

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Kerr Lake Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1245 Park Avenue Henderson, NC 27536	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff and Pharmacist interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication (Oxycodone) for 1 of 4 residents reviewed for misappropriation of property (Resident #76). The findings included: Resident #76 was admitted to the facility on [DATE] with diagnoses including diabetes, chronic pain and osteoarthritis. Resident #76's physician's orders revealed an order dated 2/25/25 for Oxycodone 10 milligrams (mg) (two 5 mg tablets) by mouth every 4 hours as needed for moderate pain; take 15 mg (three 5 mg tablets) by mouth every 4 hours as needed for severe pain. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact. A Pharmacy Narcotic Delivery Slip dated 5/6/25 revealed 3 medication cards (blister packs) each containing 30 pills of Oxycodone 5 mg were delivered by the pharmacy and signed in as being received by Nurse #3 and Nurse 4. Resident #76 was discharged from the facility on 6/20/25. Attempts were made to contact Nurse #3 and Nurse #4 on 2/10/26 at 3:10 p.m., and on 2/11/26 at 7:20 a.m. Both nurses were unable to be reached. An initial report dated 5/12/25 completed by the Administrator for an allegation of drug diversion indicated one medication card of 30 Oxycodone for Resident #76 was missing. Resident #76 had additional medication cards of Oxycodone and had not missed any medication. An interview was completed on 2/11/26 at 8:26 a.m. with Medication Aide #1. Medication Aide #1 stated she worked on the dayshift on 5/11/25 and handed over the medication cart to Nurse #1 at the end of the shift. Medication Aide #1 stated that her and Nurse #1 counted the controlled medication cards for all residents on their hall (the hall Resident #76 resided on) and there were 27 cards counted during shift to shift change. Medication Aide #1 stated that she could not explain how the Oxycodone medication card for Resident #76 went missing. Medication Aide #1 stated that she regularly worked on the medication cart on hall 1 and had not noticed narcotic medications missing in the past. Medication Aide #1 stated that she was suspended pending the investigation into the missing medication. During an interview with Nurse #1 on 2/11/26 at 7:25 a.m. she stated when she completed her shift-to-shift narcotic medication count with Medication Aide #1 on 5/11/25 at 11:00 p.m. the narcotic medication count was correct, and the number of narcotic count sheets matched the total number of narcotic medication cards. Nurse #1 stated that during shift change on 5/12/26 at 7:00 a.m. she did a narcotic medication count with oncoming Nurse #2 when they noticed that one card of Oxycodone was missing. Nurse #1 stated that she was supposed to hand over 27 medication cards and records sheets but instead had 27 record sheets and 26 medication cards of controlled substance medications. Nurse #1 stated that she did not know how she ended up missing one card of Oxycodone for Resident #76. Nurse #1 stated that a mistake occurred and she was not sure how one card went missing. Nurse #1 stated that she informed the Unit Manager who counted the medications and found a total of 26 medication cards instead of 27. Nurse #1 revealed that she was suspended pending investigations. An interview with Nurse #2 on 2/11/26 at 8:04 a.m. revealed that during shift change on 5/12/25 at</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 345321	Facility ID: 345321 If continuation sheet Page 1 of 3

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7:00 a.m. she counted controlled medications with Nurse #1, and that they identified a missing medication card for Oxycodone. Nurse #2 stated that she informed the Unit Manager of the missing controlled medication for Resident #76. Nurse #2 stated that she had completed her shift-to-shift narcotic medication count with Nurse #1 many times in the past and it was the first time that medications cards were short. Nurse #2 revealed that she was suspended pending the investigation. An interview was completed on 2/11/26 at 8:16 a.m. with the Unit Manager. The Unit Manager stated that Nurse #2 reported to the missing Oxycodone card for Resident #76 on 5/12/25. The Unit Manager stated that she counted the medication in the cart and one card of Oxycodone was missing when comparing medication cards and the controlled substance count sheets. The Unit Manager revealed an investigation was initiated. The Unit Manager stated that a 100% audit was completed by her and the prior Director of Nursing (DON) of all medication carts and medication storage rooms, and the missing Oxycodone was unable to be located. The Unit Manager further stated that the investigation could not identify how the medication was lost. During an interview with the Social Work Director on 2/11/26 at 9:30 a.m. she revealed that she interviewed Resident #76 who disclosed to her that he got his medications for pain when he needed it. The Social Work Director stated that the missing medication did not have any effect on Resident #76. An attempt to contact the investigating officer on 2/11/26 was made, however it was unsuccessful. An interview with the Administrator on 2/11/26 at 11:12 a.m. revealed that on 5/12/25 she was notified by the Unit Manager and the prior DON that there was a discrepancy with the narcotic count during shift change in the 100 hall medication cart (the hall Resident #76 resided on). She revealed that one narcotic card for Resident #76's Oxycodone 5 mg tablets containing 30 pills was missing from the medication cart. The Administrator revealed that before suspension, Nurse #1, Nurse #2 and Medication Aide #1 completed a drug screen on 5/13/25 and the results were negative. The Administrator revealed they did not have camera surveillance in the facility and Nurse #1, Nurse #2, and Medication Aide #1 were suspended pending investigation. The Administrator further revealed that a report was made on 5/12/25 to the Division of Health Service Regulation, the police, Adult Protective services and Drug Enforcement Agency. The Administrator revealed that upon completion of the facility investigation, they were unable to determine how the narcotic medication card was lost. She revealed the facility contacted the pharmacy who replaced the medication at the cost of the facility to ensure there was no interruption to Resident #76's medications. A telephone interview was conducted on 2/12/26 at 2:36 p.m. with the facility's Pharmacist. The Pharmacist verified that there was no Oxycodone 5 mg for Resident #76 returned to the pharmacy on or around the month of May of 2025. Multiple attempts made to contact the prior DON were unsuccessful. The facility provided a corrective action plan that was not acceptable to the State Agency. The plan did not include a systemic approach to prevent future incidents of misappropriation of residents' property. Education was completed on processes that were already in place and the monitoring plan would identify misappropriation of property after it already occurred.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interviews, the facility failed to keep food service equipment clean, free of grease buildup, and/or dried spills by failing to clean the convection oven during two kitchen observations. This practice had the potential to affect food served to the residents who resided in the facility. The findings included: Review of the undated /blank Weekly Deep Cleaning Schedule, sixth line down, indicated/listed Convection Ovens were included to be cleaned. Review of the Dietary Sanitation Checklist dated 12/23/25 completed by the Dietitian documented the kitchen equipment had been cleaned. Review of the Dietary Sanitation Checklist dated 1/28/26 completed by the Dietitian showed no documentation the kitchen equipment had been cleaned. During a kitchen tour on 2/09/26 at 11:03 AM, the following observations were made with the Dietary Manager: The double stacked convection ovens had a large volume of grease buildup inside of the oven, inside the door and on the seals. The bottom shelf of the top convection oven was noted with charred food particles. A second observation of the convection ovens on 2/12/26 at 8:45 AM revealed the convections ovens were in the same condition. In an interview on 2/12/26 at 9:00 AM the Dietary Manager indicated they usually cleaned the convection ovens once a week, and it looked like they had not been cleaned in a while. She stated she would make a cleaning schedule and have staff clean the ovens that day. The Administrator was interviewed on 2/12/26 at 9:10 AM. She revealed she would make sure there was a cleaning schedule and she would now monitor the kitchen to ensure the convection ovens were clean.</p>		