STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yanceyville Rehabilitation and Healthcare Center	1086 Main Street North Yanceyville, NC 27379

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Psychiatric Nurse Practitioner (NP) interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation after a new serious mental illness disorder was identified for residents previously determined to have a Level I PASRR status for 4 of 8 residents reviewed for PASRR (Residents #10, #79, #120, #145). 3. Resident #120's Level I PASRR Determination Notification document dated 6/12/25 revealed the document was valid for his stay at the facility. The document further indicated no further PASSR screening was required unless a significant change occurred. Resident #120 was admitted on [DATE] with a diagnosis of major depressive disorder. Review of physician orders revealed an order dated 10/13/25 for Risperidone (an antipsychotic medication used to treat bipolar disorder) 0.5 milligram (mg) at bedtime for mood. Review of a Psychiatric note dated 11/19/25 revealed Resident #120 was assessed by the Psychiatric Nurse Practitioner (NP). The NP diagnosed Resident #120 with bipolar disorder at that time based on his findings. The plan of care was for Resident #120 to continue taking his current order for Risperidone for bipolar disorder. An interview was conducted on 5/28/26 at 3:39 PM with Psychiatric NP. The Psychiatric NP stated Resident #120 was assessed on 11/19 25 and diagnosed with bipolar disorder. The Psychiatric NP indicated at that time the NP continued Resident 120's current Risperidone order for bipolar disorder, instead of insomnia. The Psychiatric NP indicated that when a new diagnosis for a serious mental disorder was added for a resident, a Level II PASSR should have been requested at that time. Resident #120's current medication orders showed an active order dated 5/1/26 for Risperidone 0.25 mg at night for bipolar disorder. Review of Resident #120's diagnosis list revealed a diagnosis of bipolar disorder was added on 2/4/26. Review of a Psychiatric note dated 2/4/26 revealed Resident #120 was assessed by the Psychiatric NP and diagnosed with bipolar disorder at that time. Risperidone was continued for bipolar disorder. The resident was already diagnosed with bipolar disorder on 11/19/25 per the note and the interview. An interview was conducted on 5/28/26 at 2:25 PM with Nurse Manager #1 who entered the bipolar disorder diagnosis for Resident #120 on the diagnosis list on 2/4/26. Nurse Manger #1 indicated the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bipolar disorder diagnosis was added after reviewing Resident #120's assessment completed by the Psychiatric NP on 2/4/26. Nurse Manager # 1 indicated she did not review Resident #120's assessment completed by the Psychiatric NP on 11/19/25. She further indicated Resident #120 was not part of her case load and she would have entered the bipolar diagnosis on 11/19/25, if she had reviewed the assessment. The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 120 was cognitively intact. The MDS further revealed that Resident # 120 had an active diagnosis of depression and bipolar disorder. Resident #120 received antipsychotic and antidepressant medication daily. The MDS also revealed Resident #120 the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation, or a related condition. The care plan dated 5/26/26 revealed Resident #120 had a focus area for use of psychotropic medications related to bipolar disorder. The interventions included administer psychotropic medication as ordered, monitor for side effects, and observe for adverse reactions. An interview was conducted on 5/29/26 at 9:53 AM with the Social Worker. The SW stated she was responsible for submitting requests for Level II PASRR evaluations for residents with a new mental health diagnosis. She indicated that a Level II PASRR should have been requested for Resident #120 for the new diagnosis of bipolar disorder on 11/19/55 and it was an oversight her on her part. An interview was conducted with the facility's Administrator on 5/29/26 at 4:20 PM who was not aware Resident #120's Level II PASRR had not been completed. The facility's Administrator indicated it was the responsibility of the SW to submit the request for Level II PASSR evaluation. She further indicated the SW should have submitted the request as soon as Resident #120 received the diagnosis of bipolar disorder on 11/19/25. 3. A review of Resident #145's PASRR (Preadmission Screening and Annual Resident Review) determination notification letter dated 12/17/2020 indicated that Resident #145 did not meet the federal definition for mental illness or intellectual disability, and the PASRR number was listed as Level I. Resident #145 was admitted to the facility on [DATE]. At the time of admission, the resident did not have a diagnosis of bipolar disorder. A psychiatric note dated 07/10/2023 stated, in part, that the resident had moderate bipolar disorder, current/most recent episode depressed. A review of Resident #145's diagnosis list showed that he had been diagnosed with bipolar disorder on 08/18/2023. A psychiatry medication reconciliation and monitoring note dated 04/14/2026 also listed moderate bipolar disorder, current/most recent episode depressed under the problem list. Resident #145's quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact and exhibited mood symptoms. Further review of the MDS revealed Resident #145 received antidepressants during the assessment period. An interview was conducted on 05/29/26 at 4:38 pm with the Psychiatric Nurse Practitioner, who (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed that Resident #145 had received a new diagnosis of bipolar disorder on 08/18/2023. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. Attempts had been made to contact the previous Social Worker, but these were unsuccessful. During an interview on 05/29/2026 at 5:00 p.m., the current Social Worker reported that she had started working in the facility in January 2026. She stated that Resident #145 should have had a PASRR review completed when the bipolar disorder diagnosis was made. An interview with the Administrator on 05/29/2026 at 5:06 p.m. revealed that the previous Social Worker was no longer employed at the facility and that a PASRR review should have been completed when Resident #145 received the bipolar disorder diagnosis. Example #1 of 3 The findings included: 1.Resident #10 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder. A Level I PASRR Determination Notification letter dated 12/9/24 revealed Resident #10 had a Level I PASRR with no expiration dated that indicated No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. Review of Resident #10's list of diagnoses revealed she was diagnosed with schizophrenia on 8/12/25. Review of physician order dated 8/12/25 indicated olanzapine (Zyprexa) (an atypical second-generation prescription antipsychotic used primarily to treat schizophrenia and bipolar disorder) oral tablet 5 milligrams (MG), give 1 tablet by mouth one time a day for schizophrenia. Review of Psychiatric (psych) Nurse Practitioner (NP) progress note dated 8/12/25 revealed his visit was for psych medication follow-up for bipolar. The resident stated, the voices are little better, but I am still hearing them. The resident was tolerating medication well. Resident had diagnosis of bipolar disorder which was unstable. She was to continue lamictal (a mood stabilizer) for bipolar disorder, Zyprexa for psychotic features, and lithium (prescription mood stabilizer primarily used to treat and prevent manic episodes in bipolar disorder) for bipolar disorder. Review of Psychiatric (psych) Nurse Practitioner (NP) progress note dated 10/13/25 indicated a diagnosis of schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively intact with no behaviors present. Her current diagnoses included bipolar disorder and schizophrenia. She received antipsychotic and antidepressant medications. Review of Resident #10's psychiatry medication reconciliation and monitoring progress note dated 5/11/26 by the Psychiatric Nurse Practitioner (NP) revealed resident had a history of schizophrenia. The resident stated she had fewer auditory and visual hallucinations and fewer delusional thoughts. She had been increasingly less fearful of internal stimuli. The NP note stated Zyprexa for bipolar disorder. A phone interview was held on 5/28/26 at 4:42 PM with Psychiatric Nurse Practitioner (NP). He stated Resident #10 was one of the very few residents he diagnosed with schizophrenia. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. Attempts to reach the previous social worker were unsuccessful. On 5/29/26 at 5:00 PM, an interview was held with the Director of Social Work (SW). She stated the PASRR review should have been entered for a new assessment. The SW stated she just received access to the North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) in April 2026 to submit for PASRR reviews. Interview with the Administrator was conducted on 5/29/26 at 5:06 PM. The Administrator indicated a new PASRR review should have been completed when a new mental health diagnosis was determined. The Administrator explained the previous SW was the reason the PASRR was not submitted for review. 2. Resident #79 was initially admitted to the facility on [DATE] with no diagnoses of major depressive disorder or bipolar disorder. A Level I PASRR Determination Notification letter dated 10/2/24 revealed Resident #79 had a Level I PASRR with no expiration dated that indicated No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. Review of the Psychiatric Nurse Practitioner (NP) progress note dated 6/30/25 indicated the Resident #79 stated, The antidepressant is not working patient complains of mood swings. The resident was tolerating medication well. He complained of depressed mood and mood swings. Resident was on trazodone (an antidepressant) HCl oral tablet 100 MG at bedtime. Discontinue Auvelity (used to treat major depressive disorder (MDD) in adults and agitation associated with dementia). Continue trazodone for insomnia. Start lamictal (a mood stabilizer) for bipolar disorder. Lamictal oral tablet 25 MG, give 1 tablet by mouth two times a day for bipolar disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #79's list of diagnoses revealed he was diagnosed with bipolar disorder on 6/30/25. Review of physician order dated 3/16/26 indicated Auvelity oral tablet extended release 45-105 milligrams (MG), give 1 tablet by mouth two times a day for depression related to major depressive disorder. Review of Resident #79's psychiatry medication reconciliation and monitoring progress note dated 4/14/26 by the Psychiatric Nurse Practitioner (NP) revealed resident had a history of mood disorder. Resident #79 to continue to receive Auvelity (used to treat major depressive disorder (MDD) in adults and agitation associated with dementia) for mood and trazadone for insomnia. The quarterly MDS assessment dated [DATE] revealed Resident #79 was cognitively intact with no behaviors present. His current diagnoses included depression and bipolar disorder. He received antidepressant medication daily. A phone interview was held on 5/28/26 at 4:36 PM with Psychiatric Nurse Practitioner (NP). He stated Resident #79 had bipolar disorder. He was on medication Lamictal and resident requested to be taken off that medication. The NP stated he was treating Resident #79 with Auvelity and resident was responding to this medication. The NP stated resident's psychiatric diagnosis was diagnosed by him and while Resident #79 was in the facility. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. Attempts to reach the previous social worker were unsuccessful. On 5/29/26 at 5:00 PM, an interview was held with the Director of Social Work (SW). She stated the PASRR review should have been entered for a new assessment. The SW stated she just received access to the North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) in April 2026 to submit for PASRR reviews. Interview with the Administrator was conducted on 5/29/26 at 5:06 PM. The Administrator indicated a new PASRR review should have been completed when a new mental health diagnosis was determined. The Administrator explained the previous SW was the reason the PASRR was not submitted for review.

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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 observation and staff interviews, the facility failed to store dry food away from moisture, keep dry goods covered, failed to label and date leftover food stored for use, and discard expired food. This was for 1 of 1 dry goods storage room, 1 of 1 walk-in cooler, 1 of 1 walk-in freezer and 1 of 1 reach-in refrigerator. The facility also failed to maintain the walkˆin refrigerator floor in a clean and sanitary condition, keep 1 of 4 ice machines clean, and failed to maintain the ceiling above the steam table to prevent peeling paint. These failures had the potential to affect food served to residents.Findings include:1a. On 5/26/26 at 9:20 AM during an observation of the dry storage area with Dietary Manager #1, eight 8ˆounce white disposable cups halfˆfilled with rice crisp cereal sat on a tray with white powder on the surface. The cups were covered. A second tray was stacked on top of the white disposable cups. The tray also had twelve 8ˆounce disposable cups of dry cereal that were covered. The tray also had some white powder on it. None of the cups were labeled or dated. On 5/26/26 at 9:22 AM, during an observation of the air-dry rack, three large plastic bags of dry cereal were observed on the airˆdry rack near the threeˆcompartment sink. Two bags were halfˆfilled, and one was full of breakfast cereal. None of the plastic bags were labeled or dated, and the bags were stored next to wet, recently washed dishes.During an interview on 5/26/26 at 9:20 AM, Dietary Manager #1 stated the cereal was used for the morning breakfast tray line.b. On 5/26/26 at 9:25 AM, an observation of the walk-in refrigerator with Dietary Manager #1 revealed the following: A movable cart in the center holding two large pans of green food and one large pan of whitishˆpink food, all partially covered with parchment paper and not labeled or dated, On a side rack, two trays containing twentyˆfour 6ˆounce cups of thickened liquids stacked on top of each other. The trays were wet, and none of the cups were labeled or dated, On another rack, a deep pan containing meat wrapped in foil with pink liquid inside the pan. The pan was labeled Turkey 5/28 lunch. The pan was stored on a middle shelf, Directly beneath the thawing meat, an open cardboard box held fresh cabbage, and a clear 2ˆgallon plastic bag halfˆfilled with shredded cheese stored next to it. The plastic bag was not labeled or dated.During an interview on 5/26/26 at 9:28 AM, Dietary Manager #1 stated the green food was broccoli salad and the whitishˆpink food was tuna salad, planned for lunch meal use on 5/26/26. He stated he did not know why the turkey was thawing on the middle rack and acknowledged that thawing meat should be placed on the bottom rack with no food stored beneath it. During an interview on 5/29/26 at 1:00 PM, the District Dietary Manager stated the turkey in the pan was precooked, frozen turkey, wrapped in foil and plastic wrap. The District Dietary Manager indicated the staff had placed the precooked frozen Turkey in a pan with water to prevent drying during thawing. c. On 5/28/26 at 11:35 AM, a follow-up observation of the walk-in refrigerator with the District Dietary Manager revealed two trays containing twelve 6ˆounce cups each, threeˆquarters filled with thickened liquids. None of the cups were labeled or dated. Staff had stacked two unopened cardboard boxes directly on top of the trays.During an interview on 5/28/26 at 11:37 AM, the District Dietary Manager stated the weekly stock delivery arrived and staff may have placed boxes on top of the trays. She stated she did not see an issue with stacking boxes on the trays because the cups had lids.d. On 5/26/26 at 9:35 AM, an observation of the walk-in freezer with the Dietary Manager #1 revealed the following: A large plastic pan of Brussels sprouts partially covered with cling wrap. Ice had accumulated inside the pan, and the brussels sprouts had ice in between them, were dry with shriveled leaves and pale due to loss of moisture and showed signs of freezer burn Two wet cardboard boxes under the freezer compressor covered in ice, labeled 16 oz pizza dough, A clear open plastic bag containing meat with ice buildup inside it. The meat was dry, pale, had ice crystals on the surface and showed signs of freezer burn. The bag was not labeled or dated. A thin layer of ice on the freezer floor and on the transparent curtain hanging inside the freezer near the door. The curtain was acting as a barrier between the door and inside of the walk-in freezer.During an interview on 5/26/26 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 9:37 AM, Dietary Manager #1 stated the Brussels sprouts should have been fully covered to prevent freezer burn. He stated the meat in the open bag was sausage patties and that open food bags must be closed, labeled, and dated.e. On 5/26/26 at 9:40 AM, an observation of the reach-in refrigerator revealed the following: A 4ˆquart bin containing yellow pureed food with no label or date, A 4ˆquart bin halfˆfilled with yellowish lettuce and sliced tomatoes labeled 5/21/26, Three unlabeled cups of reddish liquid, One unlabeled cup containing brownish food.During an interview on 5/26/26 at 9:40 AM, Dietary Manager #1 stated the yellow food was egg salad prepared the previous evening but was unsure why it was not labeled or dated. He stated the lettuce and tomatoes were used on 5/21/26 and should have been discarded. He identified the reddish liquid as tomato soup and the brownish food as tuna salad but did not know when they were stored in the refrigerator.During an interview on 5/29/26 at 1:25 PM, the Administrator stated all food must be labeled, dated, covered, and discarded when expired.2. On 5/26/26 at 9:25 AM, an observation of the walk-in refrigerator revealed a wet, dirty floor with brown water.A followˆup observation on 5/28/26 at 11:40 AM with the District Dietary Manager again revealed brown water with a muddy floor.During an interview on 5/28/26 at 11:40 AM, the District Dietary Manager stated holes in the refrigerator's floor caused water to rise when someone stepped on it. She demonstrated by pressing her foot on the floor, causing brown water to seep upward. She stated the facility had been aware of the issue for several months.During an interview on 5/29/26 at 11:00 AM, the Maintenance Director stated the refrigerator extended outside the building on a concrete slab placed over mud and grass. He stated previous maintenance staff drilled screws into the diamond metal plate flooring, leaving holes through which rainwater seeped during heavy rainfall. He stated the issue did not occur during dry weather. Maintenance Director stated that there were some heavy rains over the past few days. The Maintenance Director stated that he thinks the entire diamond metal plate on the concrete floor may need to be replaced.During an interview on 5/29/26 at 1:25 PM, the Administrator stated the refrigerator floor should be cleaned daily and that Corporate Maintenance staff would evaluate the issue. She stated kitchen staff should clean the refrigerator frequently to keep it dry.3. On 5/28/26 at 12:00 PM, an observation revealed two ceiling patches-one approximately 2 feet by 2 feet and another 1 foot by 1 foot above the steam table with peeling, hanging paint.During an interview at 12:01 PM, the Dietary Manager stated steam from the steam table caused the paint to peel.During an interview on 5/28/26 at 1:00 PM, the Maintenance Director stated he had painted the kitchen a year earlier and touched up the ceiling three months before. He stated steam and heat from the steam table caused the paint to peel.4. On 5/28/26 at 12:10 PM, an observation of the ice machine in the dining hall with the Registered Dietitian revealed black stains on the lid and inside the machine.During an interview on 5/28/26 at 1:00 PM, the Maintenance Director stated he previously inspected the machine monthly, but the TELS (The Environmental Life Safety system - a digital maintenance and facility management platform) software was changed to require quarterly checks. He stated he could not modify the software. He stated the machine was due for its quarterly cleaning at the end of May 2026 and he had not completed it.During an interview on 5/29/26 at 1:25 PM, the Administrator stated the ice machine was previously cleaned monthly. She stated the facility would reinstate monthly checks and cleaning to prevent the black buildup.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to develop a person-centered care plan for 1 of 4 residents reviewed for activities (Resident #9).The findings included:Resident #9 was admitted to the facility on [DATE] with diagnoses that included legal blindness and adjustment disorder with mixed anxiety and depressed mood.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had severe cognitive impairment. Resident #9's assessment of daily activity preferences revealed it was somewhat important for him to listen to music and to go outside.Review of the care plan last revised on 3/11/26 revealed no goals or interventions related to activities.Review of Resident #9's activity participation documentation for the month of May 2026 revealed self-directed activities included watching tv and relaxing in room, and 1:1 activity noted staff provided hydration and snacks.The Activity Director was interviewed on 5/29/26 at10:30 AM. The Activity Director indicated Resident #9's activity preferences included listening to music and going outdoors but that due to a busy staff schedule, a care plan had not been developed in the area of activities. An interview was conducted with the Administrator on 5/29/26 at 5:20 PM who revealed the Activity Director was responsible for creating the activity care plan for Resident #9 and did not know why this had not been done.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and record review, the facility failed to provide an on-going activity program that met the individual interests and needs for 3 of 4 cognitively impaired residents reviewed for activities (Residents #32, Resident #44 and Resident #9). The findings included: 1. Resident #32 was admitted to the facility on [DATE] with diagnoses that included dementia with psychotic behavior and Alzheimer's disease. Review of the Modified Annual Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired and dependent on staff for all Activities of Daily Living (ADL). The assessment indicated Resident #32 preferred listening to music, keeping up with news, participating in group activities, and spending time outdoors when the weather was good. Review of the care plan dated 2/13/26 revealed the resident was careˆplanned for activities and was dependent on staff to meet emotional, intellectual, physical, and social needs. Interventions included ensuring activities were compatible with the resident's physical and mental capabilities and aligned with known interests and preferences. The plan also required 1:1 bedside or inˆroom activities when the resident could not attend outˆofˆroom events, as well as staff assistance and escort to and from activities. The resident enjoyed snacks, music, movies, and spending time outdoors in favorable weather. An activity note dated 3/9/26 showed an activity staff member spent 15 minutes with the resident, discussed the weather, and talked about working in her vegetable garden. The resident asked about the staff member's family and what they did for fun. Record review revealed no activity notes or documentation after 3/9/26 through 5/28/26 showing the resident's participation in activities of interest. Record review also showed that on 5/15/26, the resident transferred from the Life Engagement Unit (LEU) to the 500 hallway (Rehabilitation Unit). Observations on 5/26/26 at 11:26 AM revealed the resident sitting in a wheelchair in the Rehabilitation unit dining room, staring at the table, with no television, music, or staff interaction except for another resident nearby. Continuous observations on 5/27/26 from 11:08 AM to 11:20 AM revealed Resident #32 was in a wheelchair sitting alone near the nursing station, bending down and looking at a white towel on her lap, with no social interaction. On 5/27/26 at 2:40 PM, Resident #32 was observed laying in bed talking to herself while a television played on low volume on the opposite side of the room. The resident was unable to see the television from her bed. The volume of the television was low and could only be heard when someone stood very close to the television Continuous observations on 5/28/26 from 9:23 AM to 9:30 AM revealed the resident in a wheelchair (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting alone in the dining room, staring out the window, with no music, television, or staff interaction. On 5/28/26 at 11:30 AM, the resident was observed sitting in the 500ˆhallway dining room staring at staff and another resident. No television or music was playing. On 5/28/26 at 2:00 PM, Resident #32 was observed lay in bed, looking toward the hallway and talking to herself. The television volume remained low. During an interview on 5/28/26 at 11:15 AM, Nurse Aide #1 stated that no activity staff came to the rehab unit. She stated Resident #32 was totally dependent on staff for ADL care and could not attend activities without assistance. She stated nurse aides could not take the resident to activities on the other end of the building when they were providing care. She confirmed the resident did not receive 1:1 activities and that there was no music system or television available in the dining room to keep the resident engaged. During an interview on 5/28/26 at 2:44 PM, the Activity Director stated the resident enjoyed preaching, pastor services, color sorting, and matching games. She explained that LEU nursing staff previously assisted activity staff with activities and transport, but staff on the 500 hallway did not. She stated the resident would not be triggered for 1:1 activities until she updated the care plan. She acknowledged no 1:1 activities were completed and no music or television was available in the dining room. She stated the census was large and she needed to determine how to conduct 1:1 activities based on residents and staffing ratio. During an interview on 5/29/26 at 11:24 AM, the Administrator stated that every resident who needed 1:1 activities and could not attend group activities should receive 1:1 activities that enriched them emotionally and intellectually. She stated the resident had been moved from LEU due to declining clinical status. She stated the resident's activity preferences needed review and revision and that activity staff must document all activities provided. 2. Resident #44 was admitted on [DATE] with diagnoses including Alzheimer's disease, dementia, and major depressive disorder. Review of the Annual MDS dated [DATE] revealed the resident was severely cognitively impaired and dependent on staff for all Activities of Daily Living (ADL). The assessment indicated preferred activities such as listening to music, being around pets, attending religious services, participating in group activities, and going outdoors in good weather. Review of the care plan dated 2/25/26 showed the resident required staff support to meet emotional, intellectual, and social needs related to cognitive impairment. Interventions included inviting the resident to activities, ensuring activities matched interests and abilities, and providing assistance or escort to activities. Record review revealed on 12/9/26, Resident #44 was moved from the LEU to the 500 hallway (Rehabilitation unit). Record review revealed no activity notes or documentation. Continuous observation on 5/26/26 from 11:00 AM to 11:07 AM revealed Resident #44 in a wheelchair, sitting in the dining room, staring ahead, with no television, music, or staff interaction. (continued on next page)

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	345265	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yanceyville Rehabilitation and Healthcare Center	1086 Main Street North Yanceyville, NC 27379

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/26 at 11:08 AM, the resident was observed in a wheelchair sitting near the nursing station watching therapy staff work with other residents. No staff or resident were interacting with her. Observations on 5/28/26 at 9:23 AM and 11:30 AM revealed the resident sitting in the 500ˆhallway dining room, staring out the window and looking around, with no television, music, or staff interaction. On 5/28/26 at 2:00 PM, Resident #44 was observed lay in bed while the television played at low volume. The resident appeared disinterested and looked around the room. During an interview on 5/28/26 at 11:10 AM, Nurse Aide #1 stated the resident moved from the memory care unit to the rehab hallway because she required more care. She stated the resident was totally dependent, responded with only simple yes or no answers, and did not receive activities because activity staff never came to the rehab unit. She stated there was no music or television available in the dining room, and although she requested music for the resident, activity staff had not provided it. She stated she could not take the resident to group activities on the other end of the building as she needed to provide care and assistance to other residents. During an interview on 5/28/26 at 2:44 PM, the Activity Director stated Resident #44 preferred music. She stated activity staff conducted 1:1 visits about once per month and acknowledged Resident #44 had not received activities since moving to the 500 hallway. She stated she would educate staff to bring the resident to activities or provide 1:1 visits. She stated the census was large and she needed to determine how to complete 1:1 activities based on staffing. During an interview on 5/29/26 at 11:24 AM, the Administrator stated residents who could not attend group programs should receive 1:1 activities. She stated Resident #44 required updated activity preferences and that activity staff must document resident participation in activities. The findings included: 3.Resident #9 was admitted to the facility on [DATE] with diagnoses that included legal blindness and adjustment disorder with mixed anxiety and depressed mood. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had severe cognitive impairment. Resident #9's assessment of daily activity preferences revealed it was somewhat important for him to listen to music and to go outside. Review of the care plan last revised on 3/11/26 revealed no goals or interventions related to activities. Review of Resident #9's activity participation documentation for the month of May 2026 revealed self-directed activities included watching tv and relaxing in room, and 1:1 activity noted staff provided hydration and snacks. There was no documentation of Resident #9 listening to music or going outside. An observation was completed of Resident #9 on 5/27/26 at 2:55 PM and he was in his room, lying in bed with eyes open facing toward the wall, no music was playing, shared television was not on, and no independent activities were being performed or available in Resident #9's room. An observation was completed of Resident #9 on 5/29/26 at10:25 AM and he was observed in his room lying in bed toward the wall with no music playing and no independent activities available in (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and television was not on. An interview was conducted with Nurse Aide (NA) #2 on 5/27/26 at 2:58 PM who revealed Resident #9 was blind and did not like to go to group activities. NA #2 also revealed that she had not seen activity staff provide him with music or assist him with any outdoor activities. The Activity Director was interviewed on 5/29/26 at10:30 AM and she indicated that upon review of Resident #9's activity documentation staff had only provided Resident #9 with snacks and hydration and Resident #9's independent activities in room included relaxing in room and watching television. The Activity Director revealed she was aware that Resident #9's activity preferences included listening to music and going outdoors but that due to a busy staff schedule the staff had not been able to provide Resident #9 with his preferred activities. An interview was conducted with the Administrator on 5/29/26 at 5:18 PM and she indicated that the Activity staff should have provided Resident #9 with activities that met his preferences.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, and Resident Representative (RR) interview, the facility failed to identify hearing aides were missing and determine whether an appointment was needed to maintain hearing abilities for a resident with reported hearing difficulties for 1 of 1 resident reviewed for communication (Resident #81). The findings included:Resident #81 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 had severe cognitive impairment and was coded for moderate hearing difficulty with the use of hearing aids.The care plan initiated on 7/25/25 and reviewed on 2/26/26 indicated Resident #81 had a care plan in place for having a communication/hearing impairment and wore bilateral hearing aids. The written interventions included staff to assist Resident #81 daily with putting the hearing aids in every morning and removing them every night and to ensure hearing aids are in place.Review of Resident #81's Medication Administration Record and Treatment Administration Record revealed no entries, or monitoring, for placement, or removal, of the resident's hearing aids.An observation and Interview were conducted on 5/26/26 at 1:07 PM with Resident #81. She was observed to have had one hearing aid in use in her right ear and was not wearing a hearing aid in her left ear. Resident #81 indicated she used to have two hearing aids but one was missing. Resident #81 indicated she would like to have both hearing aids so she could hear better.A telephone interview was conducted with Resident #81's representative on 5/28/26 at 10:56 AM. The Resident Representative stated Resident #81 was admitted to the facility with two hearing aids, but one was lost about six months ago. She further revealed she did not have the funds to pay for a replacement hearing aid and that she had not been contacted by anyone at the facility regarding options to try and replace the hearing aid.An interview was conducted with Nurse #1 on 5/28/26 at 3:14 PM and she indicated she was aware Resident #81 was missing one of her hearing aids but did not know for how long or if it had been reported to a social worker.An interview was conducted on 5/28/26 at 3:30 PM with Nurse Aide (NA) #4 who indicated Resident #81 used to have bilateral hearing aids that were stored in her bedside drawer and staff were responsible for helping Resident #81 to put the hearing aids in each morning and to remove them at night. NA # 4 revealed she had worked for the facility for over six months and was aware that Resident #81 was missing one of her hearing aids but did not know how long the hearing aid had been missing and was not aware if a social worker was made aware of the missing hearing aid.An interview was conducted with the Social Worker 5/29/26 9:15 AM and she indicated she had been in this position since January 2026 and had not been made aware Resident #81 was missing a hearing aid.An attempt was made to interview the former Social Worker on 5/29/26 at 10:17 AM but the attempt was not successful.The Administrator was interviewed on 5/29/26 at 5:15 PM and she stated she was not aware that Resident #81 had a missing hearing aid. She further explained staff should have reported this to the social worker so they could have contacted the family and made the appropriate referral to the audiologist to determine if a replacement hearing aid could have been provided. The Administrator indicated she did not know why this was not done.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, record review and staff interviews, the facility failed to provide pureed food items with a puddingˆlike consistency as required. This failure had the potential to affect 11 of 11 residents who had orders for a pureedˆtexture diet.Findings included:1a. A continuous lunch meal observation in the 500ˆhallway dining room on 5/26/26 from 12:10 PM to 12:20 PM revealed that residents on the 500 hallway received their trays first. Two residents were present in the 500-hallway dining room, each receiving assistance from staff. Both residents had meal tickets indicating a regular diet with pureed consistency.Observation of the residents' trays revealed a lunch meal consisting of pureed tuna salad, pureed broccoli salad, pureed potato salad, and pureed bread. The food was served on a divided plate. Pureed peaches and pears was dessert and served in an individual cup. The pureed food in the divided plated appeared thin and runny, with liquid separating from the solids. When staff tilted the spoon, the food ran off the spoon and did not hold its shape.During an interview on 5/26/26 at 12:10 PM, Nurse Aide #1 stated she frequently assisted the residents with feeding. Nurse Aide #1 stated the pureed food served to the resident was not usually of a pudding consistency. She reported she had notified the Administrator several times, and the Administrator had addressed the concern with Dietary Staff.During an interview on 5/26/26 at 12:12 PM, the Scheduler stated she frequently assisted with feeding and had also noticed the pureed food was thinner than appropriate. She reported she had informed Dietary Staff multiple times.The residents were not feed until the Dietary Manager arrived to the 500 hallway dining room.The Dietary Manager #1 came to the dining hall on 5/26/26 at 12:15 PM, Dietary Manager #1 observed the pureed trays and stated the consistency was incorrect. He confirmed the pureed foods were not of a pudding consistency and that liquid had separated. He stated all pureed items would be remade.At 12:25 PM on 5/26/26, both residents received new trays containing pureed food in the correct consistency.During an interview on 5/26/26 at 2:00 PM, the Dietary [NAME] stated she was the Head [NAME] and had prepared the pureed foods for lunch. She stated she normally prepared pureed foods slightly on the thinner side. She reported she had just been educated by the District Dietary Manager that pureed foods must be of a pudding consistency.During an interview on 5/28/26 at 1:20 PM, the District Dietary Manager stated the menu for the 5/26/26 meal consisted of cold items (tuna and broccoli salads). She stated the hot temperature in the kitchen caused condensation, which thinned the pureed foods.1b. A continuous trayˆline observation with the District Dietary Manager on 5/28/26 from 12:10 PM to 12:30 PM revealed Dietary Manager #1 was assisting in plating the meal for the resident. The first tray plated on the tray line was a pureed diet plate. The pureed turkey on the first plated pureed tray was not of a pudding consistency. Water was separating from the pureed turkey. Both Dietary Manager #2 and the District Dietary Manager agreed the turkey was not smooth and puddingˆlike. The District Dietary Manager reˆblended the turkey with thickener to achieve the correct consistency.During an interview on 5/28/26 at 12:12 PM, Dietary Manager #2 stated she was the interim manager. She reported she had prepared the pureed turkey to the correct consistency but believed the condensation from the steam table caused the product to become runny. She stated she had not realized the change in consistency until she plated the first tray.During an interview on 5/28/26 at 1:00 PM, the District Dietary Manager stated pureed foods must maintain a pudding consistency, but the heat in the kitchen and the steam table caused the products to be thin and lose the appropriate texture.During an interview on 5/29/26 at 2:29 PM, the Administrator stated that it was her expectation that the resident received the correct diet with correct diet consistency. Food consistency should be checked when prepared, on the tray line and prior to the tray leaving the kitchen.