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	06/15/2026

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

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, a consultant pharmacist interview, and record reviews, the facility failed to have a medication error rate below 5 percent. Three medication errors were identified out of twenty-six opportunities, resulting in a medication error rate of 11.5 percent for two of the five residents observed during the medication administration observation (Resident #4 and Resident #6).Findings included:1. Resident #4 was admitted on [DATE] with a diagnosis of congestive heart failure.Resident #4 had a physician's order dated 6/9/2026 that directed the administration of two 20-milligram tablets of Torsemide by mouth twice daily for treatment of congestive heart failure.During a medication administration observation on 6/15/2026 at 8:28 AM, Nurse #2 administered one 20ˆmilligram tablet of Torsemide to Resident #4.A review of the medication administration record showed that Nurse #2 documented that Resident #4 received two 20ˆmilligram tablets of Torsemide on 6/15/2026 at 8:50 AM.During an interview on 6/15/2026 at 10:37 AM, Nurse #2 reviewed the physician's orders and acknowledged she had administered only one 20ˆmilligram tablet of Torsemide when the order required two tablets. Nurse #2 stated she needed to administer an additional 20ˆmilligram tablet to complete the ordered dose.During a telephone interview on 6/15/2026 at 1:45 PM, the consultant pharmacist stated the Torsemide order had recently changed from one tablet to two tablets and confirmed that nursing staff must follow the physician's orders by reviewing the medication administration record prior to dispensing and administering medications.2a. Resident #6 was admitted to the facility on [DATE].Resident #6 had a physician's order for one 500-milligram tablet of Vitamin C daily administered as a supplement initiated on 7/1/2024 and discontinued on 10/16/2025.During a medication administration observation on 6/15/2026 beginning at 9:09 AM, Nurse #2 administered one tablet of 500 milligrams of Vitamin C to Resident # 6.During an interview on 6/15/2026 at 10:39 AM, Nurse #2 reviewed the physician's orders in the electronic medical record and acknowledged she had administered Vitamin C without a current physician's order. Nurse #2 stated that Resident #6 previously had an order for Vitamin C and offered this as an explanation for the error.During an interview on 6/15/2026 at 12:08 PM, the Administrator stated Resident #6 had previously been ordered Vitamin C and acknowledged the administration was an error that could not be reversed.During a telephone interview on 6/15/2026 at 1:45 PM, the consultant pharmacist stated nursing staff must follow physician orders for all medications, including supplements, by reviewing the medication administration record prior to dispensing and administration.2b. Resident #6 had a physician's order initiated on 11/1/2022 for 50 micrograms of Vitamin D to be administered as 1 tablet by mouth one time a day as a supplement.During a medication administration observation on 6/15/2026 beginning at 9:09 AM, Nurse #2 administered one 25ˆmicrogram tablet of Vitamin D to Resident #6.A review of the medication administration record showed Nurse #2 documented that Resident #6 received 50 micrograms of Vitamin D on 6/15/2026 at 9:38 AM.During an interview on 6/15/2026 at 10:41 AM, Nurse #2 rechecked the houseˆstock container of Vitamin D in the medication cart and acknowledged she had administered one 25ˆmicrogram tablet instead of the ordered 50ˆmicrogram dose. Nurse #2 stated she needed to administer an additional 25ˆmicrogram tablet to meet the ordered dose.During a telephone interview (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 6/15/2026 at 1:45 PM, the consultant pharmacist stated that nursing staff must ensure the medication administration record matches the medication dose dispensed prior to administration.