STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Lane Nursing and Rehabilitation Center	107 Magnolia Drive Morganton, NC 28655

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review, and resident and staff interviews, the facility failed to communicate the facility's efforts to address concerns and document in writing the facility's response and rationale to concerns voiced during Resident Council meetings for 5 of 10 Resident Council meetings reviewed (January 2025, March 2025, June 2025, July 2025, and August 2025).Findings included:The Resident Council minutes for December 2024 (no day listed) noted that residents voiced a concern regarding the daily menus were not being posted again. The Resident Council minutes for January 2025 (no day listed) revealed residents voiced they had noticed the daily menus were being posted but they would like more variety. There was no further details documented of the facility's response, actions and rationale taken to address of the facility concern.The Resident Council minutes for February 2025 (no day listed) revealed no documentation of the facility's response, actions and rationale taken to address the food concerns voiced during the previous meeting or if the concern was still ongoing.The Resident Council minutes for March 2025 (no day listed) revealed residents voiced they would like more consistency in who cooks and they were still unhappy with the menu. The Resident Council minutes for April 2025 (no day listed) revealed there was no documentation of the facility's response, actions and rationale taken to address the dietary concerns regarding food and menus voiced during the previous meetings. It was noted that residents had stated, the food has been better, been worse with no further details documented. The Resident Council minutes for May 2025 (no day listed) revealed the residents stated they had not noticed any concerns related to the food quality or temperature. There was no documentation of the facility's response, actions and rationale taken to address the food concerns voiced during previous meetings. The Resident Council minutes for June 2025 (no day listed) revealed residents voiced concerns regarding Nurse Aides (NAs) not making beds even on bath days and not turning the light off after care was provided, residents were still unhappy with the corporate menu, and residents had to remind dietary staff to post the daily menus in all of the menu holders, not just some. The Resident Council minutes for July 2025 (no day listed) revealed residents voiced concerns that the menus were not being posted in all the menu holders, NAs were forgetting to turn the light out after care was provided and beds were still not being made satisfactorily. There was no documentation of the facility's response, actions and rationale taken to address the concerns voiced during the previous meeting.Further review of the Resident Council minutes revealed a new document was utilized starting August 2025 for documentation of the minutes that included a sections for Old Business, New Business, Resident Rights Reviewed, Date of Next Meeting, and Signature Line for the staff member completing the minutes.The Resident Council minutes for August 13, 2025, revealed under old business residents voiced that menus were not to the residents' liking and sometimes the menus were not posted in the menu holders. Under new business, it was noted the residents would like additional bath days. There was no documentation of the facility's response, actions and rationale taken to address the concerns voiced during the previous meeting. The Resident Council minutes for September 10, 2025, revealed under old business the Administrator attended the meeting to introduce himself to the residents and to provide resolution to concerns voiced in the previous Resident Council meeting. The topics of resolution discussed with residents attending the meeting included special menu items, call light response times on evening and night shifts, and annual outing. There was no new business noted. There was no documentation of the facility's response, actions and rationale taken to address the dietary concerns and additional bath days voiced by residents during the previous meeting. The facility's grievance logs for the period December 2024 through September 2025 were reviewed and revealed no concerns were filed on behalf of the members of the Resident Council following the monthly meetings. A Resident Council group interview was conducted on 12/16/25 at 3:19 PM with Resident #9, Resident #32, Resident #44 (Resident Council President), and Resident #51 in attendance. Resident #9 stated when they voiced concerns during meetings they rarely received communication from facility staff regarding what was done to address the concerns. Resident #9 also stated they would like more communication regarding what the facility was doing to address the concerns they voiced and to be a part of the solution. When asked, Resident #32, Resident #44 and Resident #51 all stated they agreed with Resident #9.During an interview on 12/16/25 at 4:02 PM, the Activity Director revealed she had only been in her position for a few months and was still learning the process. She explained she had only facilitated two (2) resident council meetings, 10/17/25 and 11/03/25. She stated she had reviewed the minutes from previous meeting and during the meetings she facilitated she asked the residents if they had any

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the Do Not Resuscitate (DNR) form was signed by the physician and part of the medical record after the physician ordered for the resident to be Do Not Resuscitate for 1 of 21 residents reviewed for advanced directives (Resident #2). The findings included:Resident #2 was admitted to the facility on [DATE]. Review of the physician's signed orders dated [DATE] revealed admission to Hospice with diagnosis of malignant neoplasm (a cancerous tumor) of the gallbladder. Review of the physician's signed orders dated [DATE] revealed an order for Resident #2 to be a Do Not Resuscitate (DNR).An interview with the former Assistant Director of Nursing (ADON) who entered the DNR order was attempted but unsuccessful. Review of Resident #2's electronic medical record revealed no evidence a DNR form was completed and signed by the physician.An attempt to contact Resident #2's Responsible Party (RP) was made but unsuccessful.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #2 was severely cognitively impaired. Resident #2 had a condition or chronic disease that may result in a life expectancy of less than 6 months and was on Hospice.Review of the care plan dated [DATE] revealed Resident #2 was documented as do not resuscitate (DNR) (lifesaving efforts such as Cardiopulmonary Resuscitation (CPR) were not to be conducted). Goals included advance directives will be honored per established documents/ documentation through next review. Interventions included do not resuscitate. A joint interview with the Administrator and the Corporate Consultant on [DATE] at 2:02 PM revealed that advanced directives were discussed in interdisciplinary team (IDT) daily meetings. The Administrator stated nursing should review the advanced directive orders and fill out the DNR or MOST form and have the physician review it with the resident or resident representative and sign the form. The Corporate Consultant further revealed that the facility had just completed an audit of advanced directives on [DATE] and Resident #2 was overlooked. The Corporate Consultant further stated that when an advanced directive was changed the medical record should be updated with all correct information and forms within 24 hours.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, a form used by skilled nursing facilities to inform residents about potential costs and coverage limitations for services that may not be covered by Medicare) to beneficiaries who intended to continue services and the SNF believed the services may not be covered under Medicare prior to discharge from Medicare Part A skilled services for 3 of 3 residents reviewed for beneficiary notification review (Residents #6, #16, and #76).Findings included:1. Resident #6 was admitted to the facility on [DATE]. A Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with and signed by Resident #6 on 09/19/25 which indicated his Medicare Part A coverage for skilled services would end on 09/23/25. Resident #6 remained in the facility. Resident #6's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #6. During an interview on 12/16/25 at 10:05 AM, the Business Office Manager revealed the therapy team reviewed the NOMNC with the resident or their Responsible Party (RP) when Medicare Part A services were ending, had them sign the form and then returned the form to her to keep. She stated due to a miscommunication between her and the therapy team; she was not aware that SNF ABNs were not being provided along with the NOMNC. The Business Office Manager stated she had since requested that the therapy team inform her when a resident's therapy services were ending so that she had time to provide a SNF ABN to the resident or their RP, if applicable. The Business Office Manager confirmed a SNF ABN was not issued to Resident #6 prior to Medicare Part A skilled services ending on 09/23/25.During an interview on 12/19/25 at 3:17 PM, the Administrator revealed he would have expected Resident #6 to have received a SNF ABN as required when his Medicare Part A services were ending. He stated going forward, the Social Worker would be responsible for ensuring a SNF ABN was provided to the resident or their RP as required. 2. Resident 16 was admitted to the facility on [DATE].A Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with and signed by Resident #16 on 08/15/25 which indicated his Medicare Part A coverage for skilled services would end on 08/18/25. Resident #16 remained in the facility. Resident #16's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #16. During an interview on 12/16/25 at 10:05 AM, the Business Office Manager revealed the therapy team reviewed the NOMNC with the resident or their Responsible Party (RP) when Medicare Part A services were ending, had them sign the form and then returned the form to her to keep. She stated due to a miscommunication between her and the therapy team; she was not aware that SNF ABNs were not being provided along with the NOMNC. The Business Office Manager stated she had since requested that the therapy team inform her when a resident's therapy services were ending so that she had time to provide a SNF ABN to the resident or their RP, if applicable. The Business Office Manager confirmed a SNF ABN was not issued to Resident #16 prior to Medicare Part A skilled services ending on 08/18/25.During an interview on 12/19/25 at 3:17 PM, the Administrator revealed he would have expected Resident #16 to have received a SNF ABN as required when his Medicare Part A services were ending. He stated going forward, the Social Worker would be responsible for ensuring a SNF ABN was provided to the resident or their RP as required. 3. Resident #76 was readmitted to the facility on [DATE].A Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with and signed by Resident #76 on 08/22/25 which indicated her Medicare Part A coverage for skilled services would end on 08/25/25. Resident #76 remained in the facility until her discharge on [DATE]. Resident #76's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #76.During an interview on 12/16/25 at 10:05 AM, the Business Office Manager revealed the therapy team reviewed the NOMNC with the resident or their Responsible Party (RP) when Medicare Part A services were ending, had them sign the form and then returned the form to her to keep. She stated due to a miscommunication between her and the therapy team; she was not aware that SNF ABNs were not being provided along with the NOMNC. The Business Office Manager stated she had since requested that the therapy team inform her when a resident's therapy services were ending so that she had time to provide a SNF ABN to the resident or their RP, if applicable. The Business Office Manager confirmed a SNF ABN was not issued to Resident #76 prior to Medicare Part A skilled services ending on 08/25/25.During an interview on 12/19/25 at 3:17 PM, the Administrator revealed he would have expected Resident #76 to have received a SNF ABN as required when her Medicare Part A services were ending. He stated going forward, the Social Worker would be

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) determination for residents who were admitted to the facility with serious mental health disorders for 4 of 4 residents reviewed for PASRR (Resident #37, Resident #7, Resident #52 and Resident #50).Findings included: 1. A PASRR Determination Notification letter dated 07/15/25 revealed Resident #37 had a Level I PASRR with no expiration date. Resident #37 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, post-traumatic stress disorder (PTSD) and bipolar disorder. A staff progress note dated 10/01/25 at 1:44 PM written by the Social Worker (SW) revealed a baseline care plan meeting was held with Resident #37. The SW noted Resident #37 shared a history of significant trauma, including experiences related to war, and had diagnoses of PTSD and bipolar disorder. A physician's progress note dated 10/03/25 revealed Resident #37 had a diagnosis of chronic PTSD that was managed with divalproex sodium (anticonvulsant). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #37's active psychiatric/mood disorder diagnoses included depression (other than bipolar) and PTSD. He received anticonvulsant medications during the MDS assessment period. A psychiatric note dated 10/09/25 revealed Resident #37 received divalproex sodium every night at bedtime for treatment of chronic PTSD with major depressive disorder. It was noted the medication was effective, Resident #37's mood had been stable and no changes to the medication was recommended. Resident #37 had a planned discharged home on [DATE]. He was readmitted to the facility on [DATE] with diagnoses that included major depressive disorder, recurrent and PTSD. The October 2025 Medication Administration Record revealed Resident #37 received the following medications: *A physician order dated 10/28/25 for divalproex sodium 500 milligrams (mg) two tablets by mouth twice a day at 8:00 AM and 8:00 PM for mood disorder. *A physician order dated 10/28/25 for olanzapine (antipsychotic) 5 mg at bedtime for mood disorder. A physician progress note dated 10/29/25 revealed Resident #37 had diagnoses of major depressive disorder, recurrent episode and chronic PTSD. A Nurse Practitioner progress note dated 10/30/25 revealed Resident #37 had a diagnosis of major depressive disorder, recurrent episode with a plan to continue olanzapine and divalproex sodium for mood disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. He received antipsychotic and anticonvulsant medications during the MDS assessment period. Review of Resident #37's medical record revealed there was no documented evidence of a Level II PASRR evaluation. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR determination had been submitted for Resident #37. During an interview on 12/18/25 at 8:36 AM, the admission Coordinator revealed if a resident was accepted for admission, she ensured they had a PASRR and if not, she would request one. The admission Coordinator revealed she applied for PASRR evaluations by entering information into the North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) such as the resident's medications, mental health diagnoses, nursing notes and the Medicaid Long Term Care FL2 form (describes an individual's medical condition and the level of care needed). She revealed if a resident had a Level I PASRR determination and a mental health diagnosis, she informed the Social Worker (SW). The admission Coordinator revealed she had been employed at the facility for two weeks and since starting her position, she had not requested any Level II PASRR evaluations. During an interview on 12/16/25 at 2:07 PM, the SW confirmed she had not been informed by the clinical team to submit a request for an evaluation for a Level II PASRR for Resident #37. The SW stated ideally when a resident admitted with a mental health diagnosis with a Level I PASRR, a request for a Level II evaluation should have been done and was overlooked. During an interview on 12/18/25 at 3:48 PM, the Administrator revealed PASRR was discussed during daily clinical meetings and if it was determined that a resident needed a Level II PASRR evaluation, the SW would be responsible for submitting a request for a Level II PASRR evaluation determination. The Administrator acknowledged a request for an evaluation for a Level II PASRR determination should have been submitted for Resident #37 and was overlooked. 2. A PASRR Determination Notification letter dated 07/05/10 revealed Resident #7 had a PASRR Level I with no expiration date. Resident #7 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder and anxiety disorder. The most recent comprehensive Minimum Data Set (MDS) significant change in status assessment dated [DATE] revealed Resident #7 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #7's active psychiatric/mood disorder diagnoses included bipolar disorder and depression, and antidepressant and anticonvulsant medications were taken during the assessment lookback period. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan last revised on 09/09/25 revealed Resident #7 had diagnoses that included bipolar disorder, anxiety, and depression. Resident #7 received psychotropic antidepressant and antianxiety medications with the potential for side effects. Interventions included evaluate effectiveness and side effects of medications for possible reduction or elimination of psychotropic drugs. Review of Resident #7's medical records revealed there was no documented evidence that a request for an evaluation for a PASRR Level II determination was made. A Nurse Practitioner (NP) progress note dated 12/04/25 revealed Resident #7 was seen for ongoing medication management and symptom monitoring for bipolar disorder with anxiety. The NP noted Resident #7's bipolar disorder was in partial remission, and the most recent episode was depression and Resident #7 currently denied any anxiety or depression. The NP noted Resident #7's mood was stable and continued escitalopram (antidepressant) 10 milligrams (mg) daily for depression, depakote (anticonvulsant) 125 mg twice a day for mood stabilization, trazadone (antidepressant) 50 mg at hour of sleep for insomnia, and bupropion (antidepressant) extended release 100 mg daily for depression. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #7. During an interview on12/16/25 at 2:07 PM, the Social Worker (SW) revealed PASRR was discussed during the morning meetings and included review of psychotropic medications, and she would be informed if a request for a PASRR evaluation needed to be submitted. The SW revealed no request for a Level II PASRR evaluation had been completed for Resident #7 and stated ideally when a resident admitted with a mental health diagnosis and had a PASRR Level I, a request for re-evaluation should have been done. During an interview on 12/18/25 at 8:36 AM, the admission Coordinator revealed if a resident was accepted for admission, she ensured they had a PASRR and if not, she would request one. The admission Coordinator revealed she applied for PASRR evaluations by entering the resident's medications, mental health diagnoses, nursing notes, and the Medicaid Long Term Care FL2 form. She revealed if a resident had a PASRR Level I determination and a mental health diagnosis she informed the SW. The admission Coordinator revealed she had not requested PASRR reevaluations since she had started her position. An interview was conducted on 12/18/25 at 3:48 PM with the Administrator. The Administrator revealed PASRR was discussed during morning meetings and the re-evaluation for Resident #7 was missed. The Administrator revealed the process for when a resident had a mental health diagnosis and a PASRR Level I, a request for reevaluation would need to be submitted and it was the SW's responsibility for requesting PASRR evaluations. 3. There was no PASRR Determination Notification letter included in Resident #52's medical records. A screenshot copy of the PASRR lookup and tracking included in the medical records revealed Resident #52 had a PASRR Level I with no expiration date. There was no date to show when Resident #52 was screened and the PASRR Level I remained valid. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #52 was admitted to the facility on [DATE] with cumulative diagnoses that included diabetes mellitus, bipolar disorder, moderate major depressive disorder, and toxic encephalopathy (exposure to toxic substances that alters brain function). The care plan initiated on 10/18/25 revealed Resident #52 received psychotropic medications for the diagnoses of depression and bipolar disorder that had the potential for cardiac and gastrointestinal side effects. Interventions included monitor for mood, behaviors, physical aggression, feeling unsafe and document and notify the physician, administer medications per physician's orders, and monthly and as ordered pharmacy review of medications. A Medical Doctor (MD) progress note dated 10/22/25 revealed Resident #52 was seen for a new patient admission and toxic encephalopathy. The MD noted Resident #52's past history of bipolar disorder, depression, anxiety, and insomnia and continued the current medications aripiprazole (antipsychotic) 10 mg daily for depression related to bipolar disorder, sertraline (antidepressant) 25 mg once a day and 100 mg at bedtime for depression, trazodone (antidepressant) 50 mg at bedtime for insomnia, divalproex sodium (anticonvulsant) 250 mg twice a day for mood. The MD noted Resident #52 had positive effects and the psychotropic medications were used to benefit mental and physical wellbeing and were without any reported or noted side effects. The admission MDS assessment dated [DATE] revealed Resident #52 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #52's active psychiatric/mood disorder diagnoses included bipolar disorder and depression, and antipsychotic, antidepressant and anticonvulsant medications were taken during the assessment lookback period. Review of Resident #52's medical records revealed there was no documented evidence that a request for an evaluation for a Level II PASRR was made. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #52. During an interview on 12/16/25 at 2:07 PM, the Social Worker (SW) revealed PASRR was discussed during the morning meetings and included review of psychotropic medications, and she would be informed if a request for a PASRR evaluation needed to be submitted. The SW revealed no request for a PASRR review had been done for Resident #52 and stated ideally when a resident admitted with a mental health diagnosis and had a PASRR Level I, a request for re-evaluation should have been done. During an interview on 12/18/25 at 8:36 AM, the admission Coordinator revealed if a resident was accepted for admission, she ensured they had a PASRR and if not, she would request one. The admission Coordinator revealed she applied for PASRR evaluations by entering the resident's medications, mental health diagnoses, nursing notes, and the Medicaid Long Term Care FL2 form. She revealed if a resident had a PASRR Level I determination and a mental health diagnosis she informed the SW. The admission Coordinator revealed she had not requested PASRR reevaluations since she had started her position. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 12/18/25 at 3:48 PM with the Administrator. The Administrator revealed PASRR was discussed during morning meetings and the re-evaluation for Resident #52 was missed. The Administrator revealed the process for when a resident had a mental health diagnosis and a PASRR Level I, a request for reevaluation would need to be submitted and it was the SW's responsibility for requesting PASRR evaluations. 4. A Pre-Admissions Screening and Resident Review (PASRR) Determination Notification letter dated 10/14/23 revealed Resident #50 had a Level I PASRR with no expiration date. Resident #50 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic kidney disease stage 4, and diabetes mellitus type 2, post-traumatic stress disorder (PTSD), major depressive disorder, obsessive-compulsive disorder (OCD), and anxiety. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. He received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications during the MDS assessment period. Resident #50's active psychiatric/mood disorder diagnoses included anxiety disorder, major depressive disorder and PTSD. A Psychiatric progress note dated 12/04/25 revealed Resident #50 was seen for ongoing medication management and symptom monitoring of depression and anxiety with impulsivity and obsessive-compulsive symptoms, history of self-harm and inappropriate sexual actions toward staff. Resident #50 was taking sertraline (antidepressant) daily for OCD and depression, trazodone (antidepressant) for insomnia, and divalproex sodium (anticonvulsant) for mood stabilization. He was taking clonazepam for anxiety, which has changed from 0.5 mg three times per day as needed to 0.5 mg twice a day scheduled for 8:00 am and 2:00 pm as well as 0.5 mg once a day as needed. Review of Resident #50's medical record revealed there was no Level II PASRR evaluation. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #50. During an interview on 12/18/25 at 8:46 AM, the admission Coordinator revealed she was responsible for verifying if a resident had a PASRR in the North Carolina Medicaid Uniform Screening Tool (NC MUST) before admission to the facility. If the resident had a valid PASRR in NC MUST she would accept the resident, if the resident did not have a valid PASRR she would submit the application for a Level I PASRR evaluation. She stated the PASRR application required the residents' diagnoses. If the resident had a mental health diagnosis the PASRR application would be elevated to a Level II PASRR which required additional information that included the resident's medications, history and physical, FL2 form (form used by medical providers to communicate health status and care requirements of a resident to care facilities), and medical provider notes provided to NC MUST. The admission Coordinator also confirmed that Resident #50 had a Level I PASRR assigned before admission to the facility, therefore a request for a Level II PASRR evaluation had not been submitted. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Social Worker (SW) on 12/16/25 at 2:07 PM. The SW stated the PASRR process included the admission Coordinator would confirm the residents had a Level I PASRR or Level II PASRR determination upon admission to the facility. During the clinical team meeting, the team reviewed psychotropic medications and the resident diagnoses and informed the SW if a PASRR re-evaluation or significant change request was needed. The SW also revealed she had not been asked to submit a request for an evaluation for a Level II PASRR for Resident #50 until 12/16/25, when she was asked to provide documentation of the Level II PASRR. An interview with the Administrator on 12/18/25 at 3:47 PM revealed residents were discussed in daily clinical team meetings and if it was determined that a resident needed an evaluation for a Level II PASRR the SW would be responsible for requesting the evaluation for a Level II PASRR. The Administrator acknowledged a request for a level II PASRR evaluation should have been submitted for Resident #50 by the SW due to Resident #50's mental health diagnoses.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility failed to ensure a qualified staff member with the necessary skills and licensure inserted a peripheral intravenous (IV) catheter when a Medication Aide used the needle from an IV catheter kit and inserted it into a resident's arm (Resident #78). The deficient practice was identified for 1 of 5 nursing staff reviewed for sufficient and competent nurse staffing (Medication Aide #1). Findings included: Resident #78 was admitted to the facility on [DATE] with diagnoses that included arthritis, dementia, Alzheimer's disease, and diabetes mellitus. Resident #78 was discharged from the facility on 11/16/25. The admission Minimum Data Set assessment dated [DATE] revealed Resident #78 was severely impaired cognitively, was dependent or required substantial to maximum assistance with activities of daily living, and had taken antianxiety, antibiotic, antiplatelet medications during the lookback period of the assessment.Review of Resident #78's physician's order dated 06/01/25 to administer one (1) liter of 0.9% sodium chloride intravenously at 100 milliliters (ml) per hour for one day for hydration. Review of Nurse #1's progress note dated 06/01/25 revealed she had received a physician's order to administer one liter of 0.9% normal saline at 100 ml/hour intravenously to Resident #78. Nurse #1 noted attempts to start the IV were unsuccessful.An interview was conducted on 12/17/25 at 4:25 PM with Nurse #1. Nurse #1 stated she received a physician's order to administer IV fluids for Resident #78 on 06/01/25, but her attempt for intravenous access was unsuccessful. Nurse #1 stated she had left the room and did not observe Medication Aide #1 attempt to insert the IV catheter. She stated Medication Aide #2 was in the room and saw what happened and reported the incident to the former Assistant Director of Nursing (ADON) #2. Nurse #1 stated she was not made aware of the incident until the next day (06/02/25) when the former ADON #2 called her at home. Nurse #1 stated she had not witnessed a staff member attempt something out of their scope of practice but if she had she would immediately report it by following her chain of command.Review of Medication Aide #1's typed statement revealed she was in the room with Nurse #1 and was there to help calm Resident #78 and assist Nurse #1. The statement indicated Nurse #1 was successful in obtaining a blood draw but was unable to successfully get the IV started and had left the room. After Nurse #1 left the room Medication Aide #1's statement indicated she asked Resident #78 if she could try to start the IV and Resident #78 stated, yes that was fine. The statement indicated Medication Aide #1 made one attempt to insert the peripheral IV catheter and was able to get blood return but unsuccessful in maintaining the IV when the vein collapsed. Medication Aide #1's statement indicated she was attending nursing school and had practiced starting an IV and she meant no harm to Resident #78. The statement was signed on 07/29/25 by Medication Aide #1 and the former Administrator.Attempts to speak with Medication Aide #1 by phone on 12/17/25 at 2:26 PM were unsuccessful. The contact number provided by the facility was not a working number. Review of Medication Aide #2's written statement revealed on 06/01/25 she observed Medication Aide #1 opening an IV catheter kit and stick Resident #78 in the arm in attempt to insert a peripheral IV catheter. The statement indicated the attempt was unsuccessful and Medication Aide #2 used gauze and a band aid to cover the area and stop the bleeding and had spoken to the nurse about what to do.A telephone interview was conducted with Medication Aide #2 on 12/18/25 at 9:00 AM. Medication Aide #2 stated she saw Medication Aide #1 attempt to start an IV on 06/01/25 and described what she saw was Medication Aide #1 stick Resident #78 in the left arm. After the attempt to start the IV, Medication Aide #2 recalled Resident #78 stated she was, okay. Medication Aide #2 stated she told the former ADON #2 about what happened and was asked to write a witness statement. Medication Aide #2 indicated she and Medication Aide #1 were interviewed by the former ADON #2 who discussed scope of practice and told Medication Aide #1 she could not start an IV. Medication Aide #2 stated she had received multiple educational in-services related to knowing your scope of practice and she knew not to attempt injections or attempt to insert an IV catheter.A telephone interview was conducted on 12/19/25 at 12:39 PM with the former ADON #2. The former ADON #2 stated she was not at the facility on 06/01/25 when Medication Aide #1 attempted to insert an IV catheter for Resident #78. She stated she was told there was no nurse in the room, but the incident was witnessed by Medication Aide #2. She questioned both Medication Aide #1 and Medication Aide #2 and Medication Aide #1 confirmed she attempted to start an IV for Resident #78. She reinforced Medication Aides do not start an IV and informed the former Administrator who took over the investigation. A telephone interview was conducted on 12/19/25 at 1:53 PM with the former Administrator who stated after the incident was reported

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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 record review, observations, and staff interviews, the facility failed to maintain oral hygiene for a dependent resident unable to brush their teeth for 1 of 3 residents reviewed for activities of daily living (Resident #31). The findings included: Resident #31 was admitted to the facility on [DATE] with diagnoses including autoimmune disease affecting the central nervous system, paralysis or severe weakness affecting the ability to move, and visual impairment. A review of the dental visit note dated 10/13/25 revealed Resident #31's periodontal health was documented as red tissue with a heavy buildup, plaque and calculus as heavy and oral hygiene as poor. The recommendations were for routine oral hygiene and follow up as needed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was severely impaired cognitively, had upper extremity range of motion impairment on both sides, and was dependent on staff for oral hygiene. The care plan revised on 10/23/25 revealed Resident #31 required assistance with activities of daily living related to diagnoses and upper extremity contractures and was dependent on staff assistance for oral hygiene. During an interview on 12/16/25 at 9:32 AM, the Responsible Party (RP) stated Resident #31 required total care with oral hygiene and it was not routinely done. The RP revealed when family visited they had observed Resident #31's teeth were not clean and needed to be brushed, and they provided oral hygiene care. An interview and observation was conducted on 12/16/25 at 11:59 AM with Resident #31. When asked Resident #31 showed she had no lower teeth, and her upper front teeth had a white colored buildup of debris at the gum line and around several of her front teeth. When asked if staff brushed her teeth Resident #31 nodded her head as to say no. An observation on 12/17/25 at 3:41 PM revealed no change in Resident #31's front upper teeth and a white colored buildup of debris remained on the teeth and gums. An interview and observation was conducted on 12/18/25 at 11:40 AM with Nurse Aide (NA) #1. NA #1 revealed Resident #31 was dependent on staff and required total assistance with activities of daily living care. NA #1 revealed he had not offered or provided oral hygiene care for Resident #31 and stated he usually provided oral care during the afternoon. Upon request Resident #31 showed NA #1 her front upper teeth which continued to have the white colored buildup of debris on the teeth and along the gums and needed to be brushed. An observation and interview was conducted on 12/18/25 at 12:05 PM with the Director of Nursing (DON). The DON observed Resident #31's upper front teeth had a white colored buildup of debris and asked the resident if she wanted her teeth brushed. Resident #31 nodded her head as to say yes. The DON asked Resident #31 if she had been offered to have her teeth brushed and Resident #31 nodded her head as to say no. It was explained to the DON, Resident #31's teeth was observed to have a white colored buildup on 12/16/25, 12/17/25, and 12/18/25. The DON stated oral hygiene care should be done at least daily. During an interview and observation on 12/18/25 at 12:51 PM, NA #2 offered to brush Resident #31's upper teeth. NA #2 brushed Resident #31's upper teeth and the white colored buildup of debris was easily removed. NA #2 indicated oral hygiene care was done daily as part of the morning care. During an interview on 12/18/25 at 4:30 PM, the Administrator revealed oral hygiene care should be done at least daily.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews with the Pharmacy Operation Manager and staff, the facility failed to have effective systems in place for the return of controlled medications to the pharmacy for 3 of 3 residents (Resident #15, Resident #25 and Resident #79).The findings included:a. The physician's order dated 03/19/25 revealed Resident #15 was to receive hydrocodone-acetaminophen (a combination of a narcotic opioid analgesic and a non-narcotic medication to relieve pain) 5-325 milligrams (mg) every 4 hours as needed (PRN) for left leg pain.The controlled substance count record dated 03/20/25 revealed Resident #15 had 30 tablets of hydrocodone-acetaminophen 5-325 mg with the RX# (prescription number) 17427852. Starting on 03/20/25, nurses signed the form indicating the medication was removed and administered to Resident #15 as follows: one dose on 3/20/25, one dose on 3/21/25, one dose on 3/24/25, one dose on 3/26/25, one dose on 3/31/25, one dose on 4/1/25, one dose on 4/8/25, one dose on 4/11/25, one dose on 4/12/25, one dose on 4/13/25, two doses on 4/14/25, one dose on 4/16/25, one dose on 4/17/25, two doses on 4/18/25, one dose on 4/21/25, two doses on 4/22/25, and one dose on 4/23/25. Following the last dose that was administered on 4/23/25, Resident #15 had 10 tablets left remaining.The March 2025 medication administration record (MAR) revealed starting on 03/20/25 Resident #15 received a total of 5 tablets of hydrocodone-acetaminophen 5-325 mg. The medication was documented as administered per physician order on 3/20/25 at 7:28 PM, 3/21/25 at 8:09 PM, 3/24/25 at 7:34 PM, 3/26/25 at 8:15 PM, and 3/31/25 at 8:24 PM. No further doses were documented as administered for the remainder of the month.The April 2025 MAR revealed Resident #15 received a total of 15 tablets of hydrocodone-acetaminophen 5-325 mg. The medication was documented as administered on 4/1/25 at 12:45 AM, 4/8/25 at 9:40 PM, 4/11/25 at 9:08 PM, 4/12/25 at 7:56 PM, 4/13/25 at 8:27 PM, 4/14/25 at 7:42 PM and 11:50 PM, 4/16/25 at 8:30 PM, 4/17/25 at 8:11 PM, 4/18/25 at 4:40 AM and 8:03 PM, 4/21/25 at 8:15 PM, 4/22/25 at 4:50 AM and 8:23 PM, and 4/23/25 at 8:03 PM. No further doses were documented as administered for the remainder of the month.The physician's order dated 03/19/25 for Resident #15's hydrocodone-acetaminophen 5-325 mg was discontinued on 04/28/25.The Pharmacy Return of Drugs form dated 4/28/25 and signed by Medication Aide #1 revealed Resident #15's RX #17427852 for hydrocodone-acetaminophen 5-325 mg with 10 tablets remaining was being returned due to the medication being discontinued.b. The physician's order dated 03/27/25 revealed Resident #25 was to receive one tablet of oxycodone (opioid) 5 milligrams (mg) by mouth every 8 hours as needed (PRN) for post-surgical pain.The controlled substance count record dated 03/27/25 revealed Resident #25 had 30 tablets of oxycodone 5 mg with the RX# (prescription number) 17469121. Starting on 04/13/25, nurses signed the form indicating the medication was removed and administered to Resident #25 starting as follows: one dose on 4/13/25, one dose on 4/14/25, one dose on 4/15/25, one dose on 4/16/25, one dose on 4/17/25, two doses on 4/18/25, one dose on 4/19/25, one dose on 4/21/25, two doses on 4/22/25, one dose on 4/23/25, and one dose on 4/24/25. Following the last dose that was administered on 4/24/25, Resident #25 had 17 tablets left remaining.The April 2025 MAR revealed Resident #25 received a total of 13 tablets of oxycodone 5 mg. The medication was documented as administered on 4/13/25 at 7:58 PM, 4/14/25 at 7:48 PM, 4/15/25 at 6:27 AM, 4/16/25 at 8:24 PM, 4/17/25 at 8:40 PM, 4/18/25 at 6:06 AM and 8:10 PM, 4/19/25 at 7:56 PM, 4/21/25 at 8:20 PM, 4/22/25 at 5:18 AM and 8:03 PM, 4/23/25 at 7:51 PM, and 4/24/25 at 8:00 PM. No further doses were documented as administered for the remainder of the month.The physician's order dated 03/27/25 for Resident #25's oxycodone 5 mg was discontinued on 04/25/25.The Pharmacy Return of Drugs form dated 4/28/25 and signed by Medication Aide #1 revealed Resident #15's RX #17469121 for oxycodone mg with 17 tablets remaining was being returned due to the medication being discontinued.c. The physician's order dated 03/10/25 revealed Resident #79 was to receive one tablet of oxycodone-acetaminophen (a combination of a narcotic opioid analgesic and a non-narcotic medication to relieve pain) 5-325 milligrams (mg) one tablet every 4 hours as needed (PRN) for pain. The controlled substance count record dated 04/23/25 for the RX# (prescription number) 17508525 revealed Resident #79 had 30 tablets of oxycodone-acetaminophen 5-235 mg. There were no signatures indicating the medication was administered.The physician's order dated 03/10/25 for Resident #79's oxycodone-acetaminophen 5-235 mg was discontinued on 04/25/25.The Pharmacy Return of Drugs form dated 4/28/25 and signed by Medication Aide #1 revealed Resident #79's RX #17508525 for oxycodone-acetaminophen 5-235 mg with 30 tablets remaining was being returned due to the medication being discontinued The initial allegation report dated 06/21/25 revealed on 06/20/25 at 10:45 AM the facility

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with the Registered Dietitian (RD) and staff, the facility failed to follow the physician's diet order for double portions at breakfast and the enriched meal program for 1 of 5 residents reviewed for nutrition (Resident #52). Findings included: Resident #52 was admitted to the facility on [DATE] with diagnoses including adult failure to thrive and moderate protein-calorie malnutrition. The admission Minimum Data Set assessment dated [DATE] revealed Resident #52 was severely impaired cognitively, required partial to moderate assistance with eating, had no swallowing disorders, weighed 101 pounds with no documented weight changes, and had a stage two (partial-thickness loss of skin with exposed dermis) pressure ulcer that was present on admission. Review of the RD progress note dated 10/27/25 included recommendations Resident #52 participated in the enriched meal program and received double portions at breakfast. Review of the physician's orders revealed a diet order dated 10/27/25 for double portions at breakfast and participation in the enriched meal program. The nutrition care plan initiated on 11/06/25 identified risk for weight changes related to varied intake and diagnoses. Interventions included to provide diet as ordered.During an observation on 12/16/25 at 8:12 AM, Resident #52 had received a breakfast meal that consisted of 2 pieces of bacon, 3 French toast sticks, a container each of orange and grape juice. Resident #52's diet card indicated, Special diets: double portion breakfast, enhanced meal program, 8 ounces of chocolate milk, and 8 ounces of oatmeal and listed grits as a dislike. However, the tray did not include chocolate milk or oatmeal. An interview was conducted on 12/16/25 at 8:18 AM with Nurse Aide (NA) #3. NA #3 revealed he helped serve breakfast trays to the residents on the unit but did not serve Resident #52. NA #3 read the diet card instructions and confirmed Resident #52 was supposed to receive double portions and there was no oatmeal or chocolate milk on the tray. NA #3 did not know what the enriched meal plan meant. During an interview on 12/16/25 at 3:14 PM, the Dietary Manager revealed the dietary staff member who placed Resident #52's breakfast tray on the serving cart was responsible for ensuring the food served matched the instructions on the diet card. A second interview was conducted on 12/17/25 at 3:30 PM with the Dietary Manager. The Dietary Manager revealed for double portions, Resident #52 should have received four pieces of bacon and four French toast sticks. The Dietary Manager further revealed that on 12/16/25 cheese grits were served as the enhanced meal food item but was listed as a dislike on Resident #52's diet card. The Dietary Manager revealed Resident #52 should have received the substitute for the enriched meal plan which was fortified milk or an essential breakfast drink. An interview was conducted on 12/19/25 at 2:51 PM with the RD. The RD explained Resident #52 was underweight with a stage two pressure ulcer at admission. The RD explained the enriched meal program included food items like oatmeal that was made with sugar and milk for extra calories and double portions were ordered because Resident #52 consumed more at breakfast. The RD confirmed meals served should match the diet card. During an interview on 12/19/25 at 3:49 PM, the Administrator stated the food served to Resident #52 should match the physician's order and diet card.

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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 observations and staff interviews, the facility failed to discard food past its use-by date in 1 of 1 walk-in cooler and store food off the floor in 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents. The findings included:a. During an initial observation of the facility's kitchen with the Dietary Manager on 12/15/25 at 9:59 AM, the walk-in cooler had two (2) one-quart sized containers of lemon-flavored thickener with a use-by date of 10/28/25.b. During an initial observation of the facility's kitchen with the Dietary Manager on 12/15/25 at 10:12 AM the walk-in freezer was noted to have the following concerns:-Three (3) boxes of frozen turkeys, four turkeys per box, placed on the floor in the center of the walk-in freezer.-One (1) box of french toast sticks placed on the floor in the center of the walk-in freezer.An interview with the Dietary Manager on 12/16/25 3:14PM revealed that food items should not be available to be served to residents past the use-by date and the turkeys and french toast sticks were not stored correctly in the walk-in freezer. The Dietary Manager discarded the food items from the walk-in cooler that were past the use-by date. The Dietary Manager stated that all dietary staff had the responsibility to check dates on food items weekly and food items past the used-by date should be discarded. He further stated that food items in the walk-in freezer should not be placed on the floor. He revealed the facility had given turkeys to the staff for the holidays and the freezer had limited space to store the extra turkeys. He stated staff had to move the turkeys and french toast sticks to get food items off the shelf and did not put the turkeys and french toast sticks back on the shelf.An interview with the Administrator on 9/25/2025 at 1:22 PM revealed that all dietary staff should have checked use-by dates on food items daily and that food items past the use-by date would be discarded. In addition, the dietary staff should report the food items past the use-by date to the Dietary Manager. The Administrator stated food items should not have been placed on the floor of the walk-in freezer and if dietary staff discovered food items placed on the floor of the walk-in freezer they should inform the Dietary Manager.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observations, and staff interviews, the facility failed to implement their infection control policy and procedures for Enhanced Barrier Precautions (EBP) when Nurse #2 did not put on a protective gown prior to a high contact care activity that involved administering a nutritional supplement and water flushes through a resident's (Resident #45) feeding tube (a medical device inserted into the stomach). This occurred for 1 of 5 staff members reviewed for infection control practices (Nurse #2). Findings included: The facility's Infection Control Policy and Procedures guideline for initiation of precautions last revised on 6/13/24 read in part, isolation precautions for EBP was utilized by staff for residents who had an implanted medical device when providing care and precautions included to wear a gown. A continuous observation on 12/15/25 at 12:04 PM through 12:27 PM revealed an EBP sign was posted on the door of Resident #45's room with instructions staff must wear a gown for high contact resident care activities. High contact care activities listed included use of a feeding tube. An over-the-door storage bin was in place and contained protective gowns available for use. Nurse #2 accessed Resident #45's feeding tube to administer water flushes and a nutritional supplement. Nurse #2 did not wear a protective gown during high-contact care of Resident #45's feeding tube. During an interview on 12/19/25 at 11:31 AM, Nurse #2 revealed Resident #45 had been on contact precautions, but she was told the precautions had been removed. Nurse #2 revealed she was not aware Resident #45 was under any type of precautions at the time she completed the tube feeding. An interview was conducted on 12/19/25 at 10:27 AM with the Staff Development Coordinator/Infection Preventionist in the presence of the Director of Nursing (DON). The Staff Development Coordinator/Infection Preventionist revealed she recently started at the facility, and she and the DON worked together on Infection Control. The Staff Development Coordinator/Infection Preventionist stated Nurse #2 should have put on a protective gown when she administered the water flushes and nutritional supplement for Resident #45's feeding tube. An interview was conducted on 12/19/25 at 10:27 AM with the DON. The DON revealed she worked with the Staff Development Coordinator/Infection Preventionist because she recently started her position at the facility. The DON revealed Nurse #2 should have put on a protective gown when she administered the water flushes and nutritional supplement for Resident #45's feeding tube.