STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oxford Health and Rehabilitation Center	500 Prospect Avenue Oxford, NC 27565

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to immediately notify the Responsible Party (RP) of Resident #125 being sent to the hospital following a change of condition. This was for 1 of 3 residents reviewed for notification of change (Resident #125).The findings included:Resident #125 was admitted to the facility on [DATE] with diagnoses that included nontraumatic intracerebral and intracranial hemorrhage, type 2 diabetic mellitus, dysphagia, dementia, and hemiplegia and hemiparesis.Resident #125's quarterly Minimum Date Set (MDS) assessment dated [DATE] indicated her cognition was severely impaired.The responsible party was unable to be reached for an interview.Change of condition note dated 04/26/25 revealed Resident 125 was sent to the hospital at approximately 10:30 AM related to altered level of consciousness (difficult to arouse). Resident #125 had very little reaction to sternal rub, non-verbal, and overall decreased reaction to stimuli. New order received to send Resident #125 to the hospital for evaluation.Progress note dated 04/26/25 written by Nurse #8 indicated physician was notified regarding altered mental status (AMS) and lack of responsiveness. Order provided to send out. Ems called. Resident sent to ER. Responsible party (RP) notified by House Supervisor.An interview was conducted on 11/19/25 at 1:21 PM with Nurse #8. She stated she did send resident to the hospital on [DATE]. She explained she had been off for a couple of days and when she returned she noticed Resident #125 had a change in mental status and lack of responsiveness. She stated she called the physician and received an order to send resident to the hospital for evaluation. She explained that the House Nursing Supervisor assisted with sending Resident #125 to the hospital and she told Nurse #8 she would call the Responsible Party (RP) to notify her of the transfer. An interview was conducted on 11/19/2025 at 1:33 PM with the House Nursing Supervisor. She stated she remembered assisting Nurse #8 with sending Resident #125 to the hospital for evaluation on 04/26/25. She explained she did attempt to call Resident #125's Responsible Party (RP) to notify them of the transfer. She further explained no one answered when she attempted to call the RP and she did not remember if she left a voicemail. She continued by saying she got busy with another emergency in the building and could not try to call the RP back. The next morning, she attempted to call the RP back and the RP stated the hospital had notified her the evening prior to making her aware of the transfer.An interview was conducted on 11/19/2025 at 1:45 PM with the Director of Nursing (DON). She stated Resident #125's RP should have been notified on 04/26/25 of the transfer to the hospital for change of mental status.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Durable Power of Attorney interviews, the facility failed to convey (transfer) funds within 30 days of discharge from the facility to the Durable Power of Attorney for 1 of 3 residents reviewed for refund of deposit (Resident #165).Findings included:Resident #165 was admitted to the facility on [DATE]. The resident had a planned discharge to another skilled nursing facility on 4/11/25.A review of the discharge tracking MDS dated [DATE] revealed Resident #165 had a planned discharge to another facility on 4/11/25.On 11/18/25 at 1:03 PM an interview via telephone with Resident #165's Durable Power of Attorney (DPOA) occurred. The DPOA explained the resident initially paid privately for care at the facility. Resident #165 was discharged to another skilled nursing facility on 4/11/25 and was owed a refund of approximately $1700. The DPOA revealed she had been in contact with the facility's Business Office Manager (BOM) the week of 4/11/25 and was told she would receive a refund but still had not received the refund as of 11/18/25. The DPOA expressed she was mad she had to wait so long for the reimbursement. The DPOA voiced, they [the facility] were giving her the run around.The BOM was interviewed on 11/19/25 at 11:04 AM. The BOM indicated the DPOA had not yet received a refund of $1730 for two reasons. First, at the time of discharge Resident #165 had outstanding insurance claims pending and it was the facility's policy to collect all outstanding insurance payments before a refund could be issued. The pending insurance claims were completed during the week of 6/27/25 and a refund check was issued on 7/9/25. Second, the refund check was returned to the facility during the week of 8/11/25 due to an error in the mailing address. The BOM indicated she had not yet requested a new refund to be sent with the corrected address due to an oversight and she should have notified the corporate office of the mailing address error and requested another refund. On 11/19/25 at 11:27 AM a telephone interview occurred with the Director of [NAME] Office Services. The Director of [NAME] Services indicated that it was the facility policy for refunds to be provided by the 30th day of discharge and when all insurance payments had been received. The Director of [NAME] Services confirmed the last insurance payment was received by the facility on 6/27/25 and the BOM notified the corporate office on 7/9/25 of the refund request. The Director of [NAME] Services further revealed that he did not become aware that the initial refund check had been returned due to an error in the mailing address until sometime this month and had not yet received additional mailing address information from the BOM and therefore had not mailed a second refund check. An interview was conducted with the Administrator on 11/20/25 at 2:23 PM. The Administrator indicated that the resident/resident representative should have received a refund per the regulation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 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 protect the residents' right to be free from misappropriation of a controlled substance medication (oxycodone) prescribed to treat pain. This occurred for 2 of 2 residents (Resident #177 and Resident #131) reviewed for the misappropriation of property.The findings included: a. Resident #177 was admitted to the facility on [DATE] from a hospital. His cumulative diagnosis included chronic hip pain, heart failure and non-Alzheimer's dementia. A review of Resident 177's electronic medical record (EMR) revealed his physician's orders included the following pain medications:--On 9/30/25, a physician's order was received for 500 milligrams (mg) of acetaminophen (an over-the-counter pain medication) to be administered as two tablets by mouth every 8 hours for pain. --On 10/7/25, a physician's order was written for 10 mg oxycodone to be administered as one tablet by mouth every 6 hours as needed for chronic hip pain for 14 days. A Packing Slip Proof of Delivery from the facility's contracted pharmacy was provided for review. This form was signed by Nurse #5 and confirmed 40 tablets of 10 mg oxycodone were delivered to the facility on [DATE] at 2:49 AM. Documentation on Resident #177's October 2025 Medication Administration Record (MAR) indicated the resident received one dose of 10 mg oxycodone on each of the following dates/times: --10/17/25 at 2:59 AM;--10/17/25 at 4:57 PM;--10/17/25 at 11:51 PM;--10/18/25 at 8:54 PM (documented as administered by Nurse #3).This documentation indicated that as of 10/19/25, there should have been 36 tablets of 10 mg oxycodone remaining in the bubble pack card for Resident #177. The controlled drug record for Resident #177 (a declining inventory sheet which documented when each tablet of oxycodone was withdrawn from the medication cart) was not available for review. b. Resident #131 was admitted to the facility on [DATE] with re-entry on 10/10/25 from a hospital. Her cumulative diagnosis included osteoarthritis, chronic pain, diabetes, and chronic kidney disease. A review of Resident 131's physician's orders and Medication Administration Records from July 2025 through October 2025 revealed the resident had orders to receive 5 mg oxycodone on an as needed basis throughout her stay at the facility. Two Packing Slip Proof of Delivery forms sent from the facility's contracted pharmacy were provided for review. One form was signed by Nurse #11 and confirmed 40 tablets of 5 mg oxycodone were delivered to the facility on 9/19/25 at 8:47 PM. A second Packing Slip Proof of Delivery form sent from the facility's contracted pharmacy was also provided for review. This form was signed by Nurse #7 and confirmed 15 tablets of 5 mg oxycodone were delivered to the facility on [DATE] at 11:14 PM. Resident #131's physician's orders indicated her most recent order for oxycodone was written on 10/11/25. This order indicated 5 mg oxycodone was to be administered by mouth every 6 hours as needed for pain. The resident's controlled drug record (dated 7/18/25) revealed oxycodone tablets dispensed for Resident #131 on 7/18/25 was still in use with 5 tablets remaining in that bubble pack card as of 10/19/25. On 10/19/25 at 7:36 PM, Nurse #7 signed this controlled drug record to indicate one tablet of 5 mg oxycodone was withdrawn from the medication cart to be administered to Resident #131, leaving 4 tablets of oxycodone remaining in the bubble pack card. The controlled drug records for the 9/19/25 and 10/10/25 oxycodone deliveries were not available for review. An Initial Allegation Report dated 10/22/25 and signed by the facility's Administrator revealed the facility became aware of an allegation related to the diversion of resident drugs belonging to Resident #177 and Resident #131 on 10/21/25 at 6:10 PM. The accused employee was identified as Nurse #7. An Investigation Report was submitted to the State Agency on 10/27/25. A summary of the facility's investigation reported that Nurse #3 contacted Unit Manager #1 by telephone on 10/19/25. Nurse #3 explained to the Unit Manager that she was assigned to Resident #177's medication cart on the first shift of 10/18/25. She recalled Resident #177's bubble pack card of oxycodone was on the cart during that shift and remembered that she even administered one dose of oxycodone as ordered / requested by the resident during her shift. When she came back in to work for first shift on 10/19/25, the count of controlled drug records kept on the medication cart was correct during the change of shift. However, she discovered both Resident #177's bubble pack card of oxycodone and it's corresponding controlled drug record were missing from the medication cart when she went to administer the medication to Resident #177 on this date (10/19/25). Unit Manager #1 notified the facility's Director of Nursing (DON). The facility was unable to locate Resident #177's missing medication. Nurse #7 was suspended on 10/21/25 pending investigation. The facility's Investigation Report read in part, 100% audit done 10/21/25, 2 residents [Resident #177 and Resident #131] were found to be missing narcotics. However, no residents have missed their meds

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 observations, record review and staff interviews, the facility failed to ensure smoking assessments were accurate and completed quarterly for 1 of 8 residents reviewed for smoking (Resident #50).The findings included:Resident #50 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease and chronic obstructive pulmonary disease. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was not using tobacco at the time of admission and was severely cognitively impaired. Resident #50's smoking assessment dated [DATE] completed by Nurse #4 recorded Resident #50 had cognitive loss and indicated Resident #50 needed supervision when smoking. The smoking assessment specified Resident #50 had a cognitive loss, required an occupational therapy evaluation as needed, and needed supervision when smoking. An interview was conducted on 11/20/2025 at 1:37 PM with Nurse #4, Unit Manager. Nurse #4 revealed she completed the smoking assessment for Resident #50 on 6/10/2025. She stated the process for the smoking assessments was that they are to be completed quarterly on all residents who smoke. Nurse #4 explained a smoking assessment, consisted of observing residents smoking, and speaking with the nurses and nurse aides. Nurse #4 stated she spoke with staff prior to completing any smoking assessment and did this for Resident #50's June 2025 assessment. She stated she had just started working and knew she had missed a few residents' smoking assessments and she was catching up on the smoking assessments. Nurses #4 stated she had observed Resident #50 smoke independently on 6/10/25 and verified he was a safe smoker and able to smoke independently. She further stated she thought she may have completed Resident #50's June 2025 smoking assessment inaccurately. The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #50 was moderately cognitively impaired and required partial to moderate assistance with upper and lower dressing. The MDS revealed Resident #50 was a current tobacco user.Resident #50's care plan included a focus for smoking dated 6/10/2025, and interventions included may smoke independently and perform smoking assessments as needed. On 11/17/2025, a list of smokers was provided by the facility and Resident #50 was not listed on the facility's smoking list as an independent unsupervised or supervised smoker. Review of smoking assessment dated [DATE] for Resident #50 revealed he required supervision with smoking. This assessment was struck through, and another smoking assessment was completed on 11/18/2025 indicating Resident #50 was independent with smoking. Review of the smoking assessments dated 1/17/2025 and 11/18/2025 revealed both were completed by Nurse #4. An interview was conducted on 11/20/2025 at 1:37 PM with Nurse #4, Unit Manager. Nurse #4 stated she completed and removed the smoking assessment for Resident #50 on 11/17/2025 due to the assessment not being accurate. She stated she had coded Resident #50 as needing supervision, but that was a mistake, and she did another assessment on 11/18/2025. Nurse #4 indicated Resident #50 was independent with smoking based on her observations, interviews with staff, and her assessment based on the assessment completed on 11/18/2025. On 11/18/2025 at 11:28 AM, Resident #50 was observed smoking in the designated smoking area accompanied by other residents. Resident #50 was observed holding his cigarette in the left hand with controlled movements to and from the lips while smoking. Resident #50 was observed positioned approximately two feet from the self-closing metal container in a wheelchair and dropping ashes onto the concrete. There were no staff members observed in the smoking area. An interview was conducted on 11/19/2025 at 12:52 PM with Resident #50. He indicated he started smoking about 2 years ago out of boredom. But he was not smoking when he was first admitted to the facility. Resident #50 stated he recently started smoking out of boredom. Resident #50 stated he was aware of the designated smoking area and was able to identify the location. He further stated he would never smoke in his room and he kept his smoking materials in fear they would go missing. An interview was conducted on 11/18/2025 at 12:36 PM with Nurse #1. Nurse #1 stated she kept Resident #50's smoking materials in the nurse's medication cart and they were labeled with his name. She stated Resident #50's family members also brought him smoking material and sometimes he will have them in his possession. She further revealed Resident #50 does not need supervision when smoking. On 11/19/2025 at 12:57 PM in an interview with the Director of Nursing (DON), she explained smoking assessments were completed on admission, quarterly, and for a change in condition. She stated nurses were responsible for conducting smoking assessments, and Resident #50 should have had a smoking assessment conducted in September 2025. The DON stated interventions for a smoker were

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 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 physician and staff interviews, the facility failed to prevent significant medication errors when Nurse #6 did not schedule a new residents' (Resident #174) medication to start on the afternoon of admission. The medications were available in the Pyxis system (an automated, secure, and centralized system used in healthcare to manage the storage, dispensing, and tracking of medications). Resident #174 was admitted on [DATE] at approximately 4:45 PM, his medications were scheduled to start on 12/11/24 at 8:00 and 9:00 AM. This was for 1 of 6 residents whose medications were reviewed.The findings included:Based on record review and physician and staff interviews, the facility failed to have effective systems in place for obtaining and administering medications to a new admission which resulted in a significant medication error for 1 of 6 residents whose medications were reviewed (Resident #174). The findings included:Resident #174 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM) with chronic foot ulcer and atrial fibrillation. Nursing progress notes revealed Resident #174 was admitted to the facility on [DATE] at approximately 4:45 PM. A review of Resident #174's physician orders dated 12/10/24 included the following medications: - Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 24 unit subcutaneously every 12 hours for DM at 8:00 AM & 8:00 PM, start date 12/11/24. - Apixaban Oral Tablet 5 MG Give 1 tablet by mouth two times a day for atrial fibrillation at 9:00 AM & 9:00 PM, start date 12/11/24.A review of Resident #174's December Medication Administration Record (MAR) revealed all medications orders were entered into the electronic medical record (EMR) on 12/10/24 and were scheduled to start on 12/11/24. There were no orders entered on the MAR to administer the Lantus insulin at 8:00 PM or Apixaban at 9:00 PM on 12/10/24. Record reviews revealed Resident #174's blood sugar reading on 12/11/24 was 222 (normal blood sugar is 80 to 130 mg/dL). No concerns were documented related to blood sugar results on 12/11/24.An interview was conducted on 11/19/2025 at 12:30 PM with Nurse #6. She verified she worked on 12/10/25 from 7:00 AM to 7:00 PM. She stated she was not the floor nurse on 12/10/24 but she did assist with Resident #174's admission. She explained that the steps she normally would take when an admission comes in was she would call the on call provider to clarify the medication orders and then looked to see what medications were available in the Pyxis system. Nurse #6 indicated she then sends the medication list to the pharmacy and if it was past the pharmacy cut off time for submitting orders she would call the pharmacy to make them aware of the medications needed. However, for Resident #174's admission she only called the on-call provider to clarify the medication orders, she entered the medications into Resident #174's EMR and then sent the orders to the pharmacy. She did not check to verify if any medications were due on the evening of 12/10/24. She indicated that when she entered Resident 174's medications into the EMR the start date and time automatically scheduled the medications to start on 12/11/24 at 8:00 AM. Nurse #6 confirmed that she did not check the Pyxis system for the Lantus or apixaban that were to be administered at 8:00 PM/9:00 PM. She stated, I did not think about it, I was only trying to get the medications into the EMR for Nurse #3. Nurse #6 also confirmed that she did not administer Resident #174 any medications on 12/10/24. An interview was conducted on 11/19/25 at 12:59 PM with Nurse #3. She stated she was the direct care nurse for Resident #174 for second shift 3:00 PM-11:00 PM on 12/10/24. Nurse #3 explained that since the medications were entered to start on 12/11/24 she was unaware Resident #174 had scheduled medications that should have been administered on 12/10/24 at 8:00 and 9:00 PM.An interview was conducted on 11/19/24 at 12:12 PM with the Director of Nursing (DON). She indicated she was unaware Resident #174 did not receive his 8:00 and 9:00 PM medications on 12/10/24. She explained when the orders were entered into the EMR the transcribing nurse (Nurse #6) should have verified the start date and time and changed the automatic response to begin on 12/10/24 at 8:00 PM. The EMR system scheduled the medications to begin at 8:00 AM on 12/11/24. She verified Resident #174 should have received his evening medications per the physician's orders. She stated the transcribing nurse (Nurse #6) should have reviewed Resident #174's medications to determine if he had any upcoming medications due and then obtain them from the Pyxis system if they were available. If the medications were not available, the nurse should call pharmacy to have the medications sent. The DON also stated in this case the medications were available in the Pyxis system. An interview was conducted on 11/19/2025 at 11:26 AM with Physician #1. He stated he did not recall Resident #174 however he would expect medications to be administered on date of admission if they were scheduled. Physician #1 explained although there was the potential for negative