STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	1306 South King Street Windsor, NC 27983

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and Nurse Practitioner (NP) interview, the facility failed to obtain consent and inform the resident's Responsible Party (RP) of the risks and benefits of psychotropic medications prior to initiation or the treatment alternatives available. The deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #54). Findings included: Resident #54 was admitted to the facility on [DATE] with diagnoses that included stroke and non-Alzheimer's dementia. Review of Resident #54's physician orders revealed:- Mirtazapine (antidepressant) 7.5 mg, 1 tablet to be given by mouth at bedtime for depression with a start date of 10/7/25. - Trazodone (antidepressant) oral tablet 100 milligram (mg), 1 tablet to be given by mouth in the afternoon for depression with a start date of 11/13/25. Resident #54's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was severely cognitively impaired, had no behaviors and received antidepressant medications. Resident #54's Medication Administration Record for January 2026 revealed the Mirtazapine and Trazodone were initialed by a nurse indicating they had been administered daily. Resident #54's medical record revealed no information indicating her RP was informed in advance of the risks and benefits of initiating treatment with Trazodone and Mirtazapine or the treatment alternatives available or that consent was obtained. Attempts to reach Resident #54's RP were unsuccessful. In an interview with the Assistant Director of Nursing (ADON) on 1/7/26 at 3:44 PM she stated she was unsure who was responsible for obtaining consent for the use of psychotropic medications. During an interview with the Director of Nursing (DON) on 1/7/26 at 3:53 PM she stated that she had been aware that some consents for psychotropic medications were not signed because the Social Worker (SW) had previously been responsible for obtaining the consents, but nursing had not always informed the SW when a new psychotropic medication was ordered. During an interview with the SW on 1/7/26 at 4:02 PM, she stated she had been responsible for obtaining consents for psychotropic medication until recently. The SW explained that nursing staff were expected to notify her whenever a new psychotropic medication order was issued; however, this did not always occur, resulting in some missed consents. In an interview with the Nurse Practitioner (NP) on 1/7/26 at 4:15 PM, she stated nursing staff were responsible for obtaining consent for the use of newly prescribed psychotropic medications. During an interview with the Administrator on 1/8/26 at 9:54 AM, she stated she had not been aware Resident #54 lacked a signed consent for the psychotropic medications Trazodone and Mirtazapine. She further stated that she had been aware consents should have been obtained prior to the implementation of the medications.

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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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews with residents and staff, the facility failed to ensure residents' right to receive mail delivered on Saturdays. This had the potential to affect 67 of 67 residents in the facility. The findings included: During a Resident Council meeting on 1/6/26 at 1:00 PM, members reported that mail was not delivered on Saturdays. Residents present included #71, #14, #19, #56, and #62. They stated that the Activities Director delivered mail Monday through Friday and only on Saturdays if she was in the facility. An interview was conducted on 1/6/26 at 1:16 PM with the Activities Director and she stated that on weekends, the manager on duty retrieved mail from the outdoor mailbox and placed it in the Business Office Manager's office. However, mail was not delivered to residents' rooms on Saturdays. The mail was given to her on Monday for delivery to residents. An interview was conducted with the Business Office Manager on 1/6/26 at 1:25 PM and she confirmed that weekend managers retrieved mail but did not distribute it because they were unsure which mail belonged to residents. She stated that managers gave the mail to her, and she passed it to the Activities Director on Mondays for delivery. An interview was conducted with the Administrator on 1/6/26 at 1:30 PM, she stated that her expectation was for staff to deliver mail Monday through Saturday, including Saturdays, by the manager on duty.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Medical Director, Nurse Practitioner (NP), staff and Responsible Party (RP) interviews, the facility failed to notify the physician/medical provider when an ordered medication was unavailable for administration (Resident #51) and failed to notify the resident's RP when a deep tissue pressure injury (DTI) developed on his right heel (Resident #78) for 2 of 3 residents reviewed for notification of changes (Resident #51 and Resident #78).Findings included: 1. Resident #51 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus type 2 (DM II). Resident #51's quarterly Minimum Data Set (MDS) assessment dated 9/25 25 revealed she was cognitively intact. A physician's order for Resident #51 with a start date of 10/22/25 and a discontinue date of 12/12/25 revealed Ozempic (semaglutide- medication for management of DM II and weight loss) (1 mg (milligram)/dose) subcutaneous (under the skin) solution pen injector 2 mg/1.5ml. Inject 1 mg subcutaneously one time a day every 7 days related to DM II. A pharmacy packing slip proof of delivery received via email communication with Pharmacist #1 on 1/6/26 at 10:09 AM revealed a confirmation signature on 10/22/25 at 12:34 AM by Nurse #10 that she received Ozempic 4mg/3ml for Resident #51 from the pharmacy. Resident #51's October 2025 Medication Administration Record (MAR) revealed documentation on 10/30/25 at 9:30 AM by Nurse #4 indicating she did not administer Resident #51's Ozempic per the physician's order. On 1/5/2026 at 4:27 PM in a telephone interview Nurse #4 stated she recalled caring for Resident #51 on 10/30/25 on the 7AM to 3PM shift. She reported when she went to administer Resident#51's Ozempic medication that morning, it had not been available. She indicated she had looked everywhere, including in the medication room. She stated there had been other days when Resident #51 was due to receive this medication, but it had not been available. She stated she had not notified anyone including Resident #51's medical provider that the medication had not been available. Nurse #4 reported she did not know why she had not done this. Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/20/25 at 9:30 AM by Nurse #3 indicating that she had not administered Resident #51's Ozempic per the physician's order. On 1/6/26 at 4:24 PM in a telephone interview Nurse #3 stated she recalled caring for Resident #51 on 11/20/25 on the 7AM to 3PM shift. She reported Resident #51's Ozempic medication had not been available for her to administer. She stated she had not notified a provider that Resident #51's Ozempic had not been available for administration on 11/20/25. She could not say why. Resident #51's November 2025 MAR further revealed documentation on 11/27/25 at 9:30 AM by Nurse #4 indicating that she had not administered Resident #51's Ozempic per the physician's order. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51's December 2025 MAR revealed documentation on 12/4/25 at 9:30 AM by Nurse #9 indicating that she had not administered Resident #51's Ozempic per the physician's order. Attempts at telephone interview with Nurse #9 were not successful. On 1/6/26 at 8:20 AM an interview with the Assistant Director of Nursing (ADON) indicated she was familiar with Resident #51. She stated she recalled an issue where nurses including Nurse #4 had been documenting that Resident #51's Ozempic medication had not been available but had not notified a provider. The ADON reported Nurse #4, and the other nurses had not followed the proper protocol when the medication had not been available to administer to Resident #51, which would have been to immediately notify a medical provider to see if any alternate medications or other orders were required. On 1/7/26 at 12:31 PM an interview with the NP indicated a medical provider should have been made aware immediately when Resident #51's Ozempic was not available. On 1/6/26 at 10:45 AM in a telephone interview the facility's Medical Director stated there had been no harm to Resident #51 as a result of this incident because she had not experienced any blurred vision, recurrent urinary tract infections, or hospitalizations. The Medical Director reported he would have expected for a medical provider to be notified immediately when Resident #51's Ozempic medication was not available so alternate medication and monitoring orders could have been provided. He stated when the NP notified him of the issue, she assured him that Resident #51 was back on track. On 1/6/26 at 12:12 PM an interview with the Director of Nursing (DON) indicated her understanding of the situation was that nurses were documenting Resident #51's Ozempic medication was not available but had not notified a medical provider of this. She indicated if the medication was unavailable for administration a provider should be notified immediately for alternative medications or further interventions. On 1/8/26 at 8:38 AM an interview with the Administrator indicated nurses should have notified a provider immediately when Resident #51's Ozempic was not available. 2. Resident #78 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 was severely cognitively impaired and had one unhealed pressure ulcer. Resident #78's wound progress note dated 5/22/25 indicated that care had been reestablished at that time due to the development of a new DTI on the resident's right heel, measuring 3.5 cm (centimeters) x 3.5 cm x 0 centimeters cm. The plan included applying skin prep (creates a protective film on intact skin) to the heel once daily and offloading pressure. It was also documented that the plan had been discussed with both the staff and the resident. The progress note was signed by the Wound Care Nurse Practitioner. Resident #78's medical record did not reveal documentation indicating the previous wound care nurse contacted Resident #78's RP. Attempts to reach the Wound Care Nurse Practitioner for interview were unsuccessful. Attempts to interview the previous Wound Care Nurse about whether Resident #76's RP was notified of (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the new DTI on his right heel were unsuccessful. Resident #78's physician orders indicated the following: On 5/23/25, Nurse #1 entered an order to apply skin prep to the right heel daily and as needed for a DTI, and to offload pressure. On 6/2/25, an additional order was entered by Nurse #1 for Prevalon boots (special boots designed to offload pressure from the feet) to be worn while the resident was in bed. Attempts to contact Nurse #1 for interview were unsuccessful. In a telephone interview with Resident #78's RP on 1/4/26 at 10:59 AM, she stated that no one had notified her that the resident had developed a DTI on his right heel. She added that she had not learned of the pressure wound until he had been transferred to the hospital in September 2025. An interview was conducted with the Assistant Director of Nursing (ADON) on 1/6/26 at 12:36 PM. She stated that she had worked as a staff nurse in May 2025 and explained that when a new skin issue was identified, the process was for the nurse to contact the physician or the on-call provider to obtain orders and to notify the resident or the responsible party (RP), if applicable. The ADON reviewed Resident #78's medical record and did not find documentation that his RP was notified of the DTI on his right heel. In an interview with the Director of Nursing (DON) on 1/7/26 she stated that after reviewing Resident #78's medical record, she noted there was no documentation indicating that his RP had been notified of the (DTI) to his right heel. In an interview with the interim Administrator on 1/8/25 at 10:50 AM, she stated she had been unaware that residents' RPs were not being informed of new skin concerns, such as DTIs. The Administrator added that RPs should be notified of new skin concerns after the physician was called and orders for treatment were obtained. She reported that the nurse should document the notification in the medical record.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of money from their personal funds' accounts for 3 of 4 residents reviewed for misappropriation of property (Residents #51, #8, and #37).The findings included:a. Resident #51 was admitted to the facility 4/13/23. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was cognitively intact. An interview with Resident #51 on 1/4/26 at 2:17 PM revealed she recalled that in November 2025 her personal funds of $50.00 were not available when requested. She added after asking several times for her funds she did eventually receive the funds on another day.b. Resident #8 was admitted to the facility on [DATE].The annual MDS assessment dated [DATE] revealed Resident #8 was cognitively intact.On 1/6/26 at 10:55 AM an interview was conducted with Resident #8. He stated the facility had a personal funds account for him and didn't recall a time when he did not receive his funds when requested.c. Resident #37 was admitted to the facility on [DATE].The annual MDS assessment dated [DATE] revealed Resident #37 was cognitively intact.An interview was conducted with Resident #37 on 1/5/26 at 11:30 AM. He stated he was told by the Business Office Manager the facility did not have the cash available to give him the $30.00 he requested from his personal funds on 11/4/25. He stated he had to wait until the 6th day of the month to receive his money. He indicated he received his funds after speaking with the previous Administrator as she gave him cash from her own funds. He did not recall the reason why his funds were not available upon request.An initial allegation report was submitted to the North Carolina Department of Health and Human Services Division of Health Service Regulation by the previous Administrator on 11/5/25 at 4:06 PM. The allegation of misappropriation of resident property was made on 11/4/25 when Residents #51, #8, and #37 alleged that they did not receive their personal funds when requested. The local law enforcement office was notified on 11/6/25 at 2:15 PM.The facility investigation report that was completed by the previous Administrator on 11/7/25 revealed on 11/4/25 residents had requested funds from their personal trust accounts from the previous Administrative Assistant. The previous Administrative Assistant had stated she placed the funds in envelopes with all 3 residents' names (Residents #51, #8, and #37) listed on the outside of the envelope. She then placed the envelopes inside her file cabinet and walked away. The file cabinet was left unattended and unlocked and when she returned the envelopes were empty. The previous Administrative Assistant was suspended and later that day on 11/4/25 her employment was terminated. A telephone interview on 1/6/26 at 2:30 PM with the previous Administrative Assistant revealed on 11/4/25 she had put the residents' personal funds in individual envelopes with cash in her desk and then went outside to supervise residents who were smoking. When she returned to her desk, the cash was gone. The previous Administrative Assistant did recall putting cash in labeled envelopes for Residents #51 ($50.00), #8 ($50.00), and #37 ($30.00).Attempts to interview the previous Administrator were unsuccessful.Attempts to interview the law enforcement officer that took the report on 11/4/25 regarding the misappropriation of resident funds was unsuccessful.An interview was held on 1/6/26 at 11:00 AM with the Business Office Manager. She stated that the previous Administrative Assistant told her on 11/4/25 she had placed Residents #51's, #8's, and #37's requested personal funds in separate envelopes labeled with their names in her desk drawer and then went outside, leaving the desk unattended and unlocked. The Business Office Manager stated she did not believe there was a system breakdown with the personal funds accounts that caused the funds unavailability but rather a bad employee. An interview was conducted on 1/6/26 at 11:20 AM with the Social Services Director. She stated that since the 11/4/25 incident of misappropriation of residents' personal funds, she had been tasked with (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dispersing personal funds to residents upon request. An interview with the Regional Business Office Manager was conducted on 1/6/26 at 2:00 PM. She stated in November 2025 she was in the facility when the allegation of misappropriation of residents' personal funds occurred. The Regional Business Office Manager reported she spoke with the previous Administrative Assistant on 11/4/25. She indicated when she asked the previous Administrative Assistant why the funds were not available upon the residents' request, the previous Administrative Assistant told her she had put the money in envelopes to be dispersed to residents, but when she returned to her desk, the envelopes were empty. The Regional Business Office Manager added that the facility requested funds from the corporate office and restored the resident accounts.An interview was conducted on 1/6/26 at 3:45 PM with the Administrator. She revealed she would expect the Business Office Manager or designee to administer and disperse residents' funds when requested. She added that the Administrative Assistant that was employed when the allegation of misappropriation of personal funds occurred on 11/4/25 was no longer employed by the facility. She went on to say the procedure for personal funds had been changed since this incident on 11/4/25 and stated the current Administrative Assistant was no longer involved in the personal funds' procedures for the residents.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medications for 1 of 5 residents reviewed for medication administration (Resident #51).Findings included:Resident #51 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus type 2. Resident #51's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD, the last day of the assessment period) of 9/25/25 revealed she received insulin injections on 7 of the last 7 days.A review of Resident #51's September 2025 Medication Administration Record (MAR) revealed documentation of liraglutide (a non-insulin injectable medication for diabetes mellitus type 2) subcutaneous solution pen injector 1.8 milligrams (mg) subcutaneously (under the skin) one time a day for diabetes mellitus type 2 was administered at 8:00 AM daily from 9/18/25 through 9/25/25.On 1/13/26 at 2:04 PM a telephone interview with MDS Nurse #1 indicated she coded the medication section of Resident #51's MDS assessment dated [DATE]. She reported she coded insulin injections for 7 of 7 days because Resident #51 received liraglutide injections daily during this period. MDS Nurse #1 stated she had a reference sheet she found that she went by when coding medications and liraglutide was listed under insulins.On 1/13/26 at 2:07 PM a telephone interview with the Director of Nursing indicated MDS Nurse #1 coded Resident #51 as receiving insulin on the MDS assessment dated [DATE] because she had received liraglutide injections for her diabetes. She reported MDS assessments should be coded to accurately reflect the medications residents received.On 1/13/26 at 2:09 PM a telephone interview with the Administrator indicated residents' MDS assessments should be coded accurately.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, staff, Medical Director and Nurse Practitioner (NP) interviews the facility failed to administer medication as ordered by the physician for 1 of 5 residents reviewed for medication administration (Resident #51).Findings included:Resident #51 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus type 2 (DM II). Resident #51's quarterly Minimum Data Set (MDS) assessment dated 9/25 25 revealed she was cognitively intact.A physician's order for Resident #51 with a start date of 10/22/25 and a discontinue date of 12/12/25 revealed Ozempic (semaglutide- medication for management of DM II and weight loss) (1 mg (milligram)/dose) subcutaneous (under the skin) solution pen injector 2 mg/1.5ml. Inject 1 mg subcutaneously one time a day every 7 days related to DM II.On 1/5/26 at 3:15 PM an interview with Resident #51 indicated she was originally supposed to receive her first dose of Ozempic on 10/23/25, but she didn't receive her first dose until December. She reported since this had been resolved, she had begun getting her injections weekly.A pharmacy packing slip proof of delivery received via email communication with Pharmacist #1 on 1/6/26 at 10:09 AM revealed a confirmation signature on 10/22/25 at 12:34 AM by Nurse #10 that she received Ozempic 4mg/3ml for Resident #51 from the pharmacy.On 1/6/26 at 2:21 PM in a telephone interview Nurse #10 stated she did not recall what happened on 10/22/25. She reported that if her signature appeared on the proof of delivery slip on 10/22/25, this would indicate she received the medication from the pharmacy. She stated she did not usually work with Resident #51, so she would have given the medication to the nurse assigned to Resident #51 at that time.On 1/6/26 at 3:26 PM an interview with the Assistant Director of Nursing (ADON) indicated she was assigned to care for Resident #51 on 10/22/25 when her Ozempic medication was delivered from the pharmacy. She reported she recalled receiving the medication from Nurse #10, and she placed the medication into the medication refrigerator because Resident #51 had not been due for a dose on her shift.Resident #51's October 2025 Medication Administration Record (MAR) revealed documentation on 10/23/25 at 9:30 AM by Nurse #7 indicating she administered Resident #51's Ozempic per the physician's order.On 1/6/26 at 9:46 in a telephone interview Nurse #7 stated she recalled being assigned to care for Resident #51 on 10/23/25 on the 7AM to 3PM shift. She reported her documentation on 10/23/25 at 9:30 AM indicating that she administered Resident #51's Ozempic was an error. She reported she recalled looking for the medication but not being able to find it. She stated she should have called the pharmacy that day to find out why the medication had not been available, but she had gotten distracted and had forgotten.Resident #51's October 2025 Medication Administration Record (MAR) further revealed documentation on 10/30/25 at 9:30 AM by Nurse #4 indicating she did not administer Resident #51's Ozempic per the physician's order and to see the progress note.There was no corresponding nursing progress note for 10/30/25 to indicate why the medication was not given.On 1/5/2026 at 4:27 PM in a telephone interview Nurse #4 stated she recalled caring for Resident #51 on 10/30/25 on the 7AM to 3PM shift. She reported when she went to administer Resident#51's Ozempic medication that morning, it had not been available. She indicated she had looked everywhere, including in the medication room. She stated there had been other days when Resident #51 was due to receive this medication, but it had not been available. She stated she called the pharmacy at one point and had been told that a 28-day supply of the medication had been sent to the facility on [DATE], and no more could be sent. She stated she had not notified anyone that the medication had not been available. Nurse #4 reported she did not know why she had not done this.Resident #51's November 2025 Medication Administration Record (MAR) revealed documentation on 11/6/25 at 9:30 AM by Nurse #8 indicating that she administered Resident #51's Ozempic per the physician's order.On 1/6/26 at 8:09 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM an interview with Nurse #8 indicated she really couldn't recall exactly what happened on 11/6/25. She reported her documentation of Resident #51's MAR on 11/6/25 indicated that she had administered Resident #51's Ozempic per the physician's order. She stated she did not recall where she had gotten Resident #51's Ozempic medication or what she did with the pen after administering it to Resident #51.Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/13/25 at 9:30 AM by Nurse #4 indicating that she had not administered Resident #51's Ozempic per the physician's order.A nursing progress note dated 11/13/25 at 2:40 PM written by Nurse #4 indicated she had spoken to the pharmacy regarding Resident #51's Ozempic medication not being available for administration. Resident #51 had last received a dose of the medication on 11/6/25. The pharmacy had advised that a 28-day dose of the medication had been sent on 10/22/25, and a new 28-day supply could not be sent until 11/17/25. Nurse #4 reported this to Resident #51.Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/20/25 at 9:30 AM by Nurse #3 indicating that she had not administered Resident #51's Ozempic per the physician's order and to see the progress note.There was no corresponding nursing progress note for 11/20/25 to indicate why the medication was not given.On 1/6/26 at 4:24 PM in a telephone interview Nurse #3 stated she recalled caring for Resident #51 on 11/20/25 on the 7AM to 3PM shift. She reported Resident #51's Ozempic medication had not been available for her to administer. She stated she recalled calling the pharmacy on 11/20/25, and being told the medication would be sent. Nurse #3 reported she didn't know what happened after this. Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/27/25 at 9:30 AM by Nurse #4 indicating that she had not administered Resident #51's Ozempic per the physician's order and to see the progress note.There was no corresponding nursing progress note for 11/27/25 to indicate why the medication was not given.Resident #51's December 2025 Medication Administration Record (MAR) further revealed documentation on 12/4/25 at 9:30 AM by Nurse #9 indicating that she had not administered Resident #51's Ozempic per the physician's order and to see the progress note.There was no corresponding nursing progress note for 12/4/25 to indicate why the medication was not given.Attempts at telephone interview with Nurse #9 were not successful.A nursing progress note dated 12/5/25 at 11:51 PM written by Nurse #4 revealed Resident #51 reported to her that she had not been receiving her Ozempic medication and would like for someone to tell her what the status was. Resident #51 was her own Responsible Party (RP). Nurse #4 would continue to monitor this.On 1/6/26 at 8:20 AM an interview with the ADON indicated she was familiar with Resident #51. She stated she recalled an issue where nurses including Nurse #4 had been documenting that Resident #51's Ozempic medication had not been available, but had not notified her, the Director of Nursing, or a provider. The ADON stated she had initially become aware of the issue when she saw it documented on the 24-hour Nursing Report sheet by Nurse #4. She stated she thought this had been sometime in November or December 2025. She indicated as soon as she became aware there was an issue, she checked all the medication carts, and the medication refrigerator and could not locate the medication. The ADON reported she had no idea what could have happened to the Ozempic that was delivered by the pharmacy for Resident #51 on 10/22/25. She stated she had immediately notified the Nurse Practitioner (NP) and called the pharmacy to see how they could get the medication. On 1/7/26 at 12:31 PM an interview with the NP indicated as soon as she was notified by the facility that Resident #51 had not received her Ozempic as ordered, she addressed the issue. On 1/6/26 at 9:18 AM in a telephone interview Pharmacist #1 stated the first 28-day supply of Ozempic was set to the facility on [DATE]. Pharmacist #1 went on to say the next fill for the medication would have been due on 11/13/25, but due to the high cost of the medication, a preauthorization for filling the medication (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	1306 South King Street Windsor, NC 27983

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been sent to the facility but had not been received back. He reported that due to the pharmacy not receiving this authorization back, there had been a delay in filling the Ozempic prescription for Resident #51, and the next supply had not been sent to the facility until 12/11/25.On 1/6/26 at 10:45 AM in a telephone interview the facility's Medical Director stated he had been made aware that Resident #51 had not been receiving her Ozempic as ordered by the Nurse Practitioner (NP). He stated there had been no harm to Resident #51 as a result of this incident because she had not experienced any blurred vision, recurrent urinary tract infections, or hospitalizations. On 1/6/26 at 12:12 PM an interview with the Director of Nursing (DON) indicated her understanding of the situation was that nurses were documenting Resident #51's Ozempic medication was not available but had not notified a provider of this. She reported it seemed some nurses had contacted the pharmacy, but they had not reported any issue with getting Resident #51's Ozempic to herself, or the ADON so the issue could be resolved. The DON stated if an ordered medication was not available, medication carts and all medication storage areas should be searched, the medication should be obtained from the back-up supply if available or the nurse should call the pharmacy for a refill and ask when it would arrive. She went on to say the nurse should also notify her or the nurse manager on call to let them know if there were issues. In a follow up interview on 1/8/26 at 8:06 AM the DON stated the preauthorization for filling Resident #51's Ozempic prescription would have been sent by the pharmacy to a facility fax machine. She reported she did not know what happened to this authorization form, as there was not a process in place regarding which fax machine they were set to, who retrieved them, or for getting them to her so she could follow-up.On 1/8/26 at 8:38 AM an interview with the Administrator indicated nurses should have communicated with the DON or ADON when Resident #51's Ozempic was not available. She indicated pharmacy communications and pre-authorizations should be followed up on. She stated as a result of the lack of communication, medication doses were missed, and it just became a cyclical issue.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, Pharmacist, Medical Director, Nurse Practitioner and Physician interviews, the facility failed to ensure the attending physician was informed of the pharmacy recommendation to clarify a physician's order for carvedilol (medication in the class of alpha and beta blockers used to treat conditions affecting the heart and blood vessels) for 1 of 5 residents reviewed for unnecessary medications (Resident #7).Findings included:Resident #7 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and heart failure.A Report of Consultation document from Resident #7's Cardiologist dated 12/5/25 included a handwritten portion completed and signed by Physician #2 which revealed Resident #7 had coronary and peripheral artery disease (narrowing or blockage of the arteries in the heart and legs, pelvic area or arms). The recommendation was to increase Resident #7's carvedilol to 37.5 mg twice daily and to check Resident #7's blood pressure with a goal of systolic (the hearts contraction phase measuring peak pressure in the arteries) blood pressure of 110 (mmHg-millimeters of mercury) to 130 (mmHg-millimeters of mercury). A printed portion of the document titled After Visit Summary Instructions revealed increase carvedilol to 3.125 milligrams twice daily. An additional printed portion titled Your Medication List revealed carvedilol 25 mg take 1.5 tablets (37.5 mg total) by mouth in the morning and 37.5 mg by mouth in the evening.A physician's order for Resident #7 with a start date of 12/5/25 entered by Nurse #12 revealed carvedilol 3.125 mg twice daily by mouth for hypertension.The pharmacist recommendation for Resident #7 dated 12/8/25 written by Pharmacist #2 revealed Physician #2 increased Resident #7's carvedilol on 12/5/25. Resident #7's carvedilol went from 25 mg twice daily to 3.125 mg daily on her Medication Administration Record (MAR). This was a big decrease in carvedilol. Clarify the carvedilol dose and order on her MAR. There was no indication this had been reviewed by a medical provider.On 1/7/26 at 11:35 AM a telephone interview with Pharmacist #2 indicated she completed Resident #7's initial medication regime review (MRR) on 12/8/25. She reported she noted the discrepancy between Resident #7's initial admission carvedilol dose of 25 mg twice daily, the recommendation by Physician #2 on 12/5/25 to increase Resident #7's carvedilol to 37.5 mg twice daily, and the facility's order for a significantly decreased dose of carvedilol 3.125 mg twice daily. Pharmacist #2 stated she had sent a recommendation to the DON to clarify this discrepancy by email on 12/8/25. On 1/7/25 at 12:54 PM an interview with the Director of Nursing (DON) indicated she would have received the Consultant Pharmacist's Progress Note admission MRR for 12/8/25 on 12/8/25 or a few days later in her email. She reported she did not check her email daily and had not been aware of the recommendation to clarify the physician's order for Resident #7's carvedilol until 1/7/26. She reported it would have been her responsibility to provide this clarification recommendation to the provider for review, but she had not gone through these reviews for December 2025 yet.On 1/7/26 at 12:31 PM an interview with the Nurse Practitioner (NP) indicated she did not receive any pharmacy recommendations from the facility. She reported these would be handy to have. The NP stated if she had been given Resident #7's pharmacy recommendation from 12/8/25, she would have addressed it.On 1/7/26 at 2:12 PM a telephone interview with the Medical Director indicated he received the pharmacy recommendations from facilities if they gave them to him. He reported he had not received the recommendation from 12/8/25 for Resident #7. He stated this should have been provided to him within a few days of the facility's receiving it so he could have addressed it. The Medical Director indicated it should not have taken a month.On 1/8/26 at 8:38 AM an interview with the Administrator indicated there should be a be an effective process in place for addressing pharmacy (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations.

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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 record review and staff, Pharmacist, Medical Director and Physician interviews, the facility failed to clarify and resolve a discrepancy with an order for carvedilol (medication in the class of alpha and beta blockers used to treat conditions affecting the heart and blood vessels) which resulted in a significant medication error for 1 of 5 residents reviewed for unnecessary medications (Resident #7).Findings included:Resident #7's hospital Discharge summary dated [DATE] revealed her discharge medications included carvedilol 25 milligrams (mg) by mouth twice daily.Resident #7 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and heart failure.A physician's order for Resident #7 with a start date of 12/3/25 revealed carvedilol 25 mg by mouth twice daily for essential hypertension.Resident #7's December 2025 Medication Administration Record (MAR) revealed documentation indicating carvedilol 25 mg was administered to Resident #7 twice daily from 12/3/25 through 12/4/25.A Report of Consultation document completed by Resident #7's Cardiologist dated 12/5/25 included a handwritten portion completed and signed by Physician #2 which revealed Resident #7 had coronary and peripheral artery disease (narrowing or blockage of the arteries in the heart and legs, pelvic area or arms). The recommendation was to increase Resident #7's carvedilol to 37.5 mg twice daily and to check Resident #7's blood pressure with a goal of systolic (the hearts contraction phase measuring peak pressure in the arteries) blood pressure of 110 (mmHg-millimeters of mercury) to 130 (mmHg-millimeters of mercury). A printed portion of the document titled After Visit Summary Instructions revealed increase carvedilol to 3.125 milligrams twice daily. An additional printed portion titled Your Medication List revealed carvedilol 25 mg take 1.5 tablets (37.5 mg total) by mouth in the morning and 37.5 mg by mouth in the evening.A physician's order for Resident #7 with a start date of 12/5/25 entered by Nurse #12 revealed carvedilol 3.125 mg twice daily by mouth for hypertension.On 1/7/26 at 10:10 AM in an interview Nurse #12 stated recalled being assigned to Resident #7 on 12/5/25 when Resident #7 returned from her appointment with her Cardiologist (heart specialist physician). She reported as the nurse assigned to Resident #7, it was her duty to review the consultation report documents that returned with Resident #7 and to enter any new orders. She stated she saw the handwritten portion completed by Physician #2, and noticed the discrepancy between what he hand wrote, what was printed in the instructions portion, and what was printed in the medication list portion. Nurse #12 reported it was her understanding she was supposed to use what was printed in the instructions portion to enter the medication order. She indicated she knew she should have called a provider to clarify the discrepancy before she entered the order. She stated she normally would have called Physician #2's office, but it had been late in the evening, and she had not.Resident #7's December 2025 MAR revealed documentation indicating carvedilol 3.125 mg was administered to her twice daily from 12/5/25 at 8:00 PM through 12/31/25 at 8:00 PM. Resident #7's January 2026 MAR revealed documentation indicating carvedilol 3.125 mg was administered to her twice daily from 1/1/26 at 8:00 AM through 1/7/2 at 8:00 AM.Resident #7's blood pressure readings from 12/3/25 through 12/31/25 revealed Resident #7's blood pressure was checked twice daily. Resident #7's systolic blood pressure (SBP is the top number in a blood pressure reading indicating the pressure in the arteries when the heart beats with normal adult SBP being less than 120) ranged from a low of 100 to a high of 180. Resident #7's diastolic blood pressure (DBP is the lower number in a blood pressure reading, measuring the pressure in your arteries when your heart rests between beats with normal adult DBP being between 60 and 80) ranged from a low of 48 to a high of 94.Resident #7's blood pressure reading from 1/1/26 through 1/7/26 revealed Resident #7's blood pressure was checked twice daily. Resident #7's SBP ranged from a low of 111 to a high of 172. Her (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DBP ranged from a low of 55 to a high of 87.On 1/7/26 at 10:25 AM a telephone interview with Physician #2 indicated he was Resident #7's Cardiologist. He stated he recommended an increase in the dose of Resident #7's carvedilol at her appointment on 12/5/25 because Resident #7's blood pressure had not been well controlled. Resident #7's twice daily documented blood pressure and pulse readings for December 2025 and January 2026 were reviewed with Physician #2 via telephone. Physician #2 stated that while these readings were not optimal, they weren't terrible either. He reported while he did not feel that receiving the lower dose of 3.125 mg of carvedilol twice daily since 12/5/25 had caused Resident #7 any harm, it was very important that she begin receiving the correct dose of 37.5 mg of carvedilol twice daily now.On 1/7/26 at 10:36 AM in a return telephone call Physician #2 stated he was now very concerned about Resident #7 going from 3.125 mg of carvedilol twice daily to 37.5 mg of carvedilol twice daily. He stated because she had been receiving the much lower dose for so long, there could be potentially adverse consequences to Resident #7 which included a sudden drop in heart rate and blood pressure. Physician #2 reported he would need to provide titration orders to the Director of Nursing (DON) for a gradual increase in Resident #7's carvedilol from 3.125 mg twice daily to the goal of 37.5 mg twice daily.On 1/7/26 at 10:40 AM an interview with the DON indicated Nurse #12 should have immediately clarified Resident #7's carvedilol order when she saw the discrepancy in the document. The DON stated Physician #2 had just given her verbal telephone orders for increasing Resident #7's carvedilol to 12.5 mg twice daily for one week, 25 mg twice daily for one week, then 37.5 mg twice daily continuously after that and for monitoring Resident #7's heart rate and blood pressure twice daily. She reported she would consider this a significant medication error.On 1/7/26 at 11:35 AM a telephone interview with Pharmacist #2 indicated she completed Resident #7's initial medication regime review on 12/8/25. She reported she noted the discrepancy between Resident #7's initial admission carvedilol dose of 25 mg twice daily, the recommendation by Physician #2 on 12/5/25 to increase Resident #7's carvedilol to 37.5 mg twice daily, and the facility's order for a significantly decreased dose of carvedilol 3.125 mg twice daily. Pharmacist #2 stated she had sent a recommendation to the DON to clarify this discrepancy on 12/8/25. She reported carvedilol was a medication that required gradual dose titration. She stated Resident #7 going from carvedilol 25 mg twice daily to 3.125 mg twice daily could have had significant adverse effects such as heart rate changes and increased blood pressure consequences.On 1/7/26 at 2:12 PM a telephone interview with the Medical Director indicated it was a problem that the Cardiology visit summary was not accurate. He stated he did not feel Resident #7 experienced any harm as a result of this problem. He reported although carvedilol was a medication that required gradual titration up or down as it could affect heart rate, he did not feel it had been clinically significant in Resident #7's case. The Medical Director stated someone from the facility should have picked up on the discrepancy and contacted a provider for clarification.On 1/8/26 at 8:38 AM an interview with the Administrator indicated there were providers on call for the facility at all times. She stated Nurse #12 should have immediately called a provider for clarification when she noted a discrepancy.

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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 and staff interviews, the facility failed to keep medications in a locked treatment cart for 1 of 2 treatment carts observed (Treatment Cart #1).Findings included:During observation on 1/5/26 at 8:32 AM Treatment Cart #1 was observed with the locking mechanism in the unlocked position on the 100-hall outside of a resident's room. The face of the cart was pointed at a resident's room and the resident's room door was open. The privacy curtain was pulled around the resident as well as the Wound Care Nurse. The transport driver was approximately 15 feet away from the unlocked treatment cart and there were no other individuals observed. The surveyor was able to step between the resident's doorway and the unlocked treatment cart without touching the treatment cart. The Wound Care Nurse was behind the privacy curtain and could not be seen by the surveyor. At 8:35 AM the Wound Care Nurse returned to the treatment cart from behind the privacy curtain. During an interview on 1/5/26 at 8:35 AM the Wound Care Nurse stated she was unable to visualize the unlocked treatment cart while in the resident's room and did not know the surveyor was standing there. Upon observing Treatment Cart #1 she stated it was unlocked and should be locked when unattended. The Wound Care Nurse confirmed the treatment cart was out of her sight while she was providing care. During observation on 1/5/26 at 8:36 AM the contents of Treatment Cart #1 were observed to include A&D ointment (a topical emollient that contains vitamin A and vitamin D to treat diaper rash, dry skin, and skin irritation), Manuka Honey (a gel treatment for wound care, offering antibacterial, anti-inflammatory, and healing properties), Chymosin topical (a skin barrier ointment that provides protection and relief from irritation, commonly used for diaper rash, minor cuts, and other skin conditions), Cadexomer Iodine Gel 10 grams/0.35 ounce (a sterile antimicrobial dressing formulation of Cadexomer Iodine), Diclofenac Gel diclofenac sodium topical gel 1% (a nonsteroidal anti-inflammatory drug (NSAID) that helps reduce inflammation and pain when applied to the skin), Triamcinolone cream 0.5% (a topical corticosteroid used to treat various inflammatory skin conditions such as eczema, psoriasis, dermatitis, and rashes), Collagenase Santyl ointment 250 units/gram (a sterile enzymatic debriding ointment used to help clean and remove dead tissue from wounds, such as ulcers and severe burns), triamcinolone acetonide cream 0.1% (a topical corticosteroid used to treat various inflammatory skin conditions such as eczema, dermatitis, psoriasis, and rashes. It works by reducing itching, redness, and swelling associated with these conditions), nystatin topical powder (an antifungal medication used to treat fungal or yeast infections of the skin, particularly those caused by the Candida species), and Dyna-hex 4 Chlorhexidine Gluconate 4% solution (a Chlorhexidine Gluconate 4% solution used as an antiseptic for skin disinfection and surgical scrubs). During an interview on 1/5/26 8:41 AM the Director of Nursing stated any time any treatment or medication cart was out of view of the nurse, it should be locked.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to have a complete and accurate Treatment Administration Record (TAR) and failed to have a complete and accurate Medication Administration Record (MAR) for 4 of 19 residents reviewed for medical record accuracy (Resident #76, Resident #36, Resident #54, and Resident #51).Findings included: 1. Resident #76 was admitted to the facility on [DATE]. Review of Resident #76's physician orders revealed on 8/26/25 the resident had an order entered for his surgical left foot incision to be cleansed with Dakin's (a dilute solution bleach solution used as an antiseptic for wounds), pat dry, collagen particles Dakin's moistened gauze and abdominal gauze roll every day and as needed for wound care. Please read over the highlighted and revise- does not make sense. Review of Resident #76's TAR for September 2025 revealed there was no documented wound care on 9/2/25, 9/8/25, 9/13/25, 9/15/25, and 9/17/25. Review of Resident #76's wound care notes from 8/27/25 through 9/18/25 revealed his wound was decreasing in size and the wound care physician documented the wound as improving. During a telephone interview on 1/6/25 at 8:20 AM the previous Wound Care Nurse who was responsible for wound care for Resident #76 on 9/2/25, 9/8/25, 9/15/25, and 9/17/25 stated she completed wound care on those days but did not document it. During an interview on 1/5/26 at 3:56 PM the Assistant Director of Nursing who was responsible for wound care for Resident #76 on 9/13/25 stated she was covering the medication aide on 9/13/25 and did complete the wound care according to orders. She stated until it was just brought to her attention, she thought she had documented her wound care on the TAR but must have forgotten to document it. During an interview on 1/6/26 at 9:13 AM the Director of Nursing stated if wound care was completed it should be documented on the TAR to ensure the accuracy of their medical records. During an interview on 1/6/26 at 9:20 AM the Administrator stated her expectation was when wound care was completed, the wound care would be documented on the TAR to ensure the accuracy of their medical records. 2. Resident #36 was admitted to the facility on [DATE]. Resident #36's physician orders dated 4/28/25 revealed: -For the left leg with lymphedema: staff cleaned the leg with soap and water, applied triamcinolone, then applied a special gauze with Calamine, followed by rolled gauze and an ace wrap from the base of the toes to one inch below the knee, two times a week on Mondays and Thursdays. -For the right leg with lymphedema: staff cleaned the leg with soap and water, applied triamcinolone, then applied special gauze with Calamine, followed by rolled gauze and an ace wrap from the base (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the toes to one inch below the knee, two times a week on Mondays and Thursdays. Review of the Treatment Administration Record (TAR) for August 2025 revealed Resident #36's treatments for the right and left leg were not marked completed as ordered on 8/21/25. Review of the TAR for September 2025 revealed Resident #36's treatments for the right and left leg were not marked completed as ordered on 9/8/25. During a telephone interview on 1/6/25 at 8:20 AM, Nurse #11 stated she completed the treatment orders for Resident #36 in August and September 2025 but forgot to mark them as complete on the TAR. She confirmed she was assigned to Resident #36 on the days in August and September that were not marked as complete. Nurse #11 further stated she always completed her treatments as assigned. Review of the TAR for November 2025 revealed Resident #36's treatments for the right and left leg were not marked completed as ordered on 11/24/25. During an interview on 1/6/25 at 9:10 AM, Nurse #8 stated she completed the treatments for Resident #36 on 11/24/25 but forgot to mark the task complete on the TAR. Review of the TAR for December 2025 revealed Resident #36's treatments for the right and left leg were not marked completed as ordered on 12/25/25. During an interview on 1/5/26 at 4:35 PM, the Assistant Director of Nursing (ADON) stated she was assigned to provide treatments for Resident #36 in 12/25/25. She added she provided the treatments but forgot to mark them as completed on the TAR. During an interview on 1/6/26 at 9:15 AM, the Director of Nursing (DON) stated staff should document treatments complete when they finish the task. An interview with the Administrator was conducted on 1/6/26 at 9:25 AM. She stated she would have expected the treatments to be documented as complete when the tasks were completed in real time. 3. Resident #54's physician orders revealed an order dated 8/13/25 for Lispro insulin 3 units to be administered subcutaneously 3 times a day with meals. Resident #54's Electronic Medication Administration Record (EMAR) for November 2025 revealed no nurse signature that indicated Lispro insulin 3 units was administered the following dates and times: - 11/20/25 at 8:30 AM, 12:00 PM, and 5:30 PM. - 11/21/25 at 8:30 AM - 11/29/25 at 5:30 PM In a telephone interview with Nurse #4 on 1/6/26 at 2:06 PM who was scheduled to work on 11/21/25 at 8:30 AM and 11/29/25 at 5:30 PM, she stated she did not recall those particular days, however, if she did not give insulin the EMAR should have been coded with a reason why. Nurse #4 added that she must have forgotten to sign the EMAR which left the boxes blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview with Nurse #5 on 1/7/26 at 12:45 PM, she stated that she had been responsible for Resident #54 on 11/20/25 during the 7:00 AM to 7:00 PM shift. She explained that if the EMAR lacked a signature or code, it was because she had forgotten to sign it. Nurse #5 added that she did not recall a time she was not able to give insulin to Resident #54. In the final interview with the DON on 1/8/26 at 10:00 AM, she stated that there was no reason for Nurse #4 and Nurse #5 to have forgotten to sign the EMAR for Resident #54's insulin, as the resident name would have shown up as red when a medication had not been signed off as given, and green once it had been administered. She further stated that the EMAR system was set up this way to help nurses know which medications had been signed for and which had not. In an interview with the Administrator on 1/8/26 at 10:08 AM, she stated she was unaware there were medications unsigned for in Resident #54's EMAR. She further stated the EMAR system was set up to help nurses remember to give and sign off medications by highlighting the resident name with red if not signed off and green when it was signed off. 4. Resident #51 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus type 2 (DM II). A physician's order for Resident #51 with a start date of 10/22/25 and a discontinue date of 12/12/25 revealed Ozempic (semaglutide- medication for management of DM II and weight loss) (1 mg (milligram)/dose) subcutaneous solution pen injector 2 mg/1.5ml. Inject 1 mg subcutaneously (under the skin) one time a day every 7 days related to DM II. Ozempic (1 mg/dose) subcutaneous solution pen injector 2 mg/1.5ml (semaglutide) Inject 1 mg subcutaneously one time a day every 7 days related to DM II. Resident #51's October 2025 Medication Administration Record (MAR) revealed documentation on 10/23/25 at 9:30 AM by Nurse #7 indicating she administered Resident #51's Ozempic per the physician's order. On 1/6/26 at 9:46 in a telephone interview Nurse #7 stated she recalled being assigned to care for Resident #51 on 10/23/25 on the 7AM to 3PM shift. She reported her documentation on 10/23/25 at 9:30 AM indicating that she administered Resident #51's Ozempic was an error. She reported she recalled looking for the medication but not being able to find it. On 1/6/26 at 12:12 PM an interview with the Director of Nursing (DON) indicated that Nurse #7 should not have documented on Resident #51's MAR on 10/23/25 that she administered Ozempic 1 mg subcutaneously to Resident #51 if she had not actually administered it. On 1/8/26 at 8:38 AM an interview with the Administrator indicated that Nurse #7 should not have documented on Resident #51's MAR on 10/23/25 that she administered Ozempic 1 mg subcutaneously to Resident #51 if she had not actually administered it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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: 1.) to follow their infection control practices and procedures for Contact Precautions when Nurse Aide (NA) #1 entered resident's room under contact precautions without wearing a gown or gloves to pick up a meal tray 2.) follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a chronic wound when NA #2 provided a bed bath without wearing a gown and when NA #2 left dirty linens on the floor of the resident's room instead of placing them in a bag and later picked them up and held them against her body. 3.) follow CDC guidance for testing residents exposed to covid 4.) to implement their infection control policies and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident receiving enteral feedings when Nurse #2 failed to don (to put on) personal protective equipment (PPE) to include a gown. The deficient practice was identified for 4 of 17 staff observed for infection control practices (NA #1, NA #2, Nurse #2, and the previous Assistant Director of Nursing). Findings included: 1. The policy regarding contact precautions, dated October 2018, stated staff and visitors were required to perform hand hygiene and don disposable gloves and a gown upon entering the residents' room and remove them before exiting the room, performing hand hygiene upon exit. Observation of Resident #54's room door on 1/4/26 at 12:41 PM revealed signage titled Contact Precautions. The signage instructed everyone to perform hand hygiene and don gloves and a gown before entering the room and discard the gown and gloves before exiting the room and to then perform hand hygiene. Further observation revealed Nurse Aide (NA) #1 entered Resident #54's room without performing hand hygiene or donning gloves or a gown, picking up the residents' meal tray, exiting the room and placing the tray on the meal tray cart without follow-up hand hygiene. During an interview with NA #1 on 1/4/26 at 12:43 PM, she stated she had received training on infection control and contact precautions when she returned to work in December 2025. NA #1 acknowledged she should have performed hand hygiene, donned a gown and gloves before entering Resident #54's room and performed hand hygiene when leaving the room. She explained that Resident #54 was not her assigned resident and she was in a hurry, so she didn't look for the sign. On 1/4/26 at 12:49 PM, the Director of Nursing (DON) stated she and the Assistant Director of Nursing (ADON) provided infection control training, including contact precautions, to all new hires. The DON confirmed NA #1 should have performed hand hygiene and donned a gown and gloves before entering Resident #54's room and performed hand hygiene after exiting the room. She indicated that these precautions were implemented for the protection of both the staff and other residents. During an interview with the Assistant Director of Nursing (ADON), who also served as the Infection Preventionist (IP), on 1/4/26 at 12:57 PM, she stated NA #1 should have performed hand hygiene and donned a gown and gloves before entering Resident #54's room and should have performed hand hygiene after exiting the room. The facility had implemented contact precautions for Resident #54 due to a communicable disease. Contact precautions protected both the resident from any disease-causing microorganisms the NA could have introduced into the room and protected the NA from carrying disease-causing microorganisms from the resident to other residents and staff in the facility. The ADON added that she reminded nursing staff about contact precautions at least weekly and there was no reason for them to be unaware, as signs posted on the door stated hand hygiene and a gown and gloves were required before entering the room and hand hygiene was required upon exit. She confirmed NA #1 had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received this training upon hire. In an interview with the Administrator on 1/4/26 at 2:54 PM, she stated that NA #1 should have noticed the contact precaution sign on Resident #54's door and followed the recommendations to perform hand hygiene and wear a gown and gloves before she entered the room and to perform hand hygiene upon exit. During an interview with the Nurse Practitioner on 1/6/26 at 2:55 PM, she stated that contact precautions were implemented for Resident #54 due to a diagnosis of a communicable disease. She added that contact precautions protected both the resident and staff from disease-causing microorganisms and prevented the spread of infections throughout the facility. 2. The policy regarding Enhanced Barrier Precautions (EBP) stated staff and visitors were required to perform hand hygiene and don a gown and gloves only for high-contact resident care with examples that included bathing/dressing and handling linens. Observation of Resident #24's door revealed signage for EBP on 1/5/26 at 10:21 AM. The signage indicated that staff providing high contact care to Resident #24 were required to wear gowns and gloves for high contact care such as bathing/dressing or changing linens. Further observation revealed a hanging organizer in Resident #24's room, to the left of the door, that contained Personal Protective Equipment (PPE) including gowns and gloves. After knocking on the door and receiving a reply, the door to Resident #24's room was opened and entered on 1/5/26 at 10:21 AM. NA #2 was observed in Resident #24's room wearing gloves and no gown and handling what appeared to be soiled linens. NA #2 dropped the linens onto a pile on the floor at the end of the resident's bed. When asked if she had been providing care, she stated she had just given the resident a bed bath. When asked if she had been wearing a gown, she questioned whether one was needed in that room as she did not think Resident #24 required EBP. When directed to the EBP sign on the door, she replied Oh, I didn't even notice because I was in a hurry and this resident always rushes me. I guess I should have been wearing a gown. While discussing the gown, NA #2 picked the pile of linen up off the floor, held it against her body, carried it across the room and dropped it on the floor next to the trash can by the door. NA #2 then took her personal fleece jacket off of a chair, while still wearing dirty gloves, and put her jacket on. When asked if the linens should be on the floor, she stated she just set them there for a minute while she put on her jacket. When asked if the soiled linen had been on the floor at the end of the bed, she stated Oh, yeah. NA #2 went on to say that soiled linens should not be on the floor and that she should have put them directly into a plastic bag when removed from the resident or bed. NA #2 indicated she had had training on EBP and handling soiled linen when she was hired about 5 months ago. During an interview with the Assistant Director of Nursing (ADON), who also served as the Infection Preventionist (IP), on 1/5/26 at 10:30 AM, she stated NA #2 should have been wearing a gown while providing a bed bath to Resident #24 and handling his soiled linens. The facility had implemented EBP for Resident #24 due to a chronic wound. EBP protected both the resident from any disease-causing microorganisms the NA could have introduced into the room and protected the NA from carrying disease-causing microorganisms from the resident to other residents and staff in the facility. The ADON added that she reminded nursing staff about wearing EBP at least weekly and there was no reason for them to be unaware, as signs posted on the door stated a gown and gloves were required during close contact care such as bed baths and handling dirty linens. She further stated that staff were not to place soiled linens anywhere except in a plastic bag immediately after removing them from the resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or the bed and confirmed NA #2 had received this training upon hire. During an interview with the Director of Nursing (DON) on 1/5/26 at 10:34 AM she stated that NA #2 received education on checking resident room doors for precaution signs and following the recommended guidelines, including the safe handling of soiled linen. NA #2 should have worn a gown and gloves while performing a bed bath and handling soiled linens, and the linens should have been placed directly into a plastic bag. These measures were intended to prevent disease-causing microorganisms from transferring between the NA and the resident spreading to other residents in the facility. In an interview with the Administrator on 1/5/26 at 10:50 AM, she stated that NA #2 should have noticed the EBP sign on Resident #24's door and followed the recommendations to wear a gown and gloves. She added that NA #2 should have placed soiled linens directly into a plastic bag rather than on the floor to prevent disease-causing microorganisms from spreading throughout the room and being tracked into the facility. During an interview with the Nurse Practitioner on 1/6/26 at 2:45 PM, she stated that EBP was implemented for Resident #24 due to a chronic wound. She added that EBP protected both the resident and staff from disease-causing microorganisms and prevented the spread of infections throughout the facility. 3. Review of the Centers for Disease Control and Prevention (CDC) recommendations titled Infection Control Guidance: SARS-CoV-2 dated 6/24/24 revealed the CDC recommended asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Review of the policy and procedure for the facility titled Guidance and Protocol-COVID-19 dated 5/16/23 revealed when a resident was exposed to COVID-19, test immediately but generally not earlier than 24 hours after the exposure. Resident #76 was admitted to the facility on [DATE]. Review of a grievance for Resident #76 dated 9/5/25 revealed the resident felt he should be tested for COVID since his roommate had tested positive on 9/2/25. He was tested on [DATE] as a response to the grievance and was negative. During an interview on 1/5/26 at 2:57 PM the Assistant Director of Nursing stated she was a floor nurse during Resident #76's stay in the facility. Resident #76's roommate tested positive for COVID on 9/2/25. She stated if a resident was exposed to COVID the resident should be tested no sooner than 24 hours after exposure but as soon as possible and she would have tested Resident #76 prior to 9/5/25. The Assistant Director of Nursing explained she was not over infection control at that time, it was the Previous Assistant Director of Nursing. She concluded Resident #76 should have been tested prior to 9/5/25 according to their policy which reflects the CDC guidance for nursing homes. During an interview on 1/6/26 at 11:57 AM the previous Assistant Director of Nursing stated she remembered Resident #76 and she was over infection control in September 2025 and she was new to infection control at that time. She stated the previous Administrator told her they do not test for COVID (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unless a resident was symptomatic. She stated she was surprised by this because the other places she had worked had tested the entire hall after a resident ended up being positive for COVID. She stated Resident #76 was eventually tested but could not remember the specific details around why he was tested. During an interview on 1/6/26 at 1:51 PM the Director of Nursing stated she was not working for the facility at the time of this occurrence. Upon reviewing the timing of Resident #76's testing, and the fact that he had to complete a grievance to get tested after his initial exposure to COVID on 9/2/25, the Director of Nursing stated the previous infection preventionist did not follow their COVID testing policy which reflected the CDC guidance for nursing home testing. She concluded she would expect COVID testing to be completed according to their policy and CDC guidance. 4. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions and last revised in October 2018 read in part; Enhanced Barrier Precautions (EBP), appropriate notification is placed above the residents bed so personnel and visitors are aware of the need for enhanced barrier precautions, the signage informs the staff of instructions for personal protective equipment (PPE) use while providing high contact care. The policy also stated in part, EBP requires the use of gown and gloves for high contact resident care activities in the resident room such as feeding tube. On 1/7/26 at 12:20 PM during an observation of enteral nutrition (delivers liquid nutrients and fluids directly into the gastrointestinal (GI) tract via a tube bypassing the mouth and throat) Nurse #2 entered Resident #8's room which had an EBP sign posted on the exterior of the door, to administer nutrition via gastrostomy tube (a hollow tube inserted directly through the skin of the abdomen into the stomach to deliver nutrition, hydration and medication). Nurse #2 performed hand hygiene prior to entering the room and donned (put on) a clean pair of gloves but did not don a gown. Nurse #2 administered nutrition using a feeding syringe (a large 2-part syringe used to administer nutrition) through a gastrostomy tube. An interview was conducted with Nurse #2 on 1/7/26 at 12:30 PM. She stated she forgot to don a gown during the enteral feeding activity, she went on to say she should have worn a gown. An interview with the Director of Nursing (DON) was conducted on 1/7/26 at 12:45 PM. She stated Nurse #2 should have worn a gown while providing enteral nutrition when an EBP sign was posted. An interview with the Administrator was held on 1/7/26 at 12:55 PM. She stated she expected Nurse #2 to wear a gown while providing enteral nutrition to a resident in a room where there was an EBP sign posted.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a consent was documented prior to administering the Influenza vaccination for 1 of 5 residents reviewed for vaccination status (Resident #80).Findings included:Resident #80 was admitted to the facility on [DATE].Review of Resident #80's Medication Administration Record for September 2025 revealed she received the Influenza vaccine on 9/22/25.Review of Resident #80's only immunization consent form in her medical record dated 11/20/25 revealed Resident #80 left the Influenza vaccination selection blank and did not sign consent for the Influenza vaccine. During an interview on 1/8/26 at 10:18 AM the Director of Nursing stated there was no consent on file for Resident #80 regarding the flu vaccination for 9/22/25. She further stated consents should always be acquired prior to administration of a vaccine and maintained in the resident's medical record.