STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Surry Community Health Center by Harborview	542 Allred Mill Road Mount Airy, NC 27030

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of psychotropic medications prior to initiation for 1 of 5 residents reviewed for unnecessary medications (Resident #32). The findings included: Resident #32 was admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder, and depression. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 was severely cognitively impaired, had no behavioral symptoms, and received antipsychotics on a routine basis only. Resident #32's Medication Administration Record for June 2025 indicated an active order which started on 6/6/25 for Lorazepam (an anti-anxiety medication) 0.5 milligrams 1 tablet by mouth as needed for anxiety for 14 days. The order had a stop date of 6/20/25. A review of Resident #32's medical record indicated no information whether Resident #32's representative was informed in advance of the risks and benefits of initiating Lorazepam. An interview with the Director of Nursing (DON) on 6/11/25 at 11:45 AM revealed they had not been getting consents on psychotropic medications other than antipsychotic medications because their current consent forms were only for antipsychotic medications. The DON stated that they had just started working on obtaining consents for psychotropic medications after their current forms were revised to include all psychotropic medications.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff and Nurse Practitioner (NP) interviews, the facility failed to ensure an as needed (PRN) psychotropic medication, lorazepam (medication used to relieve anxiety), had a stop date of 14 days for 1 or 5 residents reviewed for unnecessary medications (Resident #7). The findings included: Resident #7 was readmitted to the facility on [DATE] with diagnoses that included anxiety. Review of Resident #7's physician orders dated 04/23/25 indicated lorazepam 0.25 milligrams (mg) every 8 hours as needed (PRN) for anxiety. There was no stop date. Review of Resident #7's quarterly Minimum Data Set, dated [DATE] revealed the Resident's cognition was severely impaired and he received an antianxiety medication. Review of Resident #7's May 2025 Medication Administration Record (MAR) revealed the lorazepam 0.25 mg every 8 hours PRN for anxiety remained an active order and was administered 21 times. Review of Resident #7's June 2025 Medication Administration Record (MAR) revealed the lorazepam 0.25 mg every 8 hours PRN for anxiety remained an active order and was administered 11 times. An interview was conducted with the Nurse Practitioner on 06/11/25 at 9:34 AM. The NP explained that she typically wrote the prn psychoactive medication orders for 14 days then she would evaluate the resident's need for the medication. The NP continued to explain that Resident #7 had a lot of behaviors, so she usually wrote the lorazepam script for 30 days at a time. The NP reported she did not put the order in the system, so she did not know why there was not a 30 day stop date on the order. An interview conducted with the Director of Nursing (DON) on 06/11/25 at 11:24 AM. The DON explained that she was aware that the PRN psychoactive medications required a stop date designated by the physician and her staff were educated on that as well. The DON indicated it was an oversight that Resident #7's lorazepam had been effective since 04/23/25 without a stop 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #7 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder with major neurocognitive disorder due to Alzheimer's Disease. Review of Resident #7's medical record revealed an order dated 03/17/25 for quetiapine 50 milligrams (mg) by mouth twice a day for major depressive disorder with major neurocognitive disorder due to Alzheimer's Disease. Review of Resident #7's Medication Administration Record for 03/2025 indicated the Resident received 50 mg quetiapine by mouth twice a day beginning 03/17/25. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Antipsychotic Medication Review section indicated the Resident had not received antipsychotic medication since readmission/reentry or since the last assessment. On 06/11/25 at 10:06 AM an interview was conducted with the Minimum Data Set Nurse who reviewed Resident #7's 03/20/25 quarterly MDS and acknowledged she had marked the wrong answer in the Antipsychotic Medication Review section when she checked NO on the MDS. The MDS Nurse explained that the correct answer should have been YES since Resident #7 was receiving an antipsychotic medication. The MDS Nurse stated she was normally very careful when completing the MDS and the error was a mistake. On 06/11/25 at 1:30 PM during interviews with the Director of Nursing and the Administrator simultaneously, the Administrator indicated she expected the MDS process to be appropriately completed. Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of hospice care and medications for 2 of 6 residents whose MDS were reviewed (Resident #16 and Resident #7). The findings included: 1. Resident #16 was admitted to the facility on [DATE] with chronic obstructive pulmonary disease. A Hospice Initial Certification dated 1/12/24 indicated Resident #16 was certified as eligible for hospice care based on her diagnosis and current condition, and that she was expected to have a limited life expectancy of 6 months of less if the terminal illness ran its course. The benefit end date was 4/10/24. A Hospice Note Attestation dated 4/8/25 by the Hospice Nurse Practitioner indicated that she confirmed she had a face-to-face encounter with Resident #16 on 4/8/25 at 11:10 AM and that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 received hospice care while a resident at the facility. However, the MDS did not indicate that Resident #16 had a condition or chronic disease that might result in a life expectancy of less than 6 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MDS Coordinator on 6/11/25 at 9:28 AM revealed Resident #16's quarterly MDS was not marked in error because she didn't have the hospice recertification on hand at the time of the MDS assessment, and it wasn't uploaded into the system until 4/29/25. She stated that this was why she had marked Resident #16 for not having life expectancy of less than 6 months. The MDS Coordinator further stated that not all hospice residents had a life expectancy of less than 6 months. An interview with the Administrator on 6/11/25 at 11:52 AM revealed the information on Resident #16's MDS regarding life expectancy and hospice care should have been coded correctly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews resident and staff interviews, the facility failed to secure an oxygen cylinder stored in Resident #11's room for 1 of 4 residents reviewed. The findings included: Resident #11 was admitted to the facility on [DATE]. Review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident's cognition was moderately impaired and she did not receive oxygen therapy. Review of Resident #11's care plan reviewed 03/12/25 indicated the Resident did not receive oxygen. Review of Resident #11's current monthly (06/2025) physician orders indicated there was no order for oxygen. On 06/08/25 at 2:31 PM an observation and interview were conducted with Resident #11 who was sitting in her wheelchair in her room. During the interview an oxygen cylinder was stored upright near the window sill that was approximately ¾ full of oxygen according to the gauge. The Resident stated she did not know why the oxygen cylinder was in her room and she did not know if she was supposed to be receiving oxygen. The Resident indicated she did not know how long the oxygen cylinder had been in her room. On 06/09/25 9:40 AM the oxygen cylinder remained stored in Resident #11's room next to the window sill. The Resident was not in her room. On 06/09/25 12:10 PM the oxygen cylinder remained stored in Resident #11's room near the window sill. On 06/09/25 12:15 PM interviews were conducted with Nurse Aides (NA) #1 and NA #2 who were the full time NAs responsible for Resident #11. The NAs were asked to observe the oxygen cylinder stored in Resident #11's room. The NAs acknowledged the oxygen cylinder was approximately ¾ full and explained that the oxygen cylinder should be stored in the oxygen storage room. The NAs continued to explain that the cylinder should be safely stored in a holder to protect it from falling over and potentially causing an explosion. The NAs reported the oxygen cylinder was placed on Resident #11's wheelchair when she needed the oxygen, but they indicated they could not recall how long ago that had been. NA #1 removed the oxygen cylinder and returned it to the oxygen storage room. Both NAs indicated they had not noticed the oxygen being stored in the Resident's room or how long it had been in the room. On 06/09/25 12:20 PM an interview was conducted with the Director of Nursing (DON) who explained that the oxygen cylinders should not be stored in the residents' rooms and should be secured in the oxygen storage room until they were needed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 31 opportunities, resulting in a medication error rate of 6. 45% for 2 of 6 residents observed during the medication administration (Resident #52 and Resident #49). The findings included: 1. Resident #52 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease. Review of Resident #52's physician orders dated 10/14/25 revealed give metoclopramide (gastrointestinal stimulant and antiemetic) 5 milligrams (mg) by mouth before meals. An observation was made of Medication Aide (MA) #1 on 0610/25 at 8:47 AM during a medication administration of Resident #52. The MA prepared Resident #52's medications which included metoclopramide 5 mg. The MA took the morning medications to Resident #52 who was sitting on the side of her bed eating her breakfast which was approximately 50% consumed. An interview was conducted with MA #1 at 11:15 AM on 06/10/25. The MA was asked to review the metoclopramide card read the directions out loud. The MA read to give the medication half an hour before meals and instantly stated she did not give Resident #52 the medication before she ate that she was eating when she administered the medication that morning. The MA stated she did not read the directions close enough when she poured up the medications that morning. An interview was conducted with the Director of Nursing (DON) on 06/10/25 at 12:00 PM. The DON indicated the MA should read the medication cards and orders closer when she passes the residents' medications. 2. Resident #49 was admitted to the facility on [DATE] with diagnoses that included depression. Review of Resident #49's quarterly Minimum Data Set assessment dated [DATE] revealed the Resident received an antidepressant medication. Review of Resident #49's physician orders dated 05/20/25 for escitalopram (antidepressant) 20 milligrams (mg) by mouth once a day for depression. An observation was made of Medication Aide (MA) #1 during a medication pass on 06/10/25 at 9:01 AM. The MA prepared Resident #49's medications for administration which included escitalopram 5 mg by mouth once a day and administered the medications to Resident #49. An interview was conducted with MA #1 on 06/10/25 at 11:20 AM. The Medication Aide was asked to review the escitalopram 5 mg medication card again. The MA removed two escitalopram medication cards from the medication cart. One card was for 5 mg and one card was for 15 mg. The MA explained that if she had read the directions on the medication card carefully she would not have made the mistake, so she would slow down and read the directions more carefully. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 06/10/25 at 12:00 PM the DON explained that she had already been made aware of the medication error that MA made during the medication pass. The DON indicated that the MA needed to be more careful when reading the directions on the orders and the medication cards.