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

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 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.

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
	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

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 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)

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

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 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

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

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 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 reviews, and resident and staff interviews, the facility failed to implement care planned interventions for fall safety for 1 of 4 residents reviewed for accidents (Resident #105). The findings included:Resident #105 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following stroke affecting the dominant right side.The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #105 was severely cognitively impaired and required total assistance from staff for activities of daily living (ADL). She was assessed as having no falls since admission.A review of Resident #105's active care plan initiated on 4/17/25 revealed there was a problem area for being at risk for falls related to muscle weakness, reduced physical mobility, requiring assistive devices to walk or transfer with an intervention of a fall mat to bilateral sides of bed.On 11/17/25 at 2:51 PM an observation revealed Resident #105 lying on her bed with no fall mats present on either side of her bed.On 11/19/25 at 12:40 PM an observation revealed Resident #105 lying on her bed with no fall mats present on either side of her bed.On 11/19/25 at 12:42 PM an interview was conducted with Nursing Assistant # 5, who was assigned to Resident #105 on 11/19/25 from 7:00 AM- 3:00 PM. She indicated Resident #105 was alert but required staff to assist with all ADL needs. Nursing Assistant #5 indicated she was not aware that Resident #105 required bilateral floor mats for fall injury prevention. On 11/19/25 12:43pm an interview was conducted with Nurse # 9, who was assigned to Resident #105 on 11/19/25 from 7:00 AM-3:00 PM. She indicated she was not aware Resident #105 had been care-planned to require bilateral floor mats while in bed for fall injury prevention.An interview was conducted with the MDS Coordinator on 11/20/25 at 12:44 PM. She indicated Resident #105 was actively care-planned for the use of bilateral floor mats at the bedside for fall injury prevention and the nursing staff should have provided the floor mats for fall injury prevention.On 11/19/25 12:47 PM an interview was conducted with the Director of Nursing. She indicated nursing staff should have followed Resident #105's care plan and provided the bilateral floor mats for fall injury prevention. On 11/20/25 2:23 PM an interview was conducted with the Administrator. She indicated nursing staff should follow a resident's care plan and staff should have provided Resident #105 with bilateral floor mats at bedside as indicated in her care plan.

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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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

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 0658 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 have effective systems in place for entering medication orders into the electronic medical record and administering medications per the physician orders for a new admission for 1 of 6 residents whose medications were reviewed (Resident #174). The findings included:Resident #174 was admitted to the facility on [DATE] at approximately 4:45 PM with diagnoses that included Type 2 diabetes mellitus with chronic foot ulcer, hypertension, atrial fibrillation, and congestive heart failure.A review of Resident #174's physician orders dated 12/10/24 included the following: Coreg Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth at bedtime for hypertension at 8:00 PM, start date 12/11/25. Hold for systolic blood pressure (SBP) below 95 and HR below 60. Gabapentin Capsule 100 MG Give 1 capsule by mouth two times a day for neuropathy at 9:00 AM & 9:00 PM, start date 12/11/25. Flomax Capsule 0.4 MG (Tamsulosin HCl) Give 1 capsule by mouth at bedtime for benign prostatic hyperplasia at 9:00 PM, start date 12/11/25. Atorvastatin Calcium Oral Tablet 10 MG Give 1 tablet by mouth at bedtime for hyperlipidemia at 9:00 PM, start date 12/11/25. Torsemide Oral Tablet 20 MG (Torsemide) Give 1 tablet by mouth every 12 hours for congestive heart failure (CHF) at 9:00 AM & 9:00 PM, start date 12/11/25. Resident #174's admission Minimum Date Set (MDS) assessment dated [DATE] indicated he was cognitively intact. A review of Resident #174's December Medication Administration Record (MAR) revealed all the medication orders were entered into the electronic medical record (EMR) on 12/10/24 and were scheduled to start on 12/11/24. There was no entry on the MAR for the administration of Coreg, Gabapentin, Torsemide, Flomax, or Atorvastatin at 9:00 PM for 12/10/24. Resident #174 started receiving his scheduled medications on 12/11/24 per orders. Record reviews revealed Resident #174's blood pressure on 12/11/24 was 119/50 (normal range is less than 120/80). No concerns were documented related to blood pressure 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-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 Coreg, Gabapentin, Torsemide, Flomax, or Atorvastatin at 9:00 PM for 12/10/24.because she did not think about the 9:00 PM medications that needed to be administered on 12/10/24, she was only trying to get the medications into the EMR. Nurse #6 continued by confirming 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 on 12/10/24. Nurse #3 explained that since the medications were entered to start 12/11/24 she was unaware Resident #174 had scheduled medications that should have been administered on 12/10/24 at 8:00 PM/9:00 PM. Nurse #3 continued by confirming that she did not administer Resident #174 any medications on 12/10/24. 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 PM/9:00 PM medications on 12/10/24. She explained the transcribing nurse should have reviewed Resident #174's medications to determine if he had any upcoming medications due. 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 wound expect medications to be administered on date of admission if they were ordered. Physician #1 explained although there was the potential for negative outcomes to occur, none resulted due to Resident #174's medications not being administered at 9:00 PM on 12/10/24.

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

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 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)

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

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 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

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

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 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)

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

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 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

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, record reviews, and staff interviews, the facility failed to follow the planned menu for renal and diabetic renal diets, and for mechanical altered and pureed diets. Failure to follow the planned menu was observed during 1 of 1 tray line observation conducted. This affected 7 residents on renal diet, 3 residents on renal diabetic diet, 17 residents on mechanically altered diet and 12 residents on pureed diet. Findings included:a. The diet spread sheet for therapeutic diets for lunch meal on 11/18/25 revealed renal and diabetic renal diets were to receive 4-ounces (oz) of carrots.The Diet Type Report revealed there were 7 residents on renal diet and 3 residents on renal diabetic diet.Tray line observation on 11/18/25 at 12:10 PM, revealed the steam table had no carrots for the renal and diabetic renal diets.On 11/18/25 at 12:22 PM the Certified Dietary Manager (CDM) entered the kitchen and stated that renal diets would be receiving sliced cucumbers. Two renal trays were observed with sliced cucumbers. During an interview on 11/18/25 at 12:25 PM, the CDM indicated carrots were on the menu for therapeutic diets. However, the product shipment had not yet arrived by lunch time. She further indicated that cucumber salad was unavailable and the renal diets would receive sliced cucumbers. She stated spinach was prepared as alternate vegetable and was not renal diet appropriate and hence had to make the decision to serve sliced cucumbers on their trays.During an interview with the Assistant Dietary Manager on 11/20/25 at 9:30 AM, she indicated carrots were supposed to be delivered earlier in the morning and the shipment had not come in until tray line time. She further stated on 11/18/25 one of dietary cooks had called out and she was assisting the cook prepare for lunch meal. The Assistant Dietary Manager stated when she came to assist on the tray line, she did not notice there was no vegetable cooked for the therapeutic diets. She further indicated she thought there was cucumber salad prepared and placed in the refrigerator and was going to use it for the lunch meal. The Assistant Dietary Manager further stated the CDM does put out the daily meal sheets and the cooks and staff review them prior to the meal and cook accordingly. She indicated she had not seen any substitutions on it for carrots. However, the the sample menu substitution sheet approved by the dietitian indicated that cucumber salad would be substitution for chips as it was renal diet friendly. She reiterated that she was stretched too thin and did not ask what the substitution was for carrots.The CDM was reinterviewed on 11/18/25 at 2:00 PM. She stated she had not communicated to the staff what the substitution for carrots were for the therapeutic diet menu. The CDM indicated carrots were on the menu for therapeutic diets. However, the product shipment had not yet arrived by lunch time. The CDM stated that chips were never on the menu for therapeutic diets and unsure who had asked for the substitution for those. CDM stated due to miscommunication no vegetable was prepared for renal and renal diabetic diets.During an interview on 11/18/25 at 1:30 PM, the Registered Dietitian (RD) stated he was approached earlier in the day by a dietary staff member (name unknown) requesting permission to substitute chips for cucumber salad. He indicated he was not aware that carrots were the planned menu item for therapeutic diets. He was only informed later that the carrot shipment had not arrived. The RD indicated there were 7 residents on renal diet and 3 residents on renal diabetic diet. The RD further indicated few of the residents on renal diet were at dialysis and did not receive a tray for lunch.b. The consistency spread sheet revealed the planned menu for mechanically altered diets was 5 oz of baked chicken leg (ground with gravy) and the planned menu for pureed textured diets was 5 oz of baked chicken leg (pureed with gravy).The Diet Type Report revealed there were 17 residents on mechanically altered diet and 12 residents on pureed textured diet.During the meal preparation observation on 11/18/25 at 11:30 AM, the Dietary [NAME] was observed cooking hamburger meat.During an interview on 11/18/25 at 11:35 AM, the Dietary [NAME] stated the hamburger meat was cooked for mechanically altered diets based on the lunch menu for that day. The Dietary [NAME] indicated the CDM places the menu spread sheet and consistency spread sheet for the meal and staff would follow them accordingly. She further indicated she does look at the menu and consistency sheets prior to prepping for any meal.During tray line observation on 11/18/25 at 12:10 PM, ground hamburger meat and pureed hamburger meat with gravy were served to residents on mechanically altered and pureed diets.During an interview on 11/20/25 at 9:30 AM, the Assistant Dietary Manager indicated one of the Dietary Cooks had called out, and she was assisting the cook. The Assistant Dietary Manager indicated that prior to the scheduled tray line, the shipment had arrived, and she was ensuring all the products had come in. She further indicated she had noticed the Dietary [NAME] taking hamburger meat for altered texture diets and cooking it. She was unsure why hamburger meat was cooked, instead of ground or pureed chicken. The Assistant Dietary Manager stated the CDM

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain the double door oven, the stove drip pan, the steam table backsplash and rack under the steam table clean. The facility failed to label, and date opened food and failed to separate raw meat from cooked food in 1 of 1 walk-in refrigerator, and in 1 of 1 walk-in freezer. The facility also failed to label and date resident's foods, failed to discard expired food, and keep nourishment refrigerators clean for 3 of the 4 nourishment refrigerators (200, 300, 400/500 hallway nourishment refrigerators) observed. The facility failed to ensure 2 of 2 dietary staff wore hair restraints and 2 of 2 male dietary staff had all facial hair contained in a face covering. The facility also failed to hold cold food (equal to or less than 40 degrees Fahrenheit (F)) on the steam table and remove chipped plates and dirty plates from the plate warmer during tray line observation. These practices had the potential to affect food being served to residents.Findings included:1a. Initial Kitchen tour was conducted with the Certified Dietary Manager (CDM) on 11/17/25 from 9 :20 AM to 9:50 AM. Observation of the double door oven on 11/17/25 at 9:35 AM revealed black oil burnt stains inside of the oven. The floor of the oven had black layer of crust that appeared like burnt food. The oven doors had dark brown oil stains.1b. Observation of the stove drip pan on 11/17/25 at 9:38 AM revealed black burnt food crumbles on it.1 c. Observation of the steam table on 11/17/25 at 9:40 AM revealed the steam table backsplash had water and food stains on it. The rack below the steam table had dust, dirt, and water stains on it. There were a few bowls kept on the rack which also had food and water stains on them.During an interview on 11/17/25 at 9:45 AM, the Certified Dietary Manager (CDM) stated the dietary staff were scheduled to clean the equipment on Monday/ Wednesday/ Friday. Cleaning was usually done at night. She indicated the stove drip pan had aluminum foil which collected all the burnt food crumbs. The aluminum foil should be removed, and new aluminum foil should be placed on it. The CDM acknowledged that the steam table backsplash should be cleaned regularly, and the rack below should also be cleaned. The CDM indicated that the bowls on the rack below the steam table were used during activities. She further indicated the bowls would be moved to a rack in the dry storage area as these were not used frequently.2a. Observation of the walk-in freezer on 11/17/25 at 9:48 AM, revealed a brown colored open cardboard box with raw frozen chicken breast in a clear plastic bag and a opened plastic bag containing slices of garlic bread in it. There was no label on raw chicken or on the garlic bread bag. During an interview on 11/17/25 at 9:50 AM, the CDM stated the dietary cook had placed the chicken in the brown box. This was the alternate meat option for lunch for the day. She did acknowledge that the raw chicken and bread slices should not have been placed together.2b. Observation of the walk-in refrigerator on 11/17/25 at 9:50 AM, revealed a plastic container with green colored food in it with no label. Two open packages of sliced deli meat that were not labeled. Two opened packages of deli cheese slices that were not labeled.During an interview on 11/17/25 at 9:52 AM, the CDM stated the sliced deli meats were sliced turkey and sliced ham. The packages should be closed and labelled. The CDM further stated plastic container with green colored food was dietary employees' lunch. The CDM indicated dietary staff should not be placing their food in the walk-in refrigerator.3 a. Observation of the nourishment refrigerator #1 on 200 hallway on 11/17/25 at 9:55 AM revealed an opened half empty 16-ounce orange flavor soda bottle, opened 23.9-ounce mango flavored juice bottle. The freezer of the nourishment refrigerator had a frozen 16-ounce water bottle with slices of lemon in it. There were no labels on these bottles. The shelves of the nourishment refrigerator had standing water and were not clean.3b. Observation of the nourishment refrigerator #2 on 300 hallway on 11/17/25 at 9:58 AM revealed a cup of cut fruit that was not labeled. A plastic grocery bag containing a sandwich in a brown bag with no label or date, and an opened store brought pepperoni 14-ounce package containing few sliced pepperoni that was not labelled.During an interview on 11/17/25 at 9:58 AM, the CDM stated the unlabeled food in the nourishment refrigerator was employee food and not residents' food. She further stated all resident's food should be labeled with resident's name and date when the food was placed in the refrigerator. All residents' perishable food should be discarded after 3 days.3c. Observation of the nourishment refrigerator #3 on 400/500 hallway on 11/17/25 at 10:00 AM revealed an unlabeled clear plastic bag with 4 cartons of chocolate milk and a pair of gloves in them. A box of cut fruit with sell-by date 10/19/25 and a box of grapes with sell by date 10/13/25. There was also a 25-ounce grape juice bottle with no label or date on it. The nourishment room floor was dirty. There were 3 empty grocery bags, few packs of cookies and crackers and used paper towels on the floor.During an interview on 11/17/25 at 10:00 AM, the CDM