STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345315	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Lumberton	1170 Linkhaw Road Lumberton, NC 28358

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and Registered Dietician (RD) and staff interviews, the facility failed to honor residents' choices to have food items stored in the refrigerator and reheated for later consumption for 3 of 9 residents reviewed for self-determination (Resident #28, Resident #48, Resident #71).The findings included:a. Resident #28 was admitted to the facility on [DATE] with diagnoses to include acute unspecified protein calorie malnutrition.Review of Resident #28's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired and was coded independent for eating.The care plan dated 12/8/2025 for Resident #28 revealed a plan of care for risk for malnutrition related to weight loss, acute on chronic illness, and impaired mobility. The goal of care was for her intake of nutrients to meet her metabolic needs. Interventions included she was to receive her diet and supplements as prescribed.An interview with Resident #28 was completed on 2/10/2026 at 11:25 AM. Resident #28 stated she really didn't like the food provided by the facility. She further stated she would prefer to eat foods provided to her by her husband from home or local restaurants. Resident #28 indicated the facility would not allow her to store any cooked foods in the refrigerator or reheat the food for her. She stated that she would like to store food items brought to her in the refrigerator, but she was told by the facility that it was not allowed. b. Resident #48 was admitted on [DATE] with diagnosis to include stroke.Review of Resident #48's annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and was coded as independent for eating.An interview with Resident #48 was completed on 2/10/26 at 11:14 AM. Resident #48 stated he did not like the food provided by the facility. He further stated that in the past he enjoyed ordering a pizza once per month and would eat some of the pizza for dinner and save the rest in the refrigerator and have it reheated for his lunch and dinner the following day. Resident #48 stated that recently he was told that he was not allowed to store any cooked food items in the refrigerator or reheat the food and the pizza that he ordered and purchased was thrown away by the staff. Resident #48 stated that he would like to store food items in the refrigerator, but he was told that the facility did not allow this. c. Resident #71 was admitted on [DATE] with diagnosis to include stroke and diabetes.Resident #71's quarterly Minimum Data Set (MDS) dated [DATE] revealed that he was cognitively intact. An interview with Resident #71 was completed on 2/10/26 at 1:28 PM. Resident #71 stated that he did not like the food provided by the facility. He further stated that he would prefer to eat foods including healthy, diabetic foods provided by his family. Resident #71 stated that he was told that the facility would not allow him to store any cooked foods in the refrigerator or reheat the food for him. He stated that he would like to store food items brought in by his family in the refrigerator but was told by the facility that it was not allowed and the facility did not allow residents to have a personal refrigerator in their room.An observation of the 300-hall nourishment room was completed on 2/10/2026 at 10:35 AM. A sign on the refrigerator for (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents read in part, No cooked food may be stored in refrigerator. No stored foods per Carrolton policy.An interview with the Dietary Manager was conducted on 1/10/2026 at 10:38 AM. The Dietary Manager stated that it was the facility's policy not to allow residents to store food in the nourishment room refrigerator to prevent any potentially hazardous food illnesses from leftover food or foods that were prepared someplace else. She indicated that residents were allowed to keep drinks and nutritional supplements in the nourishment room refrigerator.An interview with the Registered Dietician (RD) was conducted on 2/12/2026 at 1:47 PM. The RD stated that one of his recommendations to facilities was that previously cooked food items could usually be safely stored in the refrigerator for up to 3 days.An interview with the Director of Nursing (DON) was completed on 2/13/2026 at 2:40 PM. The DON stated she expected residents to be allowed to make choices about their food. She further stated that residents should be given the choice to store leftovers in the refrigerator for later consumption.An interview with the Administrator was completed on 2/10/2026 at 11:30 AM. The Administrator stated the facility policy was not to allow residents to store food in the refrigerator and not to reheat foods. He indicated that any cooked foods that were not eaten within 4 hours were discarded. The Administrator stated that residents were not allowed to have personal refrigerators in their rooms.

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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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with resident, staff, Pharmacy Director and Nurse Practitioner, the facility failed to protect the residents' right to be free from misappropriation of narcotic pain medications (Tramadol, Hydrocodone-Acetaminophen, Oxycodone, and Oxycodone-Acetaminophen) for 9 of 9 residents reviewed for misappropriation of controlled medications (Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87). Findings included: a.) Resident #21 was admitted to the facility on [DATE] with diagnoses including adult failure to thrive and debility. A physician's order with a start date of 10/16/23 which remained as an active order for Resident #21 revealed Tramadol 50 milligrams (mg) tablets, one tablet by mouth two times a day for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/27/25 at 7:09 PM a total of 30 Tramadol 50 mg tablets for Resident #21 were delivered to the facility. The delivery receipt was signed off as received by Nurse #1, a night shift nurse, on 10/28/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet (an inventory log used to record a running total for each controlled medication) found for the 30 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #21. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #21 was cognitively intact. During an observation on 2/13/26 at 4:30 PM Resident #21 was observed sitting in her room in a wheelchair with her eyes closed. She showed no signs or symptoms of distress/pain. b.) Resident #2 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (narrowed or blocked blood vessels, typically affecting legs and feet, that can cause pain and cramping in the leg muscles). A physician's order with a start date of 1/1/25 which remained as an active order for Resident #2 revealed oxycodone 5 mg tablets, one tablet by mouth every six hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/10/25 at 5:04 PM a total of 60 oxycodone 5 mg tablets for Resident #2 were delivered to the facility. The delivery receipt was signed as received by Nurse #15. The delivery receipt was not signed off as received by a second nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on 8/10/25 for Resident #2. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/19/25 at 7:11 PM a total of 60 oxycodone 5 mg tablets for Resident #2 were delivered to the facility. The delivery receipt was not signed off as received by a nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on [DATE] for Resident #2. The MDS quarterly assessment dated [DATE] revealed Resident #2 had severely impaired cognition. During an observation on 2/13/26 at 4:30 PM Resident #2 was lying in bed. She was not oriented and could not engage in conversation. She showed no signs or symptoms of distress/pain. c.) Resident #16 was admitted to the facility on [DATE] with diagnoses including cancer and heart failure. A physician's order with a start date of 5/8/24 which remained as an active order for Resident #16 revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/19/25 at 7:34 PM a total of 30 Tramadol 50 mg tablets were delivered to the facility for Resident #16. The delivery receipt was signed by Nurse #1 on 8/19/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 30 Tramadol 50 mg tablets that were delivered to the facility on 8/19/25 for Resident #16. The MDS comprehensive assessment dated [DATE] revealed Resident #16 was cognitively intact. During an observation and interview on 2/13/26 at 4:40 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM with Resident #16 she was observed lying in bed and voiced no concerns about her care or pain medications. d.) Resident #34 was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (CVA) and heart failure. A physician's order with a start date of 2/12/25 which remained as an active order for Resident #34 revealed Tramadol 50 mg tablets, one tablet by mouth every 6 hours as needed for moderate and severe pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/12/25 at 5:09 PM a total of 60 Tramadol 50 mg tablets were delivered to the facility for Resident #34. There was no nurse signature on the delivery sheet. There was no declining count sheet found for the 60 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #34. The MDS comprehensive assessment dated [DATE] revealed Resident #34 had severely impaired cognition. During an observation on 2/12/26 at 4:00 PM Resident #34 was observed sitting in his room in his wheelchair with his Responsible Party present. Resident #34 could not engage in conversation. Resident #34's Responsible Party was interviewed and voiced no concerns regarding Resident #34's pain medication. e.) Resident #43 was admitted to the facility on [DATE] with diagnoses including deep vein thrombosis (blood clot in deep veins). A physician's order with a start date of 2/25/25 which remained as an active order for Resident #43 revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/6/25 at 8:50 PM a total of 90 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/7/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 90 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #43. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 45 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 45 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #43. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. f.) Resident #52 was admitted to the facility on [DATE] with diagnoses including arthritis and diabetes. A physician's order with a start date of 10/29/25 which remained as an active order for Resident #52 revealed oxycodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 60 oxycodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #52. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 60 oxycodone-acetaminophen 5-325 mg tablets that were delivered to the facility on [DATE] for Resident #52. The MDS comprehensive assessment dated [DATE] revealed Resident #52 had severely impaired cognition. During an observation on 2/11/25 at 2:00 PM Resident #52 was lying in bed and could not engage in conversation. She was smiling and showed no signs or symptoms of distress/pain.g.) Resident #69 was admitted to the facility on [DATE] with diagnoses including diabetes and renal disease.A physician's order with a start date of 10/24/24 which remained as an active order for Resident #69 for hydrocodone-acetaminophen 10-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 9/3/25 at 7:18 PM a total of 45 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #69. The delivery receipt was signed by Nurse #1 on 9/4/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 45 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on 9/3/25 for Resident #69. The MDS comprehensive assessment dated [DATE] revealed Resident #69 was cognitively intact. During an interview on 2/11/25 at 2:00 PM Resident #69 voiced no concerns about receiving her pain medications. h.) Resident #79 was admitted to the facility on [DATE] with diagnoses including heart failure and renal disease.A physician's order with a start date of 4/5/24 that remained as an active order for Resident #79 for hydrocodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/23/25 at 7:41 PM a total of 60 hydrocodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #79. The delivery receipt was signed by Nurse #1 on 10/24/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 60 hydrocodone-acetaminophen 5-325 mg tablets that were delivered to the facility on [DATE] for Resident #79. The MDS quarterly assessment dated [DATE] revealed Resident #79 had moderate cognitive impairment. During an observation on 2/11/26 at 2:45 PM Resident #79 was observed lying on bed. Resident #79 could not engage in conversation. She showed no signs or symptoms of distress/pain.i.) Resident #87 was admitted to the facility on [DATE] with diagnoses including heart failure. A physician's order with a start date of 1/20/23 which remained as an active order for Resident #87 for hydrocodone-acetaminophen 10-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/5/25 at 5:02 PM a total of 60 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #87. The delivery receipt was signed by the weekend Nurse Supervisor and by Nurse #5 on 10/5/25. There was no declining count sheet found for the 60 hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on [DATE] for Resident #87. The MDS quarterly assessment dated [DATE] revealed Resident #87 had severely impaired cognition. During an observation on 2/11/25 at 2:30 PM Resident #87 was lying in bed and showed no signs or symptoms of distress or pain.During an interview on 2/12/26 at 9:30 AM the Director of Nursing (DON) stated on Monday morning 11/3/25 she was notified by the weekend supervisor that they could not find Resident #21's Tramadol. The DON stated she called the pharmacy and was told that 30 tablets of Tramadol 50 mg for Resident #21 were sent to the facility on [DATE]. The DON stated she checked all of the medication carts to see if it had been put on another cart by mistake. The DON stated that all 8 medication carts in the facility were checked and the Tramadol for Resident #21 delivered on 10/27/25 was never found and the declining count sheet for the Tramadol for Resident #21 was never found. The DON stated she immediately notified the Administrator and the facility's Chief Nursing Officer. She stated the Pharmacy Director and the Medical Director were also notified. The DON stated that she, the Chief Nursing Officer, and the facility's Nurse Consultant began auditing all controlled medications that included current and discharged residents from 8/1/25 through 11/4/25. During the audit they discovered that eight additional residents (Residents #2, #16, #34, #43, #52, #69, #79, and #87) were found to have missing controlled medications for active orders. The DON stated that during the medication cart audits they were able to determine that the missing controlled medications were mainly from the 200-hall medication cart. She indicated that they started interviewing the 200-hall staff and were told during staff interviews that there was a Medication Aide (Medication Aide #1) who had been acting suspicious. The DON stated they drug tested all nursing staff, and Medication Aide #1 tested positive for the missing medications. Medication Aide #1 was terminated, and Health Care Personnel Registry was notified. The DON stated the process used before the missing controlled medications in November 2025 included that when controlled (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications were delivered to the facility one nurse would go through the delivery tote that held the medications and distribute the medications to the medication carts. The DON stated there was no assigned nurse to distribute the medications to the carts, it was whichever nurse was available when the delivery driver came in. The nurse would distribute the medications to the carts then sign the delivery sheet. The DON stated the medication delivery sheet had two signature lines and the nurse that checked the medication in was to sign and the nurse who received the medication on the medication cart was to sign. The DON stated during their investigation they discovered that two nurses were not signing off on the medication delivery sheets. The DON stated once the nurses signed the delivery sheets, the delivery sheets were placed in her box outside of her office. The DON stated she was responsible for reviewing the declining count sheets and the delivery sheets once they were completed. The DON stated she did not identify a problem with the declining count sheets until the missing medications were identified on 11/3/25 because the declining counts sheets were missing, the missing controlled medications were not recorded in the narcotic book, and she did not verify delivery sheets to ensure the medications were actually on the medication carts. The DON stated the new process was for the delivery sheets and declining counts sheets to be placed in a lockbox once completed and she would review the sheets for accuracy. The DON stated that prior to the identification of the missing medications on 11/3/25, she or Unit Manager #1 would do periodic audits of the controlled medications, and the Consultant Pharmacist also conducted periodic audits of controlled medications. The DON stated they had not identified any concerns with controlled medications until this occurred with Resident #21's medications. The DON stated that Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87 continued to receive their medications as ordered due to having extra refills on the cart. During an interview on 2/12/26 at 2:00 PM the facility's Chief Nursing Officer stated she was notified on 11/3/25 of the missing controlled medications for Resident #21. She stated an investigation was initiated at that time. The Chief Nursing Officer stated once they determined that the controlled medications were missing, they began auditing all controlled medications and identified eight additional residents (Residents #2, #16, #34, #43, #52, #69, #79, and #87) with missing medications. She stated the Drug Enforcement Agency (DEA) and law enforcement were notified, and Health Care Personnel Registry was notified regarding Medication Aide #1. The Chief Nursing Officer indicated they reported a total of 660 missing controlled tablets for active orders to the DEA. She stated they identified during their investigation that Nurse Practitioner #2 would order refills of the controlled medications for residents on her visits without checking to see if the order needed to be refilled first which caused controlled medications to accumulate on the medication carts. The Chief Nursing Officer stated they had changed the process, and the Nurse Practitioner and the Medical Director now checked with a nurse to determine if a refill was needed before writing the refill orders. The Chief Nursing Officer stated this would help to reduce the number of controlled medications stored on the medication carts and reduce the risk of diversion. During an interview on 2/12/26 at 2:30 PM the facility's Nurse Consultant stated during the investigation of the missing controlled medications in November 2025, they found that there were excessive controlled medications being stored on the medication carts. The Nurse Consultant stated they determined that Nurse Practitioner #2, who was interim while Nurse Practitioner #1 was out on leave, was evaluating residents and writing orders for refills for the controlled medications without first determining if a refill was needed at that time. This led to excessive amounts of the controlled medications being delivered and stored on the medication carts. The Nurse Consultant stated that Nurse Practitioner #2 was no longer working at the facility. The Nurse Consultant stated the facility worked with the pharmacy and changed the process to where the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacy would not fill the order until a staff nurse confirmed that a refill was needed. The Nurse Consultant stated due to having excessive amounts of the controlled medications stored on the medication carts the residents continued to receive their medications. During a phone interview on 2/12/26 at 4:00 PM Nurse Practitioner #2 stated she was no longer evaluating residents in the facility due to Nurse Practitioner #1 no longer being on leave. Nurse Practitioner #2 stated when she evaluated residents for pain assessments, which was usually once a month, she would go ahead and order pain medication refills. She stated she did not necessarily check with a nurse to see if a refill was needed at the time. Nurse Practitioner #2 stated she had spoken to the facility's Nurse Consultant during the investigation of the missing medications in November 2025 and was made aware of the new process for refilling controlled medications. During a phone interview on 2/13/26 at 1:05 PM the Pharmacy Director stated he was made aware of the nine residents (Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87) who were identified in November 2025 as having missing controlled medications. The Pharmacy Director stated they audited their system, their delivery sheets and the returned medications that were sent back to the pharmacy and confirmed that the medications missing for the nine residents were filled by the pharmacy, delivered to the facility, and none of the missing controlled medications had been returned to the pharmacy. The Pharmacy Director stated when medications were delivered to the facility they sent two copies of the delivery sheets, one copy went with the delivery driver, and the second copy was to be signed by a nurse and should be sent back to the pharmacy by fax. The Pharmacy Director stated that when refill orders for controlled medications were received in the pharmacy and they had not filled it in a while they would go ahead and refill the medication. He stated due to the number of missing controlled medications from the facility, the pharmacy had changed their process and now before refilling controlled medications, including as needed medications, the nurse from the facility must call to request the refill. This new process would help to ensure excessive controlled medications were not sent if they were not needed. During an interview on 2/13/26 at 1:30 PM Nurse Practitioner #1 stated she and the Medical Director were made aware of the nine residents (Residents #21, #2, #16, #34, #43, #52, #69, #79, and #87) who had missing controlled medications in November 2025. Nurse Practitioner #1 stated she was aware of the new ordering process for controlled medications and now checked with the nurse to see if a refill was needed before she wrote refill orders. Nurse Practitioner #1 stated there had been no reports made to her regarding Resident #21, Resident #2, Resident #16, Resident #34, Resident #43, Resident #52, Resident #69, Resident #79, or Resident #87 having unrelieved pain. The facility provided a corrective action plan that was not able to be validated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to obtain orders to access and manage a port-a-cath (an implantable device placed under the skin, usually in the chest, to provide long-term, easy access to veins for chemotherapy, medications, blood draws, or intravenous fluids) for 1 of 1 sampled resident with a port-a-cath (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses to include personal history of traumatic brain injury with persistent vegetative state. The hospital discharge summary completed on 12/20/2024 for Resident #1 revealed a left chest port-a-cath was placed by vascular surgery on 12/18/2024 for future access, but it was not yet mature (approximately 7 to 14 days for the site to heal to allow for use).A progress note written by the NP on 12/4/2025 revealed Resident #1 was admitted to the hospital on [DATE] for pneumonia and sepsis (a serious condition in which the body responds improperly to an infection), and 10/14/2025 for seizure like activity. It further listed a port-a-cath was placed surgically on 12/18/2024.The quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 indicated he had no speech, was rarely/never understood and rarely/never understood others. His cognitive skills for daily decision making indicated, severely impaired-never/rarely made decisions. The care plan for Resident #1 last revised 1/7/2026 did not reveal a plan of care regarding a port-a-cath.The hospital physician's history and physical dated 1/30/2026 revealed Resident #1 was admitted to the hospital on [DATE] with seizures and a catheter associated urinary tract infection. It further read that the resident had a left upper chest port-a-cath that was available for medication administration. The hospital discharge summary for Resident #1 dated 2/5/2026 revealed he was being discharged to the facility following treatment for seizures and a urinary tract infection with sepsis. It indicated that the resident's left chest port-a-cath was last flushed with normal saline (sterile solution of salt and water) and heparin (an anticoagulant) on 2/5/2026.A review of Resident #1's physician orders from 12/20/2024 through 2/11/2026 revealed no orders related to accessing and maintaining the resident's port-a-cath. An observation of Resident #1 was completed with Nurse #4 on 2/12/2026 at 3:53 PM. The observation revealed a left chest port-a-cath.An interview with Nurse #4 was completed on 2/12/2026 at 3:55 PM. Nurse #4 stated she didn't know if there were orders to access and maintain the port-a-cath, because she was a licensed practical nurse (LPN), and only registered nurses (RN) could access and flush a port-a-cath.An interview was completed with the Unit Manager on 2/13/2026 at 8:12 AM. The Unit Manager stated that she was the nurse responsible for Resident #1's readmission from the hospital on 2/5/2026. She stated she did not realize there should have been orders to access and flush the port-a-cath, because she was an LPN and the care of a port-a-cath was not in her scope of practice. The Unit Manager indicated that the second nurse that reviewed the orders was also an LPN.An interview with the Director of Nursing (DON) was conducted on 2/13/2026 at 7:50 AM. The DON stated Resident #1 had a port-a-cath due to poor vascular access. She further stated that when the resident returned from the hospital on [DATE] the discharge summary had noted the port-a-cath was too immature to access at that time. The DON indicated that typically orders should have been obtained regarding the care and maintenance for the port-a-cath upon admission. She stated she was unsure of how long it took for a port-a-cath to heal, but that it would not take a year. The DON further stated that the facility had never accessed Resident #1's port-a-cath or provided any maintenance or care for it. She stated the hospital Discharge summary dated [DATE] indicated the port had been flushed at the hospital on 2/5/2026. She stated she thought there should have been orders in place to access and flush the port-a-cath routinely to keep it patent and prevent it from clotting off (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(ensuring it is open, unobstructed, and working properly). The DON indicated that accessing the port had to be done with a special needle and then flushed with normal saline and heparin for maintenance. She stated the facility didn't have a policy for routinely flushing a port-a-cath and that it would be ordered on an individual basis. She indicated that usually a port-a-cath was accessed monthly or every 6 weeks by an RN to maintain patency. The DON stated that accessing and flushing a port-a-cath was not on the list of competencies for nurses at the facility, and that training and education would have to be provided by the NP. An interview with the NP was completed on 2/13/2026 at 1:42 PM. The NP stated that she was aware Resident #1 had a port-a-cath for administration of intravenous (IV) fluids, medications, and blood draws, because he had poor vascular access. She further stated that she was not exactly sure how long it took a port-a-cath to heal, but they were usually able to be used approximately 2 weeks after placement. The NP indicated Resident #1's port-a-cath had not been accessed or flushed at the facility since it was placed in December 2024. The NP indicated she was aware a port-a-cath should be accessed and flushed routinely and that there had not been orders to access and maintain the port-a-cath after it was placed in December 2024. She stated that Resident #1 was admitted to the hospital at least 2 times in 2025 and she assumed that the hospital was accessing it and flushing it during the hospital stays must have been enough to keep it patent. The NP indicated she had mentioned ordering the special needles used to access a port-a-cath while speaking to nursing staff in the nurses' station on 2/9/2026, but the nursing staff indicated they did not access the port-a-cath. She could not recall which nurses made that statement. She further stated she was going to discuss care for the port-a-cath with the physician, but she had not done it yet. The NP indicated that the port-a-cath should be accessed monthly to maintain patency and she was going to write the orders and educate the registered nurse staff.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Nurse Practitioner interviews, the facility failed to provide effective supervision of a cognitively impaired resident (Resident #91) who was known to exhibit wandering behavior and rummaging. This failure resulted in Resident #91 obtaining and ingesting one gel capsule of an over-the-counter cold and flu medication containing acetaminophen, dextromethorphan (cough suppressant) and phenylephrine (nasal decongestant) that was in an unlocked drawer in the receptionist's desk located in the lobby area of the facility. This deficient practice was identified for 1 of 4 residents reviewed for supervision to prevent accidents (Resident #91).Findings included:Resident #91 was admitted on [DATE] with a diagnosis which included Lewy body dementia, atrial fibrillation (irregular heart rate), hypertension, diabetes, chronic obstructive pulmonary disease, heart failure, thyroid disease and kidney disease.Resident #91's care plan dated 3/10/24 and currently active indicated that the resident was at risk for cognitive decline related to history of delirium and diagnosis of neurocognitive disorder with Lewy Body dementia. The intervention for this problem indicated to monitor, document and report any changes in cognitive function. Resident #91's quarterly Minimum Data Set, dated [DATE] indicated that the resident had moderate cognitive impairment, wandering was not exhibited during the look back period and the resident used a wheelchair for mobility.A review of Resident # 91's electronic health record revealed a nursing progress note dated 12/27/25 at 2:51 PM written by the Unit Coordinator which indicated that Resident #91 went through the unattended receptionist's desk in the lobby and found an over-the-counter cold capsule. Resident #91 ingested the contents. The on-call provider was notified, and the staff were advised to monitor the resident and encourage fluids. The on-call provider was to be notified of any new or worsening symptoms. The note stated that Resident #91 was symptomatic with no description of the symptoms exhibited.A review of the manufacturer's instructions for the cold and flu relief gel capsule indicated to ask a doctor before use if you have: liver disease, heart disease, high blood pressure, thyroid disease or diabetes. Common side effects include but are not limited to confusion, dizziness, nervousness, and nausea.An interview was conducted with the Unit Coordinator on 2/12/26 at 2:55 PM. The Unit Coordinator stated that she was assigned to Resident #91 on 12/27/25 from 7:00 AM to 7:00 PM. The Unit Coordinator stated that on the afternoon of 12/27/25, she was in the nurse's station which is adjacent to the lobby when the Receptionist informed her that as she was returning to her desk, the Receptionist witnessed from across the room, Resident #91 ingesting a cold and flu gel capsule from the unlocked unattended desk drawer at the Receptionist's desk. The Receptionist informed the Unit Coordinator that she was unable to get to the resident in time to prevent her from taking the medication. The Unit Coordinator stated the Receptionist observed Resident #91 go into the receptionist's desk drawer, obtain one gel capsule of the cold and flu medication that was loose in the drawer and ingested it before staff could stop her. The Unit Coordinator stated that the Receptionist stated that she had the cold and flu medication loose in the desk drawer and Resident #91 opened the desk drawer, found the medication and ingested it. The Unit Coordinator indicated that throughout the day, residents were frequently in the common area in the front of the building where the receptionist's desk was and most of the residents don't wander or go into things. The Unit Coordinator stated that staff tried to supervise the residents in the common area the best they could but there was no system in place to ensure that the residents in the area were continuously monitored. The Unit Coordinator stated that the lobby area was an open area with television and seating that the residents were free to sit in and can propel wheelchairs throughout the area unrestricted with the receptionist's desk at the front of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the area by the door to the facility. The Unit Coordinator indicated that Resident #91 exhibited behaviors of wandering throughout the facility, entering other resident rooms and common areas and rummaging through other residents' belongings. The Unit Coordinator stated that prior to this incident, Resident #91 would take items from other resident rooms, and it was difficult to redirect her. The Unit Coordinator stated that staff tried to monitor Resident #91 and redirect her when she wandered or rummaged through other residents' belongings. The Nurse Coordinator stated that initially after Resident #91 ingested the medication, she seemed okay but then she became drowsy and lethargic, so she was sent to the emergency room. A message was left on the Receptionist's voicemail on 2/13/26 at 2:12 PM with no return call received.A nursing progress note dated 12/27/25 at 5:51 PM written by the Weekend Supervisor revealed that the on-call provider and emergency medical services were called at 5:15 PM. Resident #91 was lethargic and not responding after she ingested over-the-counter cold medication. Resident #91 was sent to the emergency department for evaluation. An interview was conducted with the Weekend Supervisor on 2/13/26 at 1:55 PM. The Weekend Supervisor stated that Resident #91 had dementia and was confused with wandering and rummaging behaviors. The Weekend Supervisor stated that while she was on duty on 12/27/25 from 7:00 AM to 7:00 PM, the Unit Coordinator reported that Resident #91 went into the unlocked, unattended receptionist's desk drawer and obtained a cold and flu gel capsule and ingested it. The Weekend Supervisor indicated that Resident #91 was cognitively impaired with a diagnosis of dementia, propelled her wheelchair independently throughout the facility and at times was agitated and difficult to redirect with increased confusion. The Weekend Supervisor stated that after Resident #91 ingested the cold medication Resident #91 was drowsy and lethargic, so the supervisor stated she informed the on-call provider. The Weekend Supervisor stated that she obtained an order to send Resident #91 to the emergency department for altered mental status. The Weekend Supervisor stated that Resident #91 was evaluated in the emergency department and returned to the facility the same day? with no new orders.A review of the emergency department Discharge summary dated [DATE] at 6:18 AM indicated that Resident #91 arrived in the emergency department on 12/27/25 at 5:51 PM with vital signs which were blood pressure 151/89 millimeters of Mercury (mm/Hg) (normal range is below 120/80 mmm/Hg) pulse 61 (normal range is 60-110), respirations 17 (normal range 16-20 breaths per minute), temperature 97.4 degrees (normal range is 97 to 99 degrees Fahrenheit) and oxygen saturation 96 percent (normal range is 96-100 percent). Resident #91 presented to the emergency department with altered mental status that began earlier in the day after she ingested a dose of over-the-counter cold and flu medication that she took from the receptionist's desk drawer. The discharge summary indicated that the supervisor at the facility reported that after taking the cold and flu medication, Resident #91 was very confused, not responding to her name, and was wandering into other residents' rooms at the facility. While in the emergency department, lab work, electrocardiogram, computed tomography (CT) scan of the head and urinalysis were obtained with the results being unremarkable. The note indicated that Resident #91's condition remained stable with no changes in vital signs or mental status while in the emergency department and the resident was discharged to the facility at 6:18 AM on 12/28/25 with no new physician orders. The discharge summary indicated that the facility was to follow up with the primary care physician if Resident #91 exhibited any worsening or change in symptoms. An interview was conducted with the Nurse Practitioner on 2/11/26 at 1:50 PM. The Nurse Practitioner stated that Resident #91 should not have had access to the medication and that the resident was confused with impaired cognition, wandering and rummaging behavior. The Nurse Practitioner stated that ingesting the medication had the potential for an adverse effect but Resident #91 did not suffer harm due to this incident. The Nurse Practitioner stated that one dose of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	over-the-counter cold medication containing acetaminophen, dextromethorphan and phenylephrine wouldn't normally cause lethargy but the effect of a medication, even an over-the-counter medication, is individual. The Nurse Practitioner stated that it was her professional opinion that the gel capsule was not related to Resident #91's change in status with increased lethargy. The Nurse Practitioner stated that she had no concern that the cold medication was related to Resident #91's change in status and thought that it was related to the resident's diagnosis of Lewy Body Dementia which can cause waxing and waning cognition. An interview was conducted with the Director of Nursing (DON) on 2/13/26 at 2:30 PM. The DON stated that the incident should not have happened, and the resident should have been supervised and kept free from hazards. The DON indicated that all staff were responsible for supervising the residents but there was no system in place to ensure that a staff member was continuously monitoring the residents in the common areas, including the lobby area. The DON stated that staff are frequently passing in and out of the lobby area. Prior to this incident, the facility had not considered unlocked drawers to be a potential hazard to the residents. An interview with the Administrator on 2/13/26 at 4:15 PM revealed that he expected that the residents would be kept free from hazards and supervised to prevent accidents. The Administrator stated that all staff were responsible for supervising the residents in common areas including the lobby area. Prior to this incident, the facility had not considered unlocked drawers to be a potential hazard to a cognitively impaired resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Consultant Pharmacist, Pharmacy Nurse Consultant, and Pharmacy Director, the facility failed to have effective safeguards and systems in place for the accounting of controlled medications and the return of discontinued controlled medications to the pharmacy to prevent drug diversion for 9 of 9 residents reviewed for misappropriation of medications (Resident #69, #43, #2, #21, #16, #34, #52, #79, and #87). Findings included: a. A physician's order for Resident #69 with a start date of 8/8/25 revealed Lorazepam 0.5 milligrams (mg) tablets, one tablet by mouth every 24 hours as needed for anxiety for 14 days. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/8/25 at 7:13 PM a total of 14 Lorazepam 0.5 mg tablets were delivered to the facility for Resident #69. The delivery receipt was signed by Nurse #1 on 8/8/25. There was no signature on the delivery sheet from a second nurseThere was no declining count sheet (an inventory log used to record a running total for each controlled medication) found for the 14 tablets of Lorazepam 0.5 mg that were delivered to the facility on 8/8/25 for Resident #69. Review of Resident #69's Medication Administration Record (MAR) for August 2025 revealed the as needed Lorazepam 0.5 mg order showed no documentation that the medication was administered to Resident #69 after the delivery on 8/8/25 at 7:13 PM. A review of Resident #69's physician's orders included an order (start date of 10/24/24) for hydrocodone-acetaminophen 10-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. This order remained active. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 9/3/25 at 7:18 PM a total of 45 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #69. The delivery receipt was signed by Nurse #1 on 9/4/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 45 hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on 9/3/25 for Resident #69. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. b. A physician's order for Resident #43 with a start date of 2/25/25 which remained as an active order revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/6/25 at 8:50 PM a total of 90 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/7/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 90 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #43. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 45 Tramadol 50 mg tablets were delivered to the facility for Resident #43. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 45 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #43. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. c. A physician's order for Resident #2 with a start date of 1/1/25 which remained as an active order revealed oxycodone 5 mg tablets, one tablet by mouth every six hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/10/25 at 5:04 PM a total of 60 oxycodone 5 mg tablets for Resident #2 were delivered to the facility. The delivery receipt was signed as received by Nurse #15. The delivery receipt was not signed off as received by a second nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on 8/10/25 for Resident #2. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/19/25 at 7:11 PM a total of 60 oxycodone 5 mg tablets (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Resident #2 were delivered to the facility. The delivery receipt was not signed off as received by a nurse. There was no declining count sheet found for the 60 oxycodone 5 mg tablets that were delivered to the facility on [DATE] for Resident #2. d. A physician's order for Resident #21 with a start date of 10/16/23 which remained as an active order revealed Tramadol 50 milligrams (mg) tablets, one tablet by mouth two times a day for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/27/25 at 7:09 PM a total of 30 Tramadol 50 mg tablets for Resident #21 were delivered to the facility. The delivery receipt was signed off as received by Nurse #1, a night shift nurse, on 10/28/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet (an inventory log used to record a running total for each controlled medication) found for the 30 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #21. e. A physician's order for Resident #16 with a start date of 5/8/24 which remained as an active order revealed Tramadol 50 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 8/19/25 at 7:34 PM a total of 30 Tramadol 50 mg tablets were delivered to the facility for Resident #16. The delivery receipt was signed by Nurse #1 on 8/19/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 30 Tramadol 50 mg tablets that were delivered to the facility on 8/19/25 for Resident #16. f. A physician's order for Resident #34 with a start date of 2/12/25 which remained as an active order for revealed Tramadol 50 mg tablets, one tablet by mouth every 6 hours as needed for moderate and severe pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/12/25 at 5:09 PM a total of 60 Tramadol 50 mg tablets were delivered to the facility for Resident #34. There was no signature on the delivery sheet. There was no declining count sheet found for the 60 Tramadol 50 mg tablets that were delivered to the facility on [DATE] for Resident #34. g. A physician's order for Resident #52 with a start date of 10/29/25 which remained as an active order revealed oxycodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/29/25 at 7:27 PM a total of 60 oxycodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #52. The delivery receipt was signed by Nurse #1 on 10/30/25. There was no signature on the delivery sheet from a second nurse. There was no declining count sheet found for the 60 oxycodone-acetaminophen 5-325 mg tablets that were delivered to the facility on [DATE] for Resident #52. h. A physician's order for Resident #79 with a start date of 4/5/24 that remained as an active order revealed hydrocodone-acetaminophen 5-325 mg tablets, one tablet by mouth every 8 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/23/25 at 7:41 PM a total of 60 hydrocodone-acetaminophen 5-325 mg tablets were delivered to the facility for Resident #79. The delivery receipt was signed by Nurse #1 on 10/24/25. There was no signature on the delivery sheet from a second nurse. Attempts were made to contact Nurse #1 on 2/12/26 and 2/13/26 with no response. There was no declining count sheet found for the 60 hydrocodone-acetaminophen 5-325 mg tablets that were delivered to the facility on [DATE] for Resident #79. i. A physician's order for Resident #87 with a start date of 1/20/23 which remained as an active order revealed hydrocodone-acetaminophen 10-325 mg tablets, one tablet by mouth every 6 hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 10/5/25 at 5:02 PM a total of 60 hydrocodone-acetaminophen 10-325 mg tablets were delivered to the facility for Resident #87. The delivery receipt was signed by the weekend Nurse Supervisor and by Nurse #5 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 10/5/25. There was no declining count sheet found for the 60 hydrocodone-acetaminophen 10-325 mg tablets that were delivered to the facility on [DATE] for Resident #87. During an interview on 2/12/26 at 9:30 AM the Director of Nursing (DON) stated on 11/3/25 she was notified by the weekend supervisor that they could not find Resident #21's Tramadol for an active order. She reported that they began auditing the medication carts and identified there were missing controlled medications including Resident #69's discontinued Lorazepam that was delivered on 8/8/25. The DON stated she called the pharmacy and was told that 14 Lorazepam 0.5 mg tablets were delivered to the facility for Resident #69 on 8/8/25. She stated that the 14 Lorazepam tablets delivered on 8/8/25 and the declining count sheet were never found. The DON indicated she confirmed with the pharmacy that 14 Lorazepam 0.5 mg tablets were sent to the facility on 8/8/25 and none were returned back to the pharmacy. The DON stated that Resident #69's MAR was reviewed and there was no documentation that Lorazepam was administered from the 8/8/25 delivery. The DON added that there was no declining count sheet for the 8/8/25 delivery of Lorazepam for Resident #69 and it was not recorded in the narcotic book. The DON stated she immediately notified the Administrator and the facility's Chief Nursing Officer. She stated the Pharmacy Director and the Medical Director were also notified. The DON stated that she, the Chief Nursing Officer, and the facility Nurse Consultant began auditing all controlled medications that included current and discharged residents from 8/1/25 through 11/4/25. The DON stated that during the medication cart audits they were able to determine that the missing controlled medications were mainly from the 200 hall medication cart. She reported that the facility then started interviewing 200 hall staff and were told during staff interviews that there was a Medication Aide (Medication Aide #1) who had been acting suspicious. The DON stated they drug tested all nursing staff, and Medication Aide #1 tested positive for the missing Lorazepam. Medication Aide #1 was terminated, and Health Care Personnel Registry was notified. The DON stated the process used before the missing Lorazepam was identified in November 2025 included that when controlled medications were delivered to the facility one nurse would go through the delivery tote and distribute the medications to the medication carts. The DON stated there was no assigned nurse to distribute the medications to the carts, it was whichever nurse was available when the delivery driver came in. The nurse would distribute the medications to the carts then sign the delivery sheet. The DON stated the medication delivery sheet had two signature lines and the nurse that checked the medication in was to sign and the nurse who received the medication on the medication cart was to sign. The DON stated during their investigation they discovered that two nurses were not signing off on the medication delivery sheets. The DON stated once the nurses signed the delivery sheets, the delivery sheets were placed in her box outside of her office. The DON stated she was responsible for reviewing the declining count sheets and the delivery sheets once they were completed. The DON explained that she did not identify a problem with the declining count sheet until 11/3/25 because the declining count sheet was missing, the Lorazepam was not recorded in the narcotic book, and she did not verify delivery sheets to ensure the medications were actually on the medication carts. The DON stated that they verified during their investigation that the declining count sheets were missing for nine residents (Resident #69, #43, #2, #21, #16, #34, #52, #79, and #87). The DON added that the new process was the delivery sheets and declining counts sheets would now be placed in a lockbox once completed and she would review the sheets for accuracy. The DON stated that prior to the identification of the missing medication on 11/3/25, she or Unit Manager #1 would do periodic audits of the controlled medications, and the Consultant Pharmacist also conducted periodic audits of controlled medications. The DON stated they had not identified any concerns with controlled medications until this was found in November 2025. The DON stated discontinued (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Lumberton	1170 Linkhaw Road Lumberton, NC 28358

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controlled medication declining count sheets were to be removed from the narcotic book with the witness of another staff member and the declining count sheet placed in her box. Then she would place the medication in a sealed bag and complete a return drug form then fax the form to the pharmacy. The sealed bag would be locked in the narcotic box on the medication cart until the pharmacy delivery driver picked it up. The DON indicated that process did not occur for Resident #69's Lorazepam because she did not receive a discontinued declining count sheet notifying her the Lorazepam order was discontinued for Resident #69. During an interview on 2/12/26 at 1:00 PM Unit Manager #1 stated she was responsible for checking medication orders, but she did not audit controlled medications on the medication carts, and she thought the DON was responsible for the controlled medications. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she was in the facility for monthly medication regimen reviews. She stated she was made aware of the missing controlled medications, including the discontinued Lorazepam, in November 2025. The Consultant Pharmacist stated that she did not conduct medication cart audits including auditing the controlled medications. She stated the pharmacy employed a Nurse Consultant that checked the medication carts and she thought he did random controlled medication audits, but she was not certain of this. The Consultant Pharmacist stated the Pharmacy Nurse Consultant had not reported any concerns to her regarding controlled medications. During a phone interview on 2/13/26 at 1:05 PM the Pharmacy Director stated in November 2025 he was made aware of Resident #69's missing Lorazepam that was delivered to the facility on 8/8/25. He stated the pharmacy audited their system, their delivery sheets and the returned medications that were sent back to the pharmacy and confirmed that the missing Lorazepam for Resident #69 was filled by the pharmacy, delivered to the facility on 8/8/25, and had not been returned to the pharmacy. The Pharmacy Director stated when medications were delivered to the facility they sent two copies of the delivery sheets, one copy went with the delivery driver, and the second copy was to be signed by a nurse and should be sent back to the pharmacy through fax. He stated medications should be returned to the pharmacy when the orders were discontinued. The Pharmacy Director stated the pharmacy did not track discontinued medication orders including controlled medications. He stated it was the facility's responsibility to remove the controlled medications from the medication cart when the order was discontinued and return any remaining medication to the pharmacy. During a phone interview on 2/19/26 at 3:00 PM the facility's Pharmacy Nurse Consultant stated he conducted random medication cart audits, but he was not responsible for conducting audits of the controlled medications. He stated he only checked that the narcotic box was locked when he did medication cart audits, but he never reviewed the controlled medications or the declining count sheets, and it was not a part of his medication cart audits. During a follow up interview on 2/13/26 at 2:00 PM the DON indicated she was not aware the Consultant Pharmacist did not conduct random audits of the controlled medications. She indicated she was not aware that Unit Manager #1 did not check the controlled medications. The DON stated Resident #69's discontinued Lorazepam should have been removed from the medication cart and returned to the pharmacy when the order was discontinued after 14 days, and that did not occur.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Consultant Pharmacist's interviews, the facility failed to a.) act on the Consultant Pharmacist's recommendation to address a residents (Resident #12) diuretic medication Metolazone (used to treat high blood pressure and fluid retention caused by heart failure or kidney disease) that was prescribed for increased edema. The Consultant Pharmacist reported during the monthly medication regimen review in October 2025 and November 2025 that Resident #12 was receiving Metolazone outside of the physician ordered parameters which were to hold the medication if the residents systolic blood pressure was less than 110 or the diastolic blood pressure was less than 60. b.) the Consultant Pharmacist failed to identify and address during the December 2025 and January 2026 monthly medication regimen reviews that Metolazone continued to be administered to Resident #12 outside of the ordered blood pressure parameters. This resulted in Resident #12 continuing to receive the medication when it should have been held. This occurred for 1 of 6 residents reviewed for medication administration (Resident #12). Findings included. a.) Resident #12 was admitted to the facility on [DATE] with diagnoses including heart failure, hypertension, and kidney disease. A physician's order dated 9/5/25 for Resident #12 revealed Metolazone 5 milligram (mg) tablets. Give 1 tablet by mouth one time a day every Monday, Wednesday, and Friday for edema (swelling caused by excessive fluid trapped in body tissues). Hold for systolic blood pressure less than 110, or diastolic blood pressure less than 60. Review of the Medication Administration Record (MAR) dated September 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 9/10/25 administered by Nurse #2 with blood pressure 103/629/12/25 administered by Nurse #2 with blood pressure 77/609/15/25 administered by Nurse #2 with blood pressure 99/549/17/25 administered by Nurse #2 with blood pressure 98/669/19/25 administered by Nurse #2 with blood pressure 103/689/22/25 administered by Nurse #2 with blood pressure 99/569/24/25 administered by Nurse #2 with blood pressure 89/649/26/25 administered by Nurse #2 with blood pressure 106/789/29/25 administered by Nurse #2 with blood pressure 110/53 Review of the Medication Administration Record (MAR) dated October 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 10/01/25 administered by Nurse #2 with blood pressure 89/5610/03/25 administered by Nurse #2 with blood pressure 89/6110/06/25 administered by Nurse #2 with blood pressure 96/6410/08/25 administered by Nurse #2 with blood pressure 98/6110/15/25 administered by Nurse #2 with blood pressure 105/6410/17/25 administered by Nurse #2 with blood pressure 110/5310/20/25 administered by Nurse #2 with blood pressure 108/8010/22/25 administered by Nurse #2 with blood pressure 91/7110/29/25 administered by Nurse #2 with blood pressure 104/6810/31/25 administered by Nurse #2 with blood pressure 93/64 Review of the Consultant Pharmacist's medication regimen review dated 10/9/25 revealed a note informing the Director of Nursing (DON) that Resident #12 had received Metolazone outside of the ordered blood pressure parameters on several occasions in September 2025 and in October 2025. Record review revealed Unit Manager #1 noted on the Consultant Pharmacist's medication regimen review dated 10/9/25 that nursing staff was educated. Unit Manager #1 did not specify if Nurse #2 received the education or what education was provided. Review of the Medication Administration Record (MAR) dated November 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 11/03/25 administered by Nurse (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#2 with blood pressure 98/5811/05/25 administered by Nurse #2 with blood pressure 97/6911/07/25 administered by Nurse #2 with blood pressure 103/6011/12/25 administered by Nurse #2 with blood pressure 99/6111/14/25 administered by Nurse #2 with blood pressure 97/6211/17/25 administered by Nurse #2 with blood pressure 102/7211/19/25 administered by Nurse #2 with blood pressure 100/6111/21/25 administered by Nurse #2 with blood pressure 97/6011/24/25 administered by Nurse #2 with blood pressure 101/6311/26/25 administered by Nurse #2 with blood pressure 100/5811/28/25 administered by Nurse #2 with blood pressure 103/60 Review of the Consultant Pharmacist's medication regimen review dated 11/6/25 revealed a note informing the DON that Resident #12 had received Metolazone outside of the ordered blood pressure parameters. Record review revealed Unit Manager #1 noted on the Consultant Pharmacist's medication regimen review dated 11/6/25 that nursing staff was educated regarding the Metolazone. Unit Manager #1 did not specify if Nurse #2 received the education or what education was provided. During an interview on 2/11/26 at 1:15 PM Nurse #2 stated she did administer Metolazone to Resident #12 on the above dates. She stated she was a new nurse and thought the order to hold the medication was if both the systolic and the diastolic blood pressure was less than 110/60. Nurse #2 stated she misunderstood the parameters that were ordered and the Metolazone was given in error. Nurse #2 stated she was consistently assigned to Resident #12 and did not realize that she had been administering Metolazone to Resident #12 in error on so many occasions since September 2025. Nurse #2 indicated the medication error had not been brought to her attention until now. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she completed monthly medication reviews for the facility. She stated she did see that Resident #12's Metolazone was administered outside of the parameters and included that in her monthly reports that were sent to the DON in October 2025 and November 2025. The Consultant Pharmacist indicated that she typically did not go back and review the previous months recommendations that were sent to the DON and just expected that the nursing recommendations would be followed. During an interview on 2/13/26 at 2:40 PM the DON stated she and Unit Manager #1 shared the responsibility for reviewing and acting on the monthly pharmacy reports. She was not aware that Metolazone continued to be administered to Resident #12 outside of the parameters. The DON stated the Consultant Pharmacist did address the medication error in her monthly reports in October and November 2025. The DON stated Unit Manager #1 noted on the October 2025 and November 2025 pharmacy reports that education was provided to nursing staff. The DON stated all nursing staff should have been included in the education provided by Unit Manager #1 including Nurse #2. The DON stated Unit Manager #1 was not in the facility at the time, and she was not certain where the documentation was regarding the education that was provided by Unit Manager #1 or if Nurse #2 received education regarding following blood pressure parameters. The DON stated further education would be provided to all nursing staff including Nurse # 2, regarding medication administration including following blood pressure parameters. b.) Review of the Medication Administration Record (MAR) dated December 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 12/01/25 administered by Nurse #2 with blood pressure 99/6312/03/25 administered by Nurse #2 with blood pressure 102/7012/05/25 administered by Nurse #2 with blood pressure 106/6912/08/25 administered by Nurse #2 with blood pressure 99/6512/10/25 administered by Nurse #2 with blood pressure 95/6812/12/25 administered by Nurse #2 with blood pressure 95/6212/15/25 administered by Nurse #2 with blood pressure 105/6912/17/25 administered by Nurse #2 with blood pressure 97/6212/19/25 administered by Nurse #2 with blood pressure 96/6512/22/25 administered by Nurse #2 with blood pressure 108/6112/24/25 administered by Nurse #2 with blood pressure 95/5612/26/25 administered by Nurse #2 with (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood pressure 108/6212/29/25 administered by Nurse #2 with blood pressure 105/68 Review of the Consultant Pharmacist's medication regimen review dated 12/3/25 revealed no recommendations regarding Resident #12's Metolazone. Review of the Medication Administration Record (MAR) dated January 2026 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 1/02/26 administered by Nurse #2 with blood pressure 98/641/07/26 administered by Nurse #2 with blood pressure 107/611/09/26 administered by Nurse #2 with blood pressure 94/631/14/26 administered by Nurse #2 with blood pressure 101/621/16/26 administered by Nurse #2 with blood pressure 102/611/19/26 administered by Nurse #2 with blood pressure 102/571/21/26 administered by Nurse #2 with blood pressure 99/681/26/26 administered by Nurse #2 with blood pressure 105/601/30/26 administered by Nurse #2 with blood pressure 109/55 Review of the Consultant Pharmacist's medication regimen review dated 1/27/26 revealed no recommendations were made regarding Resident #12's Metolazone. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she completed monthly medication reviews for the facility. She stated she did not address Metolazone for Resident #12 in the December 2025 or January 2026 monthly pharmacy reports, and she had previously reported the discrepancy to the DON. The Consultant Pharmacist indicated this was missed on the December 2025 and January 2026 medication regimen reviews. During an interview on 2/13/26 at 2:40 PM the Director of Nursing (DON) stated the Consultant Pharmacist did address the medication error in her monthly reports in October and November 2025 regarding Resident #12's Metolazone. The DON stated Resident #12's Metolazone was not addressed by the Consultant Pharmacist on the December 2025 or the January 2026 pharmacy reports. The DON indicated she did not review Resident #12's Metolazone in December 2025 or January 2026 to ensure the medication was not administered outside of the parameters.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff, resident, Nurse Practitioner and the Consultant Pharmacist interviews, the facility failed to hold the medication Metolazone (a diuretic medication used to treat high blood pressure and fluid retention caused by heart failure or kidney disease) when a resident's blood pressure was less than 110 systolic or less than 60 diastolic according to the parameters ordered by the physician. This resulted in a significant medication error as Resident #12 received 57 doses when the medication should have been held. Resident #12 experienced no significant outcome from receiving the medication. This occurred for 1 of 6 residents reviewed for medication administration (Resident #12). Findings included. Resident #12 was admitted to the facility on [DATE] with diagnoses including heart failure, hypertension, and kidney disease. A physician's order dated 9/5/25 for Resident #12 revealed Metolazone 5 milligram (mg) tablets. Give 1 tablet by mouth one time a day every Monday, Wednesday, and Friday for edema (swelling caused by excessive fluid trapped in body tissues). Hold for systolic blood pressure less than 110, or diastolic blood pressure less than 60. Review of the Medication Administration Record (MAR) dated September 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 9/10/25 administered by Nurse #2 with blood pressure 103/629/12/25 administered by Nurse #2 with blood pressure 77/609/15/25 administered by Nurse #2 with blood pressure 99/549/17/25 administered by Nurse #2 with blood pressure 98/669/19/25 administered by Nurse #2 with blood pressure 103/689/22/25 administered by Nurse #2 with blood pressure 99/569/24/25 administered by Nurse #2 with blood pressure 89/649/26/25 administered by Nurse #2 with blood pressure 106/789/29/25 administered by Nurse #2 with blood pressure 110/53 Review of the Medication Administration Record (MAR) dated October 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 10/01/25 administered by Nurse #2 with blood pressure 89/5610/03/25 administered by Nurse #2 with blood pressure 89/6110/06/25 administered by Nurse #2 with blood pressure 96/6410/08/25 administered by Nurse #2 with blood pressure 98/6110/15/25 administered by Nurse #2 with blood pressure 105/6410/17/25 administered by Nurse #2 with blood pressure 110/5310/20/25 administered by Nurse #2 with blood pressure 108/8010/22/25 administered by Nurse #2 with blood pressure 91/7110/29/25 administered by Nurse #2 with blood pressure 104/6810/31/25 administered by Nurse #2 with blood pressure 93/64 Review of the Medication Administration Record (MAR) dated November 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 11/03/25 administered by Nurse #2 with blood pressure 98/5811/05/25 administered by Nurse #2 with blood pressure 97/6911/07/25 administered by Nurse #2 with blood pressure 103/6011/12/25 administered by Nurse #2 with blood pressure 99/6111/14/25 administered by Nurse #2 with blood pressure 97/6211/17/25 administered by Nurse #2 with blood pressure 102/7211/19/25 administered by Nurse #2 with blood pressure 100/6111/21/25 administered by Nurse #2 with blood pressure 97/6011/24/25 administered by Nurse #2 with blood pressure 101/6311/26/25 administered by Nurse #2 with blood pressure 100/5811/28/25 administered by Nurse #2 with blood pressure 103/60 Review of the Medication Administration Record (MAR) dated December 2025 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 12/01/25 administered by Nurse #2 with blood pressure 99/6312/03/25 administered by Nurse #2 with blood pressure 102/7012/05/25 administered by Nurse #2 with (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood pressure 106/6912/08/25 administered by Nurse #2 with blood pressure 99/6512/10/25 administered by Nurse #2 with blood pressure 95/6812/12/25 administered by Nurse #2 with blood pressure 95/6212/15/25 administered by Nurse #2 with blood pressure 105/6912/17/25 administered by Nurse #2 with blood pressure 97/6212/19/25 administered by Nurse #2 with blood pressure 96/6512/22/25 administered by Nurse #2 with blood pressure 108/6112/24/25 administered by Nurse #2 with blood pressure 95/5612/26/25 administered by Nurse #2 with blood pressure 108/6212/29/25 administered by Nurse #2 with blood pressure 105/68 Review of the Medication Administration Record (MAR) dated January 2026 for Resident #12 revealed Metolazone 5 milligram tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 1/02/26 administered by Nurse #2 with blood pressure 98/641/07/26 administered by Nurse #2 with blood pressure 107/611/09/26 administered by Nurse #2 with blood pressure 94/631/14/26 administered by Nurse #2 with blood pressure 101/621/16/26 administered by Nurse #2 with blood pressure 102/611/19/26 administered by Nurse #2 with blood pressure 102/571/21/26 administered by Nurse #2 with blood pressure 99/681/26/26 administered by Nurse #2 with blood pressure 105/601/30/26 administered by Nurse #2 with blood pressure 109/55 Review of the Medication Administration Record (MAR) dated February 2026 for Resident #12 revealed Metolazone 5 milligram (mg) tablets were initialed as administered on the following dates with systolic blood pressure readings less than 110 or diastolic blood pressure less than 60: 2/02/26 administered by Nurse #2 with blood pressure 93/582/04/26 administered by Nurse #2 with blood pressure 102/582/06/26 administered by Nurse #2 with blood pressure 102/632/09/26 administered by Nurse #2 with blood pressure 103/592/11/26 administered by Nurse #2 with blood pressure 107/67 Review of Resident #12's progress notes from 9/10/25 through 2/11/26 revealed no documentation indicating Resident #12 had a change in her condition. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #12 was cognitively intact. She required staff assistance with activities of daily living and received diuretic medications. During an interview on 2/11/26 at 1:15 PM Nurse #2 stated she did administer Metolazone to Resident #12 on the above dates. She stated she was a new nurse and thought the order to hold the medication was if both the systolic and the diastolic blood pressure was less than 110/60. Nurse #2 stated she misunderstood the parameters that were ordered and the Metolazone was given in error. Nurse #2 stated she was consistently assigned to provide care to Resident #12. Nurse #2 stated Resident #12 was alert and oriented to person, and place, and was out of bed and in her wheelchair this morning and has had no change in her condition. An observation and interview conducted on 2/11/26 at 1:30 PM revealed Resident #12 was in her room sitting in her wheelchair. She was in no distress. Resident #12 voiced no concerns with her care. During an interview on 2/11/26 at 1:39 PM the Nurse Practitioner stated Resident #12 was prescribed Metolazone due to increased edema and was also on another diuretic medication each day. The Nurse Practitioner stated that Resident #12 had heart failure and her blood pressure did run low which was why the parameters were in place for the diuretics. She stated the order was to hold the Metolazone if either the systolic was less than 110 or if the diastolic was less than 60. The Nurse Practitioner stated she was not aware that Resident #12 had received Metolazone outside of the parameters. The Nurse Practitioner indicated she recently evaluated Resident #12 and although Resident #12 had received the Metolazone when it should have been held she has had no change in her condition. She stated the hold parameters were put in place for a reason and the nurse should have followed the parameters and held the dose when Resident #12's blood pressure was outside of the parameters. During a phone interview on 2/13/26 at 9:00 AM the Consultant Pharmacist stated she completed monthly medication reviews for the facility. The Consultant Pharmacist stated that taking Metolazone when it was not indicated could (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cause hypotension and contribute to an increased risk of falls. During an interview on 2/13/26 at 2:40 PM the Director of Nursing (DON) stated she was not aware that Metolazone continued to be administered to Resident #12 outside of the parameters. The DON stated Resident #12 has had no falls and no change in her condition. The DON stated further education would be provided to all nursing staff regarding medication administration including following blood pressure parameters.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review, and staff interviews, the facility failed to discard expired medications and record an opened date on ophthalmic drops that had shortened expiration dates on 2 of 6 medication carts that were reviewed for medication storage (200 hall medication cart #1 and medication cart #2). Findings included. a.) An observation of the 200-hall medication cart #1 on 2/10/26 at 2:50 PM along with Nurse #1 revealed the following medications: One bottle of Latanoprost .005% ophthalmic drops that was opened with no opened date labeled on the bottle. Review of the manufacturer's guidelines for Latanoprost ophthalmic solution instructed that once a bottle was opened for use, it may be stored at room temperature for 6 weeks then discarded. One bottle of Rocklatan ophthalmic drops that was opened with no opened date labeled on the bottle. Review of the manufacturer's guidelines for Rocklatan ophthalmic solution (a combination of two medications) instructed that once a bottle was opened for use, it may be stored at room temperature for 6 weeks then discarded. b.) An observation of the 200-hall medication cart #2 on 2/10/26 at 3:00 PM along with Nurse #1 revealed the following medications: Pyridium (phenazopyridine) 95 milligram tablets, a urinary analgesic, with an expiration date of March 2025. One bottle of Dorzolamide 2% ophthalmic drops with an expiration date of 11/30/25. During an interview on 2/10/26 at 2:05 PM Nurse #1 stated she was the assigned nurse today for medication cart #1 and medication cart #2. Nurse #1 stated all nurses were responsible for checking the medication carts for expired medications and recording opened dates on the eye drops. Nurse #1 indicated she had not administered any of the expired medications today and she had not checked for expiration dates on either medication cart. Nurse #1 further stated she did not open the eye drops on medication cart #1 and the eye drops should have been dated when opened. During an interview on 2/13/26 at 2:34 PM the Director of Nursing (DON) stated the assigned nurse was responsible for checking medication carts for expired medications and to ensure all medications with shortened expiration dates were labeled with an opened date. The DON stated the expired medications should have been discarded and the eye drops should have been labeled with opened dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345315	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Lumberton	1170 Linkhaw Road Lumberton, NC 28358

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the facility assessment identified and addressed the care required for the population of residents with a port-a-cath (a small implanted device placed under the skin in the chest to provide easy, long-term access to a vein for chemotherapy, medication, intravenous (IV) fluids, or blood sampling), and to address the staff training necessary to competently provide port-a-cath care for residents for 1 of 1 resident (Resident #1).Findings included:Review of the facility assessment revealed the assessment was last updated on 9/8/2025. The document indicated the facility had completed education, training and competencies with staff specific to resident care needs; however, the document lacked training and competency to care for residents who required a port-a-cath.Resident #1 was admitted to the facility on [DATE]. Review of the electronic medical record (EMR) revealed Resident #1's port-a-cath was placed 12/18/2024 during a hospitalization for pneumonia.An interview with the Director of Nursing (DON) was completed on 2/13/2026 at 11:04 AM. The DON confirmed that the nursing staff had not received training and competencies regarding the care of a port-a-cath. An interview with the Administrator was conducted on 2/13/2026 at 9:40 AM. The Administrator confirmed the facility had one resident with a port-a-cath. The Administrator also stated he was not aware the nursing staff had not received education and had competencies checked regarding providing care for residents with a port-a-cath. He indicated that he was responsible for updating the facility assessment with input from the DON and other administrative staff. The Administrator confirmed he had just updated the facility assessment 1/1/2026 to reflect the change in therapy providers. The Administrator indicated he knew that all of the care needs regarding residents should be reflected in the facility assessment.