember how long. Nurse #1 stated the resident was insistent on taking her Linzess this way and that was why she administered it that way. An interview with Nurse #3 on 01/29/26 at 7:15 AM revealed she worked night shift and she would administer the Magnesium Citrate at approximately 1:30 AM on Wednesday and Saturday mornings. Nurse #3 stated on Saturday AM when she brought in Resident #19's ordered Linzess, she would stay with the resident until she took the medication. Nurse #3 stated Resident #19 always asked Nurse #3 to put it in the bottle stored on her bedside table, but Nurse #3 stated she would never leave a medication in a different bottle in a resident's room and she always made sure residents took their medications, including Resident #19, as ordered before she left the room. An interview was conducted with Medication Aide #1 on 01/29/26 at 7:30 AM. Medication Aide #1 stated she had been working at the facility for 6 months. MA #1 stated she placed the Linzess capsule in a bottle that was kept on Resident #19's bedside table whenever she worked. MA #1 stated if she was assigned to Resident #19 on Tuesdays and Fridays she would remove three capsules from the bottle that they were stored in and put them in a medication cup in the morning for Resident #19 to take at a later time so that she could hydrate herself throughout the day before taking them. MA #1 stated she was told by the nurse that trained her (could not remember who it was) that was how Resident #19 took her Linzess. MA #1 stated she never questioned the physician order and should have because it was not being given as written. MA #1 thought that was the way the Linzess should be administered for this resident. MA #1 stated she should have questioned this process because she was trained as a Medication Aide to follow the physician's order. An interview with Medication Aide #2 on 01/29/26 at 8:40 AM revealed she had worked for the facility for 4 years and since she has been here she has been leaving the Linzess capsule in the bottle with the pink cap (Simethicone bottle). MA #2 stated on Wednesday and Saturday, Resident #19 received Magnesium Citrate on the night shift and on Tuesdays and Fridays she would take all 3 of her Linzess capsules. She stated she liked to take all 3 capsules together and that was how she requested it. MA #2 stated Resident #19 would hydrate all day long on Tuesdays and Fridays with water at her bedside and was able to drink her water because it was set up beside her on her bedside table and she was able turn her head and drink her water from a straw. MA #2 stated she should have asked the Nurse Practitioner or Director of Nursing about the way this medication was being administered because the way Resident #19 was taking it was not how the order was written. MA #2 stated that was how she was told to administer the medication from the nurses (She could not recall any specific nurse). An interview with Nurse #4 on 01/29/26 at 8:40 AM stated she had been working at the facility on and off for several years and Resident #19 had been taking the 3 capsules of Linzess every Tuesday and Friday for as long as she could remember. Nurse #4 stated Resident #19 was very adamant about the way she wanted to take her medications. Nurse #4 stated she knew that leaving the pills in the room was wrong and that she was not following the physician order as written and she should have been. An interview was conducted with the Director of Nursing on 01/28/26 at 4:30 PM. She stated she had no idea Resident #19 was taking her Linzess this way and that the nursing staff should have been following the order as written. She stated she spoke with the Nurse Practitioner and the Consulting Pharmacist regarding the Linzess and that Resident #19 was taking 870 micrograms twice per week instead of 290 mcg daily as ordered. An interview was conducted with the Nurse Practitioner on 01/29/26 at 10:15 AM. The Nurse Practitioner stated she was made aware by the DON that Resident #19 was taking 870 mcg of Linzess twice per week instead of 290 mcg daily as ordered. The Nurse Practitioner stated she had no knowledge that Resident #19 was taking the medication this way and spoke with the Consulting Pharmacist and the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility Physician on 01/28/26 regarding this dose and it was discussed that this dose exceeded the recommended dose. The Nurse Practitioner stated the biggest risk of taking this high of a dose of Linzess twice per week was dehydration. The Nurse Practitioner stated it was very important to hydrate while taking this type of laxative. The Nurse Practitioner stated had she been made aware of Resident #19's request and how the nurses were administering Resident #19 this medication, she would have intervened much sooner and revised the bowel regimen with another type of laxative that would have been safer and stronger for her. The Nurse Practitioner reviewed Resident #19's lab results to check for any indication of dehydration. The most recent labs ordered was on 10/27/2025, and the Resident's lab values to assess dehydration were all within in normal limits and did not indicate Resident #19 was dehydrated. The Nurse Practitioner stated she reviewed Resident #19's medical record and there was no order from the GI doctor to administer Linzess 3 capsules twice per week. She stated if the GI physician wanted her to take the medication that way, there would have been order for it. The Nurse Practitioner added, Resident #19 had not seen this GI doctor since 2019. The Nurse Practitioner added she was made aware by Resident #19 that she was doing more hydration on Tuesdays and Fridays and called them her hydration days. The Nurse Practitioner stated she would have expected the nursing staff to follow the physician order as prescribed and that it was not up to the nursing staff to administer the medication the way Resident #19 requested. An interview was conducted with the Consulting Pharmacist on 01/30/26 at 1:00 PM. The Consulting Pharmacist stated the purpose of the Linzess medication was meant to increase the intestinal motility to aide in evacuating stool. She stated the medication worked by absorbing fluid into the colon to help loosen contents of the colon and if Resident #19 was not hydrating enough it could cause dehydration. She stated the side effects were similar to a laxative such as diarrhea, gas, bloating, and too much water loss. The Consulting Pharmacist stated that Linzess 290 mcg was the highest recommended maximum dose to take daily and that was how the medication was ordered and Resident #19 should have been taking the medication as prescribed. The Consulting Pharmacist stated she reviewed Resident #19 labs and there were no concerns with dehydration. A follow up interview was conducted with the Director of Nursing on 01/30/26 at 1:30 PM. The DON revealed she had no knowledge that the nurses and medications aides were leaving the Linzess capsule in the Simethicone bottle instead of administering the medication daily as ordered nor did she have any knowledge that Resident #19 was taking 3 capsules twice weekly. She stated had she known she would have consulted the Nurse Practitioner to see if the order could be revised to meet the resident's needs. She stated she reviewed Resident #19's record and did not see any notes or orders from Resident #19's GI doctor ever indicating that Resident #19 should take 3 tablets twice per week of Linzess instead of daily. The DON stated she would have expected the nurses and medication aides to explain the policy to Resident #19 that they could not leave medications stored in the room and that the nursing staff should not leave the room until the resident has taken the medication. The DON stated the nurses and medications aides have been trained to follow the 5 rights of drug administration to include right resident, right drug, right dose, right route and right time and they should have been following the policy as well as the physician's order.

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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 record review, observation, and staff and Nurse Practitioner (NP) interviews, the facility failed to provide incontinence care safely for a resident who was agitated, combative and dependent on staff for all care for 1 of 4 residents reviewed for falls (Resident #5). On 4/10/25 Nurse Aide (NA) #2 was providing incontinence care to the resident when the resident, who was holding onto the bed frame, rolled off the bed striking his head on a dresser as he fell. Resident #5 was treated at the hospital for a soft tissue skin tear to the forehead that required cleansing and the application of steri-strips.Findings included:Resident #5 was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease, Parkinson's disease without dyskinesia (a movement disorder causing involuntary, uncontrolled muscle movements like writhing, fidgeting, or grimacing), history of transient ischemic attack (mini stroke), primary insomnia, chronic pain syndrome, essential hypertension, major depressive disorder, and orthostatic hypotension.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had long and short-term memory problems with no recall ability and severely impaired cognitive skills for daily decision making. He had no signs of delirium, behaviors, or moods identified. He had no range of motion impairments of his upper extremities but had impairments of both lower extremities. Resident #5 was dependent for all care, and he had an indwelling urinary catheter and bowel incontinence. His primary diagnosis was non-traumatic brain dysfunction. He had one fall since admission or prior assessment with minor injury. He had received antibiotic, opioid, and antipsychotic medication during the assessment period. He had received hospice care.The care plan for Resident #5 initiated on 03/11/25 included the categories:1. Falls. The problem was identified as at risk for falls related to using the lift for transfers. He had a history of recurrent falls in calendar year 2024 including on 12/22/24. The goal was for Resident #5 to remain free from injury for 90 days.2. Behavior. The problem was identified as at risk for behavior problems related to dementia and refusing care/medications at times. He had a history of anxiety, refusing medications and care, choking a staff member, restlessness, wandering, suicidal ideations, and being combative. Staff reports that some of the residents behaviors are during care or when staff is assisting him with needs-reports that resident will hit or kick at staff. Resident does not like to be bothered per staff. Resident has been redirected per team however it has not decreased his need to be physically abusive to staff. Staff is to continue to re-educate and allow him time to process before providing the care. The resident has displayed the following behaviors: start date 03/11/25:- 4/5/25: 7:00 AM to 3:00 PM shift: during care the resident was swinging his hands with balled up fists, grabbing onto staff and squeezing their hands.- 4/6/25: 3:00 PM to 11:00 PM shift: Combative to staff when providing incontinence care.- 4/7/25: During morning care, resident grabbing at staff and digging his nails into their skin. Clinches up arms and legs while trying to bath to prevent care. Staff will place stuffed animals or wash clothes in resident's hands, but he will throw to floor and grab onto staff's clothing or arms.- 4/8/25: Nurse in to change his pain patch and the resident hit the nurse with an open hand. He attempted to hit the nurse again, but the nurse was able to move away from his reach.The goal was for the resident to have no reported behaviors that were not easily altered x 90 days. Interventions included, in part: Assist with self-care needs (specialized chair when up and mechanical lift with two person assist with transfers); determine if behaviors are stimulated by certain activities, noise levels, persons involved, or time of day; intervene as needed to ensure my safety and the safety of others; pancake call pads on each side of resident; administer and monitor effectiveness/side effects of my medications; offer comfort measures that may help with behaviors; notify (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician and Responsible Party if refusal of care or if resident falls; call family for 1:1 support if unable to successfully redirect; monitor closely for negative statements made by resident; when providing care staff to monitor resident hand placement and ensure resident is not in a position to grab at staff face/throat area as able; and gently hold residents hands during care as able and ensure not to restrict residents movement.An interview was conducted with NA #2 on 01/28/26 at 1:45 PM. She stated Resident #5 had a bowel movement on 04/10/25 at suppertime but that the trays had not come to the unit yet, so she decided to provide incontinent care to him prior to the meals arrival. She explained she provided care for the first bowel movement, and he had remained calm as she talked to him during care; however, after she put the adult brief on the resident he had a second bowel movement, so she started incontinence care again. She explained that was when Resident #5 started to hit and pinch her as she was attempting to clean him. She stopped care and used her radio to summon a second person to help but all other staff were also providing care in other resident rooms. She explained as she waited for help, she managed to talk to the resident and calm him down, so she resumed care. She noted Resident #5 was not care planned for a two person assist during activities of daily living (ADL) care. NA #2 stated she would have waited for the second person if Resident #5 had remained combative. It was during the second attempt to provide incontinence care that Resident #5 grabbed the metal frame under the bed and fell hitting his head on the dresser beside the bed on the way down. She noted the resident was facing away from her and she tried to hold onto him, but he slipped out of her grasp. She recalled it was normal for him to hold onto the bed frame during care. She thought it was a comfort measure for the resident to hold onto something during care. NA #2 concluded if she had waited for a second person to come and help her provide care to the resident, the accident may have been avoided. NA #2 explained she was trained to calm the resident by talking to him and offering him a stuffed animal to hold during care.Nurse #6 documented in a progress note dated 04/10/25 at 5:17 PM that NA #2 called her for assistance in the resident's room. NA #2 informed her the resident had a large soft bowel movement and while she was cleansing him he pulled himself off the bed, hit his head on the dresser causing a laceration to his forehead. Nurse #6 documented that she contacted the provider and received an order to send the resident to the emergency department for further evaluation. She called 911 and the hospital. Nurse #6 called the family and made the Hospice nurse aware at the request of the family. Resident #5's vital signs were blood pressure 176/110, heart rate 73, temperature 98.3, and oxygen saturation 98% on room air. Resident #5 left the facility by ambulance at 6:06 PM.An interview was conducted with Nurse #6 on 01/28/26. She stated she was the nurse caring for Resident #5 on 04/10/25. She recalled NA #2 called her on the radio to the resident's room and she responded immediately. She did not recall any other request for assistance from NA #2 over the radio until after Resident #5 had fallen. Nurse #6 stated Resident #5 was lying on the floor between the bed and the dresser when she arrived. He was bleeding from his forehead, so Nurse #6 called the provider and 911. She notified the family and the Hospice provider. She explained the family wanted to wait until the Hospice provider came to the facility and assessed the resident. When the Hospice provider and EMS (Emergency Management Systems) arrived, the resident was taken to the hospital. Nurse #6 stated she was familiar with Resident #5 and knew he became combative during ADL care. She remarked that since the last fall having two staff members present for all care has helped along with the side rails on the bed for the resident to grab during care. Nurse #6 could not recall NA #2 asking for help on the night he fell. She stated the accident could have potentially been avoided had two staff members been in the room.Review of the hospital emergency department physician progress note dated 04/10/25 revealed Resident #5 was treated for a soft tissue skin tear to the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forehead. The wound was cleansed and steri-strips were applied. Diagnostic imaging of the head was nonacute. A plain film of the pelvis was also ordered and showed no acute fracture. A head CT exam was performed and was negative for any new injury. Resident #5 was released back to the nursing home from the emergency room on [DATE] to follow up with his provider as needed.An interview with the Nurse Practitioner was conducted on 1/29/26 at 10:32 AM. Stated she cared for Resident #5. She stated she assessed Resident #5 the next day on 04/11/25 and he was at his baseline with no new issues or concerns.An interview was conducted with the Director of Nursing (DON) on 01/29/26 at 9:45 AM. She stated she was notified on 04/10/25 that Resident #5 had fallen during care. She explained that when she returned to work on 04/11/25 she interviewed NA #2 to learn what had happened. The DON learned from the interview with NA #2 that NA #2 had called for help on her radio from other staff members when Resident #5 became combative and agitated during incontinence care. While NA #2 waited for assistance to arrive she was able to calm the resident and NA #2 resumed incontinence care. The DON stated that NA #2 explained to her that Resident #5 was holding onto the bed frame during care and pulled himself off the bed. The [NAME] stated that NA #2 who was standing behind him to wipe his rectal area could not hold onto him as he fell. The DON determined there had been no deviation from NA #2's practice identified because Resident #5 was not determined to be a 2 person assist for incontinent care prior to the fall on 04/10/25 and NAs were trained according to the facility procedure guide to turn a resident on his or her side away from the caregiver. The DON explained NA #2 had worked with Resident #5 for many years and she was usually able to calm Resident #5 and provide incontinent care to him. The DON reiterated that during the second brief change NA #2 had been able to calm the resident before she proceeded but that Resident #5 then pulled himself off the bed.An interview was conducted with the Administrator on 01/28/26 at 3:43 PM. She stated she conducted a full investigation and NA #2 explained to her that it was dinnertime and NA #2 wanted to provide incontinence care to the resident prior to the evening meal being served. NA #2 explained to the Administrator that Resident #5 began to be resistive to care so she called over the radio for assistance and while NA #2 waited for assistance the resident calmed down so she resumed care. The Administrator stated that the fall may have potentially been avoided had there been another staff member on the other side of the bed or if he had quarter side rails to grab onto, but the side rails had been removed previously during a re-evaluation of side rail use assessment that determined that it was unsafe to have rails on the bed because he was putting his arms through the bed rails.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and resident interviews, the facility failed to store medications in a secured medication cart when medications were observed stored in a resident's room and two of the medications were expired for 1 of 1 resident with medications observed at the bedside (Resident #19). In addition, the facility failed to date an opened insulin pen and discard an expired insulin pen for 1 of 2 medication carts observed for medication storage (Lantana Cart). Findings included: a). Resident #19 was admitted to the facility on [DATE]. The Minimum Data Set, dated [DATE] revealed Resident #19 was cognitively intact. The following physician orders were in place for Resident #19: Clobetasol Propionate 0.05% spray (a steroid medication to treat skin conditions) apply to scalp as needed daily. This order was written on 04/15/25. Linzess (a medication for chronic constipation) 290 micrograms (mcg) one capsule by mouth daily on Sunday, Monday, Tuesday, Wednesday, Thursday, and Friday. Linzess 290 mcg one capsule one capsule by mouth daily on Saturday. These orders were written on 04/16/25. Simethicone (a medication to treat gas or bloating) 180 milligrams take 2 capsules by mouth every 4 hours as needed for gas and bloating. This order was written on 05/23/25. Biotin (a type of Vitamin B) 5,000 mcg one tablet daily. This order was written on 08/06/25. An interview and observations were conducted with Resident #19 in her room on 01/28/26 at 3:50 PM to inquire about her Linzess order. Resident #19 explained that the nursing staff put the daily capsule of Linzess in an empty medication bottle which was left on her bedside table and that there was one capsule of Linzess in the bottle now. During this interview, the Director of Nursing (DON) entered the room and asked Resident #19 about the Linzess being left in the room. The DON stated she understood that Linzess capsules were being stored in Resident #19's room. At this time, she opened the medication bottle stored on Resident #19's bedside table which was labeled Simethicone and there was one capsule of the Linzess medication in the bottle. The DON also observed that there were also two opened bottles of Biotin. One bottle of the Biotin contained 1,000 mcg tablets and the other bottle contained 5,000 mcg tablets which had an expiration date of 04/2024. Additionally, she observed there was an opened bottle of Simethicone with an expiration date of 01/24/2024, and a spray bottle of Clobetasol Propionate 0.05%. These were all stored on her bedside table. The DON explained to Resident #19 that medications were not allowed to be stored in her room. Resident #19 stated she was not taking this Biotin or Simethicone or using the Clobetasol and that they had been in her room for a while. Resident #19 could not say who brought the medications in her room or why they were stored in her room. An interview was conducted with Nurse #1 on 01/28/26 at 4:05 PM. Nurse #1 stated she did not administer the Linzess on 01/28/26 and she was aware that Resident #19 was requesting that the nursing staff (including herself) put the Linzess capsule in an empty bottle kept on her bedside table. Nurse #1 stated she should not have left the Linzess capsule in the empty Simethicone bottle at any point. Nurse #1 did not realize the bottle was labeled Simethicone. Nurse #1 stated she was not aware the Biotin, Simethicone or Clobetasol Spray were being stored in Resident #19's room or where Resident #19 would have gotten them because she administered them to her from the medication cart. Nurse #1 stated there should be no medications kept in a resident's room.An interview was conducted with Medication Aide #1 on 01/29/26 at 7:30 AM. Medication Aide #1 indicated she had been working at the facility for 6 months and she placed the Linzess capsule in a bottle that was kept on Resident #19's bedside table whenever she worked. Medication Aide #1 stated she had not seen the opened Biotin, Clobetasol or Simethicone bottles in Resident #19's room. Medication Aide #1 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she was only aware of the empty Simethicone bottle that Resident #19 stored the Linzess capsules in. Medication Aide #1 stated she left the Linzess in the bottle on 01/28/26 at Resident #19's request when she brought in her medications to her room and she knew she should not have left the medication in the bottle. Medication Aide #1 stated all medications should be stored in the medication cart and should not be left in the residents' rooms. An interview with Medication Aide #2 on 01/29/26 at 8:40 AM revealed she had worked for the facility for 4 years and since she has been here, she has been leaving Resident #19's Linzess capsule in the bottle with the pink cap (Simethicone bottle). Medication Aide #2 stated she had no knowledge of the other medications stored in Resident #19's room, and that she administered those medications directly from the medication cart. Medication Aide #2 stated she should not have stored the Linzess capsules in Resident #19's room in the empty Simethicone bottle when she brought her medications to her room and all medications should be stored in the medication cart and not in a Resident's room. An interview was conducted with Nurse #4 on 01/29/26 at 8:40 AM. Nurse #4 stated she was aware that the Linzess capsules were being stored in the labeled Simethicone bottle in Resident #19's room until Resident #19 took them on Tuesdays and Fridays, but she was not aware of the other medications that were stored in her room. Nurse #4 stated she had placed the Linzess capsules in the bottle in Resident #19's room at her request when she brought her medications to her room even though she knew residents were not to have medications at the bedside. Nurse #4 stated all medications should be stored in the Medication Cart and if any medications were expired, they should be disposed of. An interview with the Director of Nursing on 01/30/26 at 10:30 AM revealed the nursing staff were aware that medications should never be stored in the resident's room without a physician order and she expected the nursing staff to make sure all medications were stored on the medication cart. The DON added, the medications left in Resident #19's room were located next to the empty Simethicone bottle the staff were using to store the Linzess in and they should have been removed from her room. b) An observation of the Lantana hall medication cart on 01/29/26 at 8:10 AM with Nurse #2 revealed the follow medications: Novolog prefilled insulin pen was opened with no opened date indicated on the pen.Lantus prefilled insulin pen was opened and expired on 11/24/25. The manufacturer's instructions for both the NovoLog and Lantus insulin pens read to discard after 28 days once opened. An interview with Nurse #2 on 01/29/26 at 8:12 AM revealed nurses and medications aides were responsible for checking the medication carts daily to make sure there were no expired medications. Nurse #2 stated nurses should be making sure all insulin pens were dated once opened and disposing them if expired. Nurse #2 stated she had not administered the Novolog or the Lantus insulins this morning. An interview was conducted with the Director of Nursing (DON) on 01/30/26 at 10:30 AM. The DON reported her expectation was that once an insulin pens were opened the nurses should be putting an opened date on them. She stated insulins pens have a manufacturer's instruction to discard after so many days once opened and without having the initial opened date recorded on the on the pen, nurses would not be able to determine if the medication was still good for use. The DON also stated she would have expected the nurses to remove the expired medication from the cart.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to ensure the outside area surrounding the kitchen exit and outdoor equipment cleaning area remained free of debris, leaves, and broken equipment for 1 of 1 kitchen/housekeeping/maintenance cleaning area observed. This failure had the potential to attract pests and rodents. Findings included: An observation of the kitchen's outside cleaning area (4 feet from the kitchen's exit door) with the Dietary Manager (DM) on 01/27/26 at 1:00 PM revealed scattered debris, leaves, broken sauna bathtub, broken recliner, with additional discarded broken equipment from maintenance, housekeeping, and kitchen, as well as blown debris and leaves around the sides and back area of the enclosed brick cleaning area. The cleaning area was unable to be utilized due to the large amount of debris, broken metal racks, sauna tub, recliner, all stored in the enclosed cleaning area. An interview was conducted with the Dietary Manager on 01/27/26 at 1:15 PM. He stated it was the responsibility of the Maintenance, Housekeeping, and Dietary Departments to keep the outside cleaning area clean and functional, with trash removed from the area, allowing the cleaning area's drain to function when using water pressure hoses to clean kitchen items, wheelchairs, and beds. The DM stated currently the area could not be utilized due being full of discarded broken equipment, blown debris, leaves blocking the drain, which would not allow for water drainage when water pressure hoses were used. An interview and tour of the cleaning area behind the kitchen on 01/27/26 at 1:45 PM was conducted with the Maintenance Director and Administrator. The tour revealed scattered debris, leaves, broken sauna bathtub, broken recliner, multiple discarded items from maintenance, housekeeping, and kitchen, with leaves around the sides and back of the enclosure area, open to the elements available to pests and rodents. The Maintenance Director stated it was the responsibility of Dietary, Housekeeping, and Maintenance Departments to ensure the area around the kitchen exit to be clean and free of debris, allowing the cleaning area to be utilized by all departments. A follow-up interview and tour of the kitchens outside cleaning area was conducted with the Administrator and Maintenance Director on 01/29/26 at 1:35 PM. The Administrator expected maintenance to ensure the cleaning area was usable and free of debris and broken facility equipment.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, record review, and Nurse Practitioner, Consulting Pharmacist, staff and resident interviews, the facility failed to accurately document the administration of Linzess (a medication for long-lasting or chronic constipation from unknown reasons) for 1 of 1 resident reviewed (Resident #19).Findings included: A Physician's order written on 04/16/25 revealed Linzess 290 micrograms (mcg) one capsule by mouth daily on Sunday, Monday, Tuesday, Wednesday, Thursday, and Friday. Review of the November Medication Administration Record (MAR) from 11/01/25 through 11/30/25 revealed the Linzess 290 mcg one capsule was being signed off as administered to Resident #19 on the following days: Nurse #1 documented she administered one capsule on 11/02/25, 11/05/25, 11/06/25, 11/10/25, 11/12/25, 11/16/25, 11/17/25, 11/19/25, and 11/26/25. Nurse #4 documented she administered one capsule on 11/03/25 and 11/13/25. Medication Aide #1 documented she administered one capsule on 11/09/25, 11/20/25, 11/24/25 and 11/27/25. Medication Aide #2 documented that she administered one capsule on 11/30/25. Review of the December Medication Administration Record from 12/01/25 through 12/31/25 revealed the Linzess 290 mcg one capsule was being signed off as administered to Resident #19 on the following days: Nurse #1 documented she administered one capsule on 12/03/25, 12/04/25, 12/08/25, 12/10/25, 12/22/25, 12/24/25, 12/25/25, 12/28/25, and 12/29/25. Medication Aide #1 documented she administered one capsule on 12/01/25, 12/18/25, and 12/31/25. Medication Aide #2 documented that she administered one capsule on 12/11/25, 12/14/25, and 12/15/25. Review of the January Medication Administration Record from 01/01/26 through 01/28/26 revealed the Linzess 290 mcg one capsule was being signed off as administered to Resident #19 on the following days: Nurse #1 documented she administered one capsule on 01/01/26, 01/05/26, 01/11/26, 01/14/26, 01/19/26, 01/25/26, and 01/28/26. Nurse #4 documented she administered one capsule on 01/21/26 and 01/26/26. Medication Aide #1 documented that she administered one capsule on 01/15/26 and 01/22/26. An interview was conducted with Nurse #1 on 01/28/26 at 4:05 PM. Nurse #1 confirmed she was documenting the administration of Resident #19's Linzess capsule on Sundays, Mondays, Wednesdays and Thursdays on the Medication Administration record and had been doing so for an unknown period of time. Nurse #1 stated she should not have documented that the medication was given on the days that she signed off on the MAR since Resident #19 did not take the medication on those days and the medication was left at the bedside. An interview was conducted with Medication Aide #1 on 01/29/26 at 7:30 AM. Medication Aide (MA) #1 confirmed she had documented the administration of the Linzess capsule to Resident #19 on Sunday, Monday, Wednesday, and Thursday on the Medication Administration Record for the last 6 months. MA #1 stated she should not have documented that the medication was given on those days since the medication was not administered to Resident #19 and was instead stored in her room. During an interview with Medication Aide #2 on 01/29/26 at 8:40 AM she confirmed that she was documenting the administration of the Linzess capsule to Resident #19 on Sunday, Monday, Wednesday and Thursday on the Medication Administration Record for as long as she could remember. MA #2 stated this was a documentation error because Resident #19 did not actually take the medication on those days and she should not have documented that she did. An interview was conducted with Nurse #4 on 01/29/26 at 8:40 AM. Nurse #4 stated she had been working at the facility on and off for several years and Resident #19 had been taking the 3 capsules of Linzess every Tuesday and Friday for as long as she could remember. Nurse #4 confirmed that she should not have documented that Resident #19 received the medication on 11/03/25 and 11/13/25 and 01/21/26 and 01/26/26 since the resident did not actually take the medication on those days. An interview was conducted with the Nurse Practitioner on 01/29/26 at 10:15 AM. The Nurse Practitioner stated she relied on what nursing staff was documenting in (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	the Medication Administration Record to determine if there should be any changes to the medications. The Nurse Practitioner stated she expected the nursing staff to document accurately on the Medication Administration Record at all times. An interview with the Consulting Pharmacist on 01/30/26 at 1:00 PM revealed she would have expected nursing staff to accurately document the refusal of the daily dose of Linzess. She stated it was important for nursing staff to accurately document on the Medication Administration Record because it was used to make clinical decisions and if the documentation to support the refusal of the medication was accurate, an earlier intervention, such as a medication change, could have been implemented. An interview was conducted with the Director of Nursing (DON) on 01/30/26 at 1:17 PM. The DON stated the nursing staff should have been accurately documenting the refusal of the Linzess medication. The DON added the Medication Administration Record was an important clinical tool to evaluate the administration of medications and needed to be accurate at all times.

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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 observation, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to maintain infection control procedure for the care of a nephrostomy tube (a thin catheter that drains urine directly from the kidney into a urinary drainage bag) when a nurse failed to perform hand hygiene after she had removed her soiled gloves and donned a pair of sterile gloves to apply the new dressing during the dressing change. This deficient practice occurred for 1 of 2 staff members observed for infection control practices (Nurse #3).The findings included:Review of the facility Policy and Procedure for Care of a Nephrostomy Tube (undated) revealed the following, in part: Dresing Changes: 4) Carefully remove the wet or soiled dressing; 5) Discard the dressing in the disposable waste bag; 6) Observe the dressing site for signs of skin breakdown, infection, or drainage; 7) Remove gloves and discard in the disposable waste bag; 8) Wash and dry your hands; 9) Put on sterile gloves.An observation of nephrostomy tube care was completed on 1/29/26 at 11:03 AM. The care was provided by Nurse #3 for Resident #15. Nurse #3 donned a gown and gloves and set up supplies for a sterile cleansing of the nephrostomy area. The old dressing was removed by Nurse #3, and no drainage was noted on the old dressing. The nurse discarded the old dressing and cleansed the tubing with alcohol pads along with the tube to the drainage connection port. Nurse #3 discarded the soiled items and removed her gloves and discarded them. Nurse #3 donned sterile gloves and did not wash her hands prior to donning the sterile gloves. Nurse #3 applied the new sterile dressing to the nephrostomy tube insertion site. Nurse #3 discarded her gown and gloves and washed her hands prior to exiting the resident's room.During an interview with Nurse #3 on 01/29/26 at 11:20 AM she stated she should have washed her hands after she removed the gloves she wore while changing the old dressing and before donning the sterile gloves, but she forgot to do it. She explained she understood proper handwashing was an important part of infection control.An interview was conducted with the Infection Preventionist (IP) on 01/30/26 at 8:48 AM. She stated Nurse #3 should have performed hand hygiene after she removed the old dressing and prior to donning the sterile gloves. The IP explained that hand hygiene was one of the most important steps in preventing infections.An interview was conducted on 1/30/26 at 1:40 PM with the NP who was the physician extender for Resident #15. The NP stated Nurse #3 should have washed her hands between the old dressing and the new dressing application. The NP further explained that when Nurse #3 did not follow the protocol to wash her hands prior to applying the new dressing Nurse #3 put the resident at risk for introduction of bacteria to the ostomy site which could cause infection. The NP stated that even though Nurse #3 did put on sterile gloves prior to applying the new dressing, she should have washed her hands after she had removed the old dressing before putting on the sterile gloves.An interview was conducted with the Director of Nursing (DON) on 01/29/26 at 2:37 PM. She stated a nurse changing any dressing should wash his or her hands before beginning, after removing the old dressing, before applying the new dressing, and after completing the dressing change. She stated Nurse #3 should have washed her hands after removing the old dressing and her gloves before donning the sterile gloves to apply the new dressing.