STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland Terrace	2300 Aberdeen Boulevard Gastonia, NC 28054

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 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 reviews, Responsible Party (RP) interview, and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of Hospice Care for 1 of 7 residents reviewed for MDS accuracy (Resident #56). The findings included:Resident #56 was admitted to the facility on [DATE] with diagnoses which included chronic ischemic heart disease and chronic obstructive pulmonary disease (COPD). Review of Resident #56's electronic medical record (EMR) revealed a Hospice admission Agreement was signed by Resident #56's RP on 09/08/2025. Resident #56 transitioned to hospice services on 09/08/2025.Review of Resident #56's electronic medical record (EMR) revealed Resident #56's care plan was revised on 09/08/2025 and included the following area of focus, in part: Resident requires Hospice Care and will be kept comfortable through next review.Review of Resident #56's quarterly Minimum Data Set (MDS) assessment dated [DATE] did not indicate Resident #56 was receiving Hospice care.An interview with Resident #56's RP on 02/10/2026 at 11:32 AM revealed Resident #56 had been receiving Hospice care since last fall. The RP stated the Hospice nurse telephoned her weekly and provided her with updates on Resident #56's condition. An interview was conducted with the MDS Coordinator on 02/12/2026 at 2:32 PM. The MDS Coordinator reviewed Resident #56's quarterly MDS assessment dated [DATE] and verified that Hospice services had not been captured on the assessment. The MDS Coordinator stated the MDS was coded incorrectly and should have indicated Resident #56 had received Hospice services. An interview was conducted with the Administrator on 02/12/2026 at 2:40 PM. The Administrator stated that her expectation was for all MDS assessments to be completed accurately based on the resident's clinical condition.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, and psychiatrist interview the facility failed to refer one resident with a new mental health diagnosis for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 1 resident for PASRR (Resident #10).The findings included:Review of Resident #10's medical record revealed Resident #10 was admitted to the facility on [DATE]. A PASRR level I was completed prior to Resident #10's admission with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition.Review of the electronic medical record (EMR) revealed Resident #10 was diagnosed with post-traumatic stress disorder (PTSD) on 09/30/2025. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation.An interview with Resident #10's psychiatrist was conducted on 02/12/2016 at 2:00 PM. The psychiatrist stated when Resident #10 was admitted to the facility, she had no known history of PTSD. The psychiatrist explained Resident #10 started having panic attacks out of the blue and during a conversation with Resident #10's family member, the family member asked if Resident #10's past experience of sexual trauma could have anything to do with her panic attacks. The psychiatrist also stated that she added the PTSD diagnosis to Resident #10's EMR on 09/30/2025, removed all male caregivers from her assignment, and made some medication adjustments to Resident #10's medication profile. The psychiatrist further stated that Resident #10's panic attacks had markedly decreased in frequency and severity.An interview on 02/12/26 at 1:00 PM with the Social Worker revealed she was responsible for completing PASRR paperwork for residents. The SW revealed she was aware of Resident #10's diagnosis of PTSD but she failed to submit a request for an evaluation for a Level II PASRR. The SW further explained that she was not sure how she missed requesting the evaluation for a Level II PASRR. The SW also stated that she was aware PASRR level II requests should be completed for residents when they received a new mental health diagnosis including PTSD. The SW stated that based on Resident #10's new mental health diagnosis, a request for PASRR level II should have been completed. The SW stated that she received the information regarding Resident #10's PTSD diagnosis during the morning clinical meetings.During an interview on 02/12/26 at 1:11 PM with the Administrator, she communicated her understanding that PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident and staff interviews, the facility failed to secure medications left unattended in a resident's room for 1 of 1 resident reviewed medication storage (Resident #90). Findings included:Resident #90 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation and hypertension.Review of Resident #90's active physician orders included apixaban (anticoagulant) 5 milligrams (mg) twice a day started on 2/3/26, metoprolol (antihypertensive) extended release 25 mg with directions to hold for systolic blood pressure (SBP) less than 100 or diastolic blood pressure (DBP) less than 50 or a heart rate less than 50 started on 2/3/26, and diltiazem hydrochloride (antiarrhythmic) extended release 300 mg with directions to hold for SBP less than 120 or DBP less than 60 started on 2/3/26. There was no active physician's order for dextromethorphan/guaifenesin (analgesic/decongestant) 600 mg.During an observation on 2/11/26 at 8:29 AM, a clear resealable plastic storage bag was left unattended in Resident #90's room and contained 3 brown colored medication bottles and a single foil package of medication. The bag was left on the counter by the sink in clear view. The labels on the medication bottles indicated it contained apixaban 5 mg, metoprolol extended release 25 mg, and diltiazem hydrochloride extended release 300 mg. The single foil package contained dextromethorphan/guaifenesin (analgesic/decongestant) 600 mg.During an interview on 02/11/26 at 8:29 AM, Resident #90 stated a family member brought the medications in the bag to the facility. Resident #90 revealed the family member brought the medications to help the nurses identify what she had taken prior to being admitted . Resident #90 stated she took the medications the nurses gave her and she did not want to self-administer medications.On 02/11/26 at 8:38 AM, Nurse #1 was made aware that a resealable plastic storage bag containing medications was not securely stored in Resident #90's room.An interview was conducted on 02/11/26 at 9:12 AM with Nurse #1. Nurse #1 confirmed she was assigned to administer Resident #90's medications on 2/11/26 and had been in the room earlier but did not notice the resealable plastic storage bag of medications. Nurse #1 stated medications should be stored in the medication cart for safety. Nurse #1 confirmed she had removed the bag of medications from Resident #90's room after she was made aware by the surveyor.An interview was conducted on 02/11/26 at 8:38 AM with the Director of Nursing (DON). The DON revealed medications should not be left unattended in a resident's room and should be stored in the medication cart. The DON revealed she would review Resident #90's physician orders to ensure the medications in the resealable plastic storage bag had an order.During an interview on 02/13/26 at 11:56 AM, the Administrator stated medications should not be left in a resident's room and she expected unsecured medications were removed by staff when identified. The Administrator stated the medications were removed from Resident #90's room when the nurse was made aware. It was explained to the Administrator during the interview that the nurse was made aware of the medications left in Resident #90's room by the surveyor.

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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 ensure thawed, raw chicken available for use was labeled with a use by date in 1 of 4 walk-in refrigerators. This practice had the potential to affect food served to residents. Findings included:An observation of the walk-in refrigerator in the main kitchen was conducted on 2/10/26 at 10:18 AM with the Kitchen Operations Manager. At the front of the walk-in refrigerator on the bottom shelf was an opened 20-pound case with one package of raw chicken and one 20-pound case of raw chicken with a sticker that read use first. There was no use by date to specify when the chicken should not be used. The delivery dates on the cases was 2/3/26.During an interview on 2/10/26 at 10:18 AM, the Kitchen Operations Manager revealed when the raw chicken was delivered on 2/3/26 it was frozen and now it had thawed and was ready for use. He revealed the system in place was to rotate frozen raw chicken using a First In First Out policy and explained when raw chicken was delivered it was frozen and placed in the back of the walk-in refrigerator to thaw and rotated towards the front and a use first sticker was placed on the case to identify which one needed to be used. He did not state a use-by date was needed on thawed, raw chicken and confirmed it was not placed on chicken that was stored in the walk-in refrigerator. The Kitchen Operations Manager stated chicken stored in the walk-in refrigerator was typically used within seven days. During an interview on 02/13/26 at 12:06 PM, the Administrator revealed a use by date should be placed on thawed, raw chicken stored in the walk-in refrigerator and available for use.