STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Citizens Home	2275 Ruin Creek Road Henderson, NC 27537

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to keep food service equipment free of debris and corrosion by failing to clean 2 of 3 HVAC (heating and air conditioning system) filters observed. This practice had the potential to affect food served to the residents who resided in the facility.The findings included:During the tour of the kitchen with the Certified Food Manager on 3/10/26 at 11:56 AM the kitchen preparation table was observed. Two feet above the food preparation table where wrapped silverware was stacked ready for lunch service, 2 of the 3 HVAC vents were observed with dark debris on the metal vents. The air filter system was off at the time. A second observation on 03/11/2026 11:08 AM the kitchen filters were observed in the same condition with dark debris on the metal vents. The air filter system was on and blowing towards the tray line, 6 feet away. The tray line was not in use at the time.In an interview on 3/11/26 at 11:10 AM the Certified Food Manger stated the HVAC filters were not on a kitchen cleaning schedule as Maintenance came in every 1-2 months to clean the vents. The CFM indicated she was not sure when the filters had last been cleaned.In an interview on 3/11/26 at 11:29 AM the Maintenance Director stated they recently switched company ownership, and the reminder to clean the kitchen vents, was no longer in his Tel's report (software program that tracks and assigns work orders). He indicated the filters looked original that had corrosion and was not sure when he last cleaned the kitchen vents. In an interview on 3/11/216 at 11:30 AM the Administrator stated they would get the HVAC filters replaced and cleaned on a regular basis.

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

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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 - Few	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, Director of Nursing, Nurse Practitioner, Pharmacy Technician, and Pharmacist, the facility failed to provide services to ensure the acquiring, dispensing, and administration of medications for 1 of 5 sampled residents whose medications were reviewed (Resident #59). The facility failed to have an anticonvulsant, antipsychotic, and a triple-therapy bronchodilator available for administration to Resident #59.The findings included:Resident #59 was admitted to the facility on [DATE] with diagnoses that included COPD, depression and bipolar disorder.a. Resident #59 had a physician order initiated on 2/5/26 for Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 milligrams(mg) (an anticonvulsant medication sometimes used for mood stabilization)- Give 1000 mg by mouth at bedtime for bipolar disorder.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/6/25 at 8:34 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.b. Resident #59 had a physician order initiated on 2/5/26 for Olanzapine 2.5 mg tablet (an antipsychotic medication)- Give 2.5 mg by mouth at bedtime for bipolar disorder.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/6/25 at 8:35 PM and written by Nurse #1 revealed Olanzapine medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.A Medication Administration note dated 2/7/26 at 9:37 PM and written by Nurse #2 revealed Olanzapine medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Olanzapine medication was on order.c. Resident #59 had a physician order initiated on 2/5/26 for Trelegy Ellipta Inhalation Aerosol powder Breath Activated 200-62.5-25 milligrams per actuation (mg/act) Fluticasone Umeclidinium-Vilanterol- One puff -inhale orally one time a day for Chronic Obstructive Pulmonary Disease (COPD).Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.Review of a Medication Administration note dated 2/6/26 at 1:29 PM and written by Nurse #1 revealed Trelegy Ellipta medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.A Medication Administration note dated 2/7/26 at 3:06 PM and written by Nurse #2 revealed Trelegy Ellipta was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.A health status note dated 2/8/26 at 6:19 PM and written by Nurse #1 revealed the on-call provider was notified that the facility was still awaiting delivery of Resident #58's medication from pharmacy. Nurse #1 documented staff to continue to monitor.A Medication Administration note dated 2/8/26 at 9:45 PM and written by Nurse #1 revealed Trelegy Ellipta medication was on order.Documentation on the February Medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/9/26 by Nurse #3, with a chart code that referenced the progress notes.Review of the electronic medical record revealed no documentation of a medication administration note written by Nurse #3 on 2/9/26.Nurse #1 was interviewed on 3/10/26 at 2:29 PM. Nurse #1 stated that when a resident was newly admitted to the facility it could take a little while for the residents to receive their medications from the pharmacy. Nurse #1 stated she did not check the pyxis (an automated, secure, and centralized system used in healthcare to manage the storage, dispensing, and tracking of medications) on 2/6/25 to see if medications were available for Resident #59. Nurse #1 stated that when medications were not available the provider was notified and a follow-up phone call was placed to the pharmacy. Nurse #1 stated she placed a call to the on-call provider on 2/8/26 to notify the provider that the facility was still awaiting delivery of Resident #59's medications. Nurse #1 stated in some cases the nurse has reached out to the resident representative to see if the resident had a supply of the medication at home. Nurse #1 denied reaching out to Resident #59's family. Nurse #2 was interviewed on 3/10/26 at 4:26 PM. Nurse #2 stated when Resident #59 was admitted he did not get all his medications delivered from the pharmacy. Nurse #2 stated Resident #59's medications were ordered from the pharmacy when he was admitted by the administrative nurses. Nurse #2 stated the administrative nurses were responsible for entering the physician orders and verifying the orders with the discharge summary and ordering medications from the pharmacy. Nurse #2 stated when medications were not received from the pharmacy the nurse followed up with pharmacy about medication status. Nurse #2 further stated the provider was notified that Resident #59 did not have his Trelegy inhaler on 2/7/26 for further orders and the pharmacy was notified. Nurse #2 stated she was instructed to monitor resident. Nurse #3 who administered Resident #59's medication on 2/9/26 did not respond to a request for interview. An interview was conducted with the Pharmacist Services Technician on 3/10/26 at 2:12 PM. The technician verified that Resident #59's Trelegy Ellipta, Depakote and Olanzapine medication orders were received from the facility on 2/9/26 and the medications were delivered the evening of 2/9/26.An interview was conducted with the Director of Nursing on 3/11/26 at 2:23 PM. The DON stated the previous process was for the physician order to be entered into the electronic medical record and the information was transmitted to the pharmacy electronically. The DON stated the facility had just switched over to a new pharmacy on 2/1/26. The DON stated the facility was not aware that Resident #59's medication orders had not been transmitted electronically to the pharmacy on 2/5/26. The DON stated she was notified by Nurse #3 on 2/9/26 that Resident #59 did not have his Trelegy inhaler. The DON stated once she became aware of the issue on 2/9/26 she faxed the physician orders for Trelegy, Olanzapine and Divalproex Sodium for Resident #59 to the pharmacy. The DON stated she could not recall any education from the pharmacy during the transition training about the transmittal process for orders changing. The DON stated that when a resident missed a medication the nurse was supposed to follow up with the pharmacy and the provider. The DON further stated the nurses had access to the medication pyxis which housed emergency medications and frequently used medications. The DON stated the facility had not been faxing orders to the pharmacy prior to 2/1/26. An interview was conducted with the Pharmacist on 3/12/26 at 11:44 AM. The pharmacist revealed orders were received from the facility for Resident #59 via fax on 2/9/26. The Pharmacist verified orders for Depakote 125mg, Olanzapine 2.5 mg and Trelegy Ellipta were received and the medications were delivered to the facility on the second pharmacy delivery at 7:00 PM on 2/9/26. The Pharmacist revealed the facility had received education from the pharmacy staff on the new pharmacy process prior to the system change on 2/1/26. The Pharmacist stated changes to the process for submitting physician orders which included physician orders that were to be faxed to the pharmacy were included in the in-service education. She further stated that pharmacy staff were at the facility before the pharmacy switch over and during the transition. During an interview with the Administrator on 3/12/26 at 11:32 AM, she stated the facility changed to a new pharmacy on 2/1/26. The Administrator stated that the staff was trying to get acclimated with the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new pharmacy. The Administrator stated she was made aware that there was an issue with the integration of the new system. The Administrator stated the facility had no knowledge that there was an issue with the transmission of medication orders until the issue with Resident #59's medications was brought to the nursing staff's attention. The Administrator stated the nursing staff was under the impression that the orders would be transmitted electronically just like the previous system. The Administrator stated when the DON followed up on 2/9/26 with the pharmacy, it was discovered there was an interface problem with the current system communicating to the new pharmacy.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Nurse Practitioner, Pharmacist, Assistant Director of Nursing, and Director of Nursing, the facility failed to prevent a significant medication error for 1 of 5 residents whose medications were reviewed (Resident #59). The facility failed to administer prescribed antipsychotic medication, anticonvulsant medication and triple therapy bronchodilator to Resident #59. The findings included:Resident #59 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), depression and bipolar disorder. a. Resident #59 had a physician order initiated on 2/5/26 for Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 milligrams(mg) (an anticonvulsant medication sometimes used for mood stabilization) Give 1000 mg by mouth at bedtime for bipolar disorder.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/6/25 at 8:34 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.b. Resident #59 had a physician order initiated on 2/5/26 for Olanzapine 2.5 mg tablet (an antipsychotic medication) Give 2.5 mg by mouth at bedtime for bipolar disorder.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/6/25 at 8:35 PM and written by Nurse #1 revealed Olanzapine medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.A Medication Administration note dated 2/7/26 at 9:37 PM and written by Nurse #2 revealed Olanzapine medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Olanzapine medication was on order.c. Resident #59 had a physician order initiated on 2/5/26 for Trelegy Ellipta Inhalation Aerosol powder Breath Activated 200-62.5-25 milligrams per actuation (mg/act) Fluticasone Umeclidinium-Vilanterol. One puff -inhale orally one time a day for COPD.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.Review of a Medication Administration note dated 2/6/26 at 1:29 PM and written by Nurse #1 revealed Trelegy Ellipta medication was on order.A health status note dated 2/6/26 and written by Nurse #1 revealed Resident #59 was on oxygen at 2 liters per minute via nasal cannula. Resident #59's respirations were even and unlabored.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.A Medication Administration note dated 2/7/26 at 3:06 PM and written by Nurse #2 revealed Trelegy Ellipta was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.A Medication Administration note dated 2/8/26 at 9:45 PM and written by Nurse #1 revealed Trelegy Ellipta medication was on order.Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/9/26 by Nurse #3, with a chart code that referenced the progress notes.Review of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the electronic medical record revealed no documentation of a medication administration note written by Nurse #3 on 2/9/26.During an interview on 3/10/26 at 2:29 PM, Nurse #1stated she had notified the on-call provider on 2/8/26 that the facility was still awaiting delivery of Resident #59's medication from pharmacy. Nurse #1 stated she was given the directive to continue to monitor Resident #59. Nurse #1 confirmed she did not administer Divalproex Sodium, Olanzapine and Trelegy to Resident #59 on 2/6/26 and 2/8/26 because they were not available/on order.During an interview on 3/10/26 at 4:26 PM, Nurse #2 stated Resident #59's medications had not arrived on 2/7/26 and she notified the pharmacy on 2/7/26 when Resident #59's medication had not arrived. Nurse #2 confirmed she did not administer Trelegy and Olanzapine to Resident #59 on 2/7/26 because it was on order. Nurse #3 did not respond to a request for interview.An interview was conducted with Resident #59 on 3/10/26 at 10:12 AM. Resident #59 stated he did not have his inhaler and a couple of other medications when he first got to the facility in February. Resident #59 stated the facility did get all his medications, but it took a few days. Resident #59 denied having any adverse effects from not receiving medications.Documentation in the Nurse Practitioner Progress Note dated 2/9/26 at 8:00 AM revealed Resident #59 was seen for a follow up visit for missing medication. The progress note indicated Resident #59 was admitted on Friday and his medications were not delivered until Saturday night. The note indicated Resident #59 had missed doses of Trelegy, Valproic Acid and Olanzapine. Resident #59 was described as calm and cooperative with care. There were no behaviors reported. Resident #59 had oxygen in place and exhibited no shortness of breath. The plan was to monitor Resident #59 for adverse reactions. An interview was conducted with the Nurse Practitioner on 3/12/26 at 12:10 PM. The Nurse Practitioner explained that interruption of Depakote and Olanzapine could cause mood instability and increased behaviors. She further stated that the omission of Trelegy could cause increased breathing issues. The NP stated Resident #59's medication should have been administered as ordered.A health status note dated 2/9/26 at 8:33 AM and written by the Director of Nursing (DON) revealed the on-call provider was made aware that Resident #59 had missed medications. The provider instructed to monitor Resident #59. The note further revealed the DON contacted the pharmacy to find out about Resident #59's missing medications. The note indicated a medication profile had to be created for Resident #59 and the missing medications would be sent out with the next pharmacy delivery.An interview was conducted with the Director of Nursing on 3/11/26 at 2:23 PM. The DON stated that Resident #59 was expected to receive medications as prescribed. The DON stated the medication orders were entered into the system on 2/5/26 and she thought the pharmacy had received the orders electronically on 2/5/26 when they were entered. The DON reported that when the facility became aware that the orders did not transmit electronically to the pharmacy, Resident #59's orders were faxed over to the pharmacy on 2/9/26. An interview was conducted with the Pharmacist on 3/12/26 at 11:44 AM. The Pharmacist stated that orders were to be faxed to the pharmacy so that a resident profile could be created. The Pharmacist stated delivery of the medications would prevent residents from missing any doses at the scheduled administration times. The Pharmacist confirmed Resident #59's medication orders were faxed to the pharmacy on 2/9/26 and the facility received the medications the night of 2/9/26. During an interview on 3/12/26 at 11:32 AM, the Administrator stated the facility should have made sure that the resident received his medications on time as prescribed. The Administrator further stated communication with the pharmacy may have prevented the medication errors.