STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Juniper Gardens Center for Nursing and Rehabilitat	4414 Wilkinson Blvd Gastonia, NC 28056

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, and family interviews, the facility failed to ensure residents' rights to maintain dignity for 3 of 3 residents reviewed for dignity (Resident #33, Resident #41, and Resident #24). The findings included: 1. Resident #33 was admitted to the facility on [DATE] with diagnoses that included chronic pain, muscle weakness, and reduced mobility. The 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #33 was cognitively intact with no behaviors, had adequate vision and no issues with communicating. The MDS documented Resident #33 was frequently incontinent of urine and bowel and required substantial to max assistance with toileting. On 11/18/25 at 11:56 AM an interview was conducted with Resident #33. She stated there was a night shift (11:00 PM to 7:00 AM) Nurse Aide (NA) #1 who made her lay wet when she was incontinent. Resident #33 stated when she called before first rounds on night shift and informed NA #1 she needed an incontinence change, NA #1 told her, No ma'am, not for 2 hours, that's what the regulations say and the previous shift (3:00 PM to 11:00 PM) should have provided incontinence care on their last round. Resident #33 shook her head and angrily stated her bladder was not on a schedule or timer, and she felt she was being caught in a battle between staff. Resident #33 stated the previous shift had done an incontinence round at approximately 10:00 PM but she had not been incontinent nor needed to use the bathroom at that time. Resident #33 stated this happened several times a week, but she had not reported it. She shared she used her cell phone (noted on overbed table) to track NA #1's response time. A follow up interview was conducted on 11/20/25 at 8:30 AM with Resident #33 to clarify NA #1 not addressing her incontinence care needs. Resident #33 shook her head and stated, while [NA #1] did come to the room to answer the call bell after change of shift she did not check or provide incontinence care at that time. Resident #33 stated she was aware of when she was incontinent and was made to lie wet until the next rounding on the 11:00 PM to 7:00 AM shift, sharing that lying there wet made her feel forgotten. Resident #33 stated this happened multiple times but did not provide exact number of times this has happened with NA #1. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/20/25 at 6:00 AM with Nurse Aide (NA) #1 who was named by Resident #33 as the staff member who left her wet. NA #1 stated she had been working at the facility for 6 months. NA #1 explained she received hand off report and completed an initial walk-through on the rooms on her assignment beginning at 10:45 PM. NA #1 stated she began her first incontinence round between 12:30 and 1:00 AM with her second incontinent round beginning between 2:30 AM and 3:00 AM. NA #1 explained her final rounding began at approximately 5:30 AM. NA #1 stated she was usually assigned to 300 hall and split the 100 hall with the 2nd nurse aide on duty. NA #1 reported Resident #33 requested assistance between rounds stating, she was wet. NA #1 would inform Resident #33 the 3:00 PM to 11:00 PM shift should have changed you at 10:00 PM on their last round. NA #1 explained this happened several times a week and she has told Resident #33 the regulations say we round every 2 hours. When asked if she checked Resident #33 for incontinence and completed incontinence care when Resident #33 called for assistance before the first round on night shift, NA #1 stated, yes. Later in the interview, NA #1 shared Resident #33 was one of the two residents who regularly requested assistance between incontinence rounds on night shift and had to be reminded that rounds occur every 2 hours and requests for incontinence care made at the beginning of night shift should have been addressed by the 3:00 PM to 11:00 PM shift. Resident #33's weekly skin check was completed on 11/20/25. Review of the skin check revealed Resident #33's skin was intact with no redness or other issues. An observation of incontinence care for Resident #33 was completed on 11/21/25 at 9:30 AM. The observation revealed Resident #33's skin was intact with no redness, rash or other issues. On 11/20/25 at 5:35 AM an interview was conducted with Nurse #3. She stated she worked night and had no concerns with any of the nurse aides that worked that shift. She stated there were consistent staff that worked the night shift. Nurse #3 stated all the staff worked well together. Nurse #3 was not aware of Resident #33's concern regarding being informed to wait for incontinent care by NA #1. On 11/20/25 at 5:40 AM an interview was conducted with Nurse #4 who stated she worked night shift and she had no concerns with any of the nurse aides that worked night shift and had not received any resident concerns about the nurse aides. Nurse #4 was not aware of Resident #33's concern regarding being informed to wait for incontinent care by NA #1. An interview was conducted on 11/20/25 at 4:00 PM with the Administrator and Director of Nursing (DON). They both stated they were not aware of this issue and NA #1's behavior was unacceptable. The Administrator stated NA #1 would be taken off schedule immediately. An interview was conducted on 11/21/25 at 5:05 PM with the Administrator and Director of Nursing (DON). Both stated all residents should be responded to promptly. The DON stated a resident should never be told it was not time to provide care. NA #1 should have taken care of Resident #33's incontinence care needs regardless if incontinence rounds had just been completed on the previous shift. The Administrator stated the staff member should not have made those statements to Resident #33 and should have promptly responded to her request. The Administrator stated all residents should be treated in a dignified manner and this would not be considered treating a resident with dignity by making them wait for care. 2. Resident #41 was admitted on [DATE] with diagnoses including paraplegia, muscle weakness and depression. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #41's 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was cognitively intact, had functional impairment of both sides of his lower extremities, was dependent on staff for toileting hygiene, was always incontinent with bowel and bladder, had adequate vision. An interview occurred with Resident #41 on 11/18/2025 at 11:45 AM, Resident #41 stated on many occasions during the night shift (11:00 PM to &7:00 AM) his call light was answered with wait times for care between 1 to 1.5 hours. Resident #41 stated he always had his phone and checked the times he had to wait for care to be rendered. Resident #41 claimed Nurse Aide (NA) #1 deferred incontinence care and would tell him that state law says I only needed to change you every 2 hours. Resident #41 questioned, What would happen if something really bad happened like choking or falling or having a stroke and the aide wasn't coming for 2 hours? On 11/20/25 at 5:35 AM an interview was conducted with Nurse #3. Nurse #3 stated she worked night shift and had no concerns with any of the nurse aides that worked the night shift. She stated there were consistent staff that worked the night shift. Nurse #3 stated all the staff worked well together. Nurse #3 was not aware of Resident #41's concern regarding being informed to wait for incontinence care by NA #1. On 11/20/25 at 5:40 AM an interview was conducted with Nurse #4. Nurse #4 stated she worked night shift and she had no concerns with any of the nurse aides that worked the night shift and had not received any resident concerns about the nurse aides. Nurse #4 was not aware of Resident #41's concern regarding being informed he had to wait for incontinence care by NA #1. During an interview on 11/20/2025 at 6:06 AM NA #1 stated Resident #41 often used his call light for assistance, requesting incontinence care, snacks or drinks. NA #1 further stated she told Resident #41 that state law was you get changed every 2 hours. NA #1 explained when Resident #41 used his call light she would tell him she would come back when it was time. A follow up interview with Resident #41 on 11/20/2025 at 8:26 AM revealed he used his call light around 12 AM last night (11/20/2025) to request incontinence care. Resident #41 stated NA #1 entered his room and turned off his light. Resident #41 continued to state, NA #1 did not come back until 3 AM. Resident #41 revealed he used his phone to know what time it was. Resident #41 explained when NA #1 provided care NA #1 just took his wet brief off and put on a dry brief. Resident #41 said, no wipes, no towels, just the wet one off and a dry one on. During an observation of incontinence care on 11/20/2025 at 9:18 AM of Resident #41, NA #2 removed the soiled brief, cleaned Resident #41's groin area and buttocks with disposable wipes. Resident #41 complained to NA #2 of a rash and feeling itchy. NA #2 recleaned the groin area while looking for a rash. NA #2 stated she did not notice a rash. Resident #41 expressed relief after being cleaned again by NA #2. NA #2 provided a new brief and assisted Resident #41 with getting dressed for the day. Observation revealed Resident 41's skin on his groin and buttocks were intact, clean with no visible rash or reddened areas. During an interview with NA #2 on 11/20/2025 at 9:25 AM NA #2 she had not worked with NA #1 and had no knowledge of NA #1 withholding care. NA #2 stated Resident #41 had never expressed complaints of lack of care by night shift nurse aides to her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/21/25 at 5:05 PM with the Administrator and Director of Nursing (DON). Both stated all residents should be responded to promptly. The DON stated a resident should never be told it was not time to provide care. NA #1 should have taken care of Resident #41's incontinence needs regardless if incontinence rounds had just been completed on the previous shift. The Administrator stated the staff member should not have made those statements to Resident #41 and should have promptly responded to his request. The Administrator stated all residents should be treated in a dignified manner and this would not be considered treating a resident with dignity by making them wait for care. 3. Resident #24 was admitted on [DATE] with diagnoses of dysphasia, and cancer of the kidney, liver, lung, and brain. Resident #24's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was moderately cognitively impaired with inattention and disorganized with his thinking. Resident #24 was noted to have some impairment and needed a minimum of set up assistance for meals and supervision or touch-assistance with oral and toileting hygiene, putting on his shoes, rolling left to right in bed, and showering. He had no behavioral symptoms indicated. Resident #24 was occasionally incontinent of bowel and bladder and required assistance with toileting hygiene. Resident #24's activities of daily living (ADL) deficit due to being hard of hearing care plan dated 03/27/2025 included interventions to speak on an adult level, speak clearly and slower than normal and to validate resident's message by repeating aloud. Review of the Facility Reported Entity report dated 06/05/2025 revealed the Director of Nursing (DON) interviewed Resident #24 on 06/05/2025. Resident #24 stated he was sitting on the edge of the bed when Nurse Aide #3 (NA) was aggressive with him during care. The Facility Reported Entity report stated, Resident #24 alleged NA #3 jerked him around like a rag doll and pushed him back onto the bed. Resident #24 stated NA #3 told him he could do it himself and threw a brief at him and stated, to quit being lazy. When asked if he felt safe at the facility, Resident #24 replied Yes, when that big gorilla isn't here. An observation and interview were conducted on 11/18/2025 at 12:00PM with Resident #24. He was observed in bed in a hospital gown, clean and odor free. Resident #24 had some trouble with his thoughts and communicating. His voice was very weak and barely a whisper. Resident #24 indicated he had been mistreated by NA #3 on the third shift (11:00PM to 7:00AM) as was described by Resident #24 as being big and black. Resident #24 was not able to verbalize how this incident with NA #3 made him feel before moving on to other non-related topics. Resident #24 could not recall or provide any additional information. A telephone interview on 11/19/2025 at 9:00AM with NA #3 stated she recalled the events of 06/05/2025 with Resident #24. During the last rounds at about 4:30AM Resident #24 had soiled the bed. She explained Resident #24 was hard of hearing. NA #3 stated she raised her voice and stated, 'Let's get you out of these wet clothes.' She further stated she repeated her request because Resident #24 kept saying 'what did you say, what did you say?' NA #3 explained she had not or did not touch him at that time. Resident #24 was able to put his incontinent product on himself with cueing. NA #3 communicated she assisted Resident #24 with taking off his shirt due to it being wet. NA #3 continued to communicate she washed him up and gave him an incontinent brief to put on. NA #3 verbalized this was the only time she physically touched or assisted Resident #24. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2025 at 8:50PM NA #4 revealed she never saw NA #3 abuse or mistreat anyone. She indicated that Resident #24 didn't like NA #3 and Resident #24 called NA#3 some inappropriate names. NA #4 confirmed Resident #24 was hard of hearing and staff needed to take their time when communicating with him. A telephone interview was conducted on 11/20/2025 at 11:22AM with former Resident #54 who was roommates with Resident #24 while at the facility. Former Resident #54's MDS report, dated 04/15/2025 indicated he was cognitively intact. Former Resident #54 indicated he clearly watched the incident involving Resident #24 who he said was out of bed and incontinence care. Former Resident #54 said that NA #3 entered the room and turned the light on. Former Resident #54 stated that NA#3 was yelling at and pushed Resident #24 on to bed and threw the brief at him, which hit him in the stomach. Former Resident #54 stated NA #3 told Resident #24 could change himself. When asked, Former Resident #54 was not aware of any other incidents with NA #3 treating him or Resident #24 badly. During an interview on 11/21/2025 at 9:40AM the Administrator indicated that she found out about the allegation when the Assistant Director of Nursing (ADON) was doing a random customer service check with various residents. She did not indicate any residents by name except Resident #24 and Resident #54. The Administrator could not recall whether it was Resident #24 or #54 who was the one that reported the allegation. The Administrator recalled that the alleged NA #3 was rough with Resident #24. The Administrator questioned if NA #3 startled Resident #24 because it was nighttime and NA #3 was a very big statured person. She stated NA #3 was terminated. The Administrator stated it was never okay to treat any residents roughly or disrespectfully.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interviews, the facility failed to post a list of names, addresses (mailing and email) and telephone numbers of all required state agencies and advocacy groups, such as the State Survey Agency, Department of Social Services, the State Long Term Care Ombudsman Program and the resident advocacy network. These observations occurred on 3 of the 4 days of the onsite recertification survey.The findings included:On 11/18/2025 at 1:00 PM, 11/19/2025 at 9:50 AM and 11/20/25 at 10:00 AM, an observation of the facility (inclusive of all hallways) revealed no postings of name or contact information for the following: the local Department of Social Services, the State Long Term Care Ombudsman, State Survey Agency or the resident advocacy network.During the Resident Council meeting on 11/20/2025 at 10:31 AM, Resident Council attendees (Resident #4, Resident # 23, Resident #42, and Resident #53) stated they did not know who the local Ombudsman was or how to contact them and did not know how to contact the State Agency to file a complaint or where that information would be found in the facility. During a walking tour of the facility and interview on 11/20/2025 at 11:02 AM with the Activities Director and the Director of Nursing, there were no postings of name or contact information for the local Department of Social Services, the State Long Term Care Ombudsman, State Survey Agency or the resident advocacy network. The Director of Nursing reported it was the Administrator's responsibility to ensure that postings were present. The Director of Nursing confirmed that all residents and their representatives should be informed of all available resources and that the postings be in a location easily visible and accessible if any resident or their representative needed them.On 11/21/2025 at 5:14 PM an interview was conducted with the Administrator who stated that contact information for the local Department of Social Services, the State Long Term Care Ombudsman, State Survey Agency or the resident advocacy network should be posted in a location easily visible and accessible should any resident or their representative need to access them. The Administrator stated she thought the Federal posting related to Medicare/Medicaid was adequate.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, resident and staff interviews, the facility failed to display survey results in a location accessible to residents and the public. This deficient practice occurred for 4 out of 4 days of the survey.The findings included:During an initial tour of the facility on 11/18/25 at 1:00 PM, survey result signage was observed in a picture frame on a table behind the receptionist in the main lobby. The survey signage revealed the following statement: State Survey results are in the binder under this sign. Survey signage was not observed in any other area in the facility. No binder was observed under the signage.An observation on 11/19/25 at 11:00 AM revealed the survey results binder was not located in any other area of the facility. Further observation of the desk behind the receptionist continued to reveal no evidence of the survey results binder.An additional observation on 11/20/25 at 10:00 AM revealed the survey results binder was not located in any other area of the facility. Further observation of the desk behind the receptionist continued to reveal no evidence of the survey results binder.A Resident Council group meeting was conducted on 11/20/25 at 10:31 AM. During the meeting, the resident council attendees indicated they did not know where the survey results were located (Resident #4, Resident # 23, Resident #42, and Resident #53). The Resident Council President shared he had been at the facility for 3 years and did not know the location of the survey results. An interview and observation were completed with the Activities Director (AD) and the Director of Nursing (DON) on 11/20/25 at 11:02 AM. Both stated that the survey results binder would be located behind the receptionist desk in the front lobby. During the walking tour the AD and DON were unable to locate the survey results binder. The DON stated she was not sure where the binder was, but she would ask the Administrator. In an interview with the Administrator on 11/21/2025 at 5:14 PM, she explained the survey result binder should be behind the receptionist desk and a sign was posted there identifying the location of the survey results under this signage. The Administrator stated the survey results binder was located on 11/20/25 on the bookshelf in the main dining room and offered that perhaps a resident had removed it from the table behind the receptionist and placed it in this bookshelf. The Administrator stated that survey results should be available to all residents, their representatives, and visitors at all times.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and resident interviews the facility failed to ensure advance directive information was accurate throughout the medical record for 1 of 1 resident reviewed for advance directives (Resident #4).The findings included:Resident # 4 was admitted to the facility on [DATE] and readmitted to the facility on [DATE].Review of Resident #4's electronic health record (EHR) revealed an active physician order dated [DATE] that stated Do Not Resuscitate (DNR).Resident #4's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact.Further review of Resident #4's electronic health record revealed an active physician order dated [DATE] stated that he was a Full Code. Resident #4's advance directive care plan dated [DATE] revealed residents' code status to be Full Code.An observation conducted on [DATE] of the Advance Directives binder located at the nursing station revealed a yellow Do Not Resuscitate form dated [DATE] and indicated no expiration date that was signed by the physician. Further review of the binder revealed Resident #4 had a Medical Orders for Scope of Treatment (MOST) form dated [DATE] that was signed by the resident and the physician. The MOST form read Attempt to Resuscitate (Full Code).An observation and interview were conducted with the Social Worker on [DATE] at 4:21 PM After review and observation of the Advance Directives binder, the Social Worker stated Resident #4's face sheet indicated he was a Full Code and his MOST form dated [DATE] indicated he was a Full Code. The Social Worker further observed a yellow DNR form dated [DATE] that indicated no expiration date. The Social Worker stated the yellow DNR was no longer valid. The Social Worker was observed to place the yellow DNR form back into the Advance Directives binder along with the face sheet and MOST form. During an interview and observation with Nurse #1 on [DATE] at 1:37 PM she indicated she would initiate Cardiopulmonary Resuscitation (CPR) on Resident #4 if he was unresponsive with no respirations or heartbeat. Nurse #1‘s observation of the Advance Directive binder indicated she would disregard the DNR form dated [DATE]. The nurse was observed to place the yellow DNR form back in the Advance Directives binder. Nurse #1 stated she would check the EHR and MOST form to confirm a resident's code status.During an interview on [DATE] at 1:41 PM Resident #4 stated he was a DNR. Resident #4 stated a DNR meant the staff would not provide CPR if needed.An interview with the Director of Nursing (DON) on [DATE] at 3:45 PM stated the code status information in the Advance Directive binder and the EHR should match. The DON revealed she expected nurses to check the MOST form in the Advance Directives binder and the code status in the EHR.