STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Compass Healthcare and Rehab Hawfields, Inc.	2502 S NC 119 Mebane, NC 27302

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 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. (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident, staff, pharmacy and physician, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 1 of 1 resident reviewed for misappropriation of residents' property (Resident #2).The findings included:The facility's Abuse and Neglect Prohibition policy last revised 6/12/25 indicated that each resident had the right to be free from abuse which included misappropriation of property which was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Resident #2 was admitted to the facility on [DATE]. Review of her recent quarterly Minimum Data Set (MDS) assessment, dated 9/31/25, revealed the resident was cognitively intact. Record review of the physician's order for Resident #2, dated 1/20/25, revealed Oxycodone (narcotic medication) 5 mg (milligrams), to give 1 tablet by mouth, 4 times a day as needed for chronic pain syndrome.Record review of the physician's order for Resident #2, dated 6/6/25, revealed Oxycodone 5 mg, to give 1 tablet by mouth at bedtime for chronic pain syndrome. Review of the Medication Administration Record (MAR) for Resident #2 for October 2025, revealed that scheduled and as needed Oxycodone 5 mg tablets were administered as ordered, including 10/6/25 and 10/7/25.On 1/23/26 at 12:10 PM, during the phone interview, Nurse #2 indicated that she worked from 11:00 PM on 10/6/25 to 7:00 AM on 10/7/25. She counted the narcotics on the medication cart with Nurse #1 at the beginning of her shift on 10/6/26 and the count was correct. Nurse #2 stated she could not recall what the count was but there was no discrepancy. Nurse #2 explained during the shift, Resident #2 did not require as needed narcotic medications. On 10/7/25 at 7:00 AM, during the shift change report with Medication Aide #1, the narcotic count was correct. Nurse #2 confirmed that during her shift, she did not remove the narcotic medication card or narcotic count sheet for Resident #2. Nurse #2 indicated the staff and Staff Development Coordinator (SDC) started the investigation. On 1/22/26 at 9:30 AM, during an interview, Medication Aide #1 indicated that on 10/7/25 she worked 7:00 AM to 3:00 PM shift on medication cart utilized for the A-hall. At 7:00 AM she completed the shift change report, including narcotic count for the medication cart with Nurse #2. Medication Aide #1 stated that when they completed the narcotic count, the number of narcotic medication cards in the locked drawer of the medication cart matched the number of the narcotics noted on the controlled drug count record (used to monitor narcotics that were added and removed from the medication cart). At 7:15 AM, during the medication administration on A-Hall, Medication Aide #1 could not locate the narcotic medication card or controlled drug count record for Resident #2 in the medication cart. She reported it to SDC, who was at the facility at the time. The SDC began looking through the medication cart with Medication Aide #1 to determine if any narcotics were missing. It was found that Resident #2 had narcotic medication card and narcotic count sheet for this medication missing from the medication cart. Record review of the Initial Allegation Report, completed by the Administrator, revealed the facility became aware of misappropriation of Resident 2's property on 10/7/25 when the Staff Development Coordinator (SDC) and Director of Nursing (DON) notified the Administrator that Resident #2 had missing narcotics and the medications were unable to be located in the facility. All medication carts were audited to locate the missing card of oxycodone. All residents were assessed for pain and alert, and oriented residents were interviewed for concerns with pain medication administration. Record review of the Investigation Report, completed by the Administrator on 10/16/25, revealed that the allegation of misappropriation of resident property for Resident #2 was substantiated by the facility. The facility's investigation indicated that Resident #2 had one medication card, which contained 53 tablets of Oxycodone 5 mg, that was unable to be located in the facility. Nurse #1, named in the investigation report, was terminated on 10/10/25. The attempts to conduct a telephone interview with Nurse #1 on 1/21/26 at 1:45 PM and 1/22/26 at 9:30 AM were not successful. Nurse #1 was not available for interview. On 1/22/26 at 9:15 AM, during an interview, Resident #2 indicated that she received pain medications every day and had no concerns related to pain management. On 1/22/26 at 10:35 AM, during a phone interview, the Pharmacy Manager indicated that when narcotics were sent from the pharmacy to the facility, each narcotic medication pack was sent with an individual count down sheet. He confirmed that on 10/7/25, the facility notified the pharmacy about alleged drug diversion with Oxycodone 5 mg tablets. The facility submitted new prescription for Oxycodone 5 mg tablets. The Pharmacy Manager stated that according to the facility, the affected resident continued to receive her narcotics per order with no pain management interruption. On 1/23/26 at 12:30 PM, during an

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records review, and staff interviews, the facility failed to implement the abuse policy and procedure in the area of reporting when the facility failed to report an abuse allegation to the State Agency within the specified timeframes, and failed to notify the Adult Protection Services (APS) for 1 of 1 resident reviewed for misappropriation of residents' property (Resident #2).The findings included:The facility's Abuse and Neglect Prohibition policy last revised 6/12/25 indicated that each resident had the right to be free from abuse which included misappropriation of property which was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The allegations are reported immediately, but no later than 2 hours if the events that cause the allegation involve abuse or result in serious injury, or no later than 24 hours if the events that cause the allegations do not involve abuse or result in serious injury to the Administrator, and other officials (including to the State Survey Agency and Adult Protection Services were state law provides for jurisdictions in long-term care facilities). This included an allegation regarding any individual against whom an allegation was made. The Administrator or designee will ensure that a completed Initial Allegation Report is submitted to DHSR in the required timeframe. The Administrator or designee will ensure that a report of the investigation is submitted within 5 working days of the allegation using the DHSR Investigation Report. Record review of the Initial Allegation Report, completed by the Administrator, revealed the facility became aware of misappropriation of resident property on 10/7/25 when the Staff Development Coordinator (SDC) and Director of Nursing (DON) notified the Administrator that Resident #2 had missing narcotics and the medications were unable to be located in the facility. The Administrator submitted an Initial Allegation Report to the Division of Health Service Regulation for misappropriation of resident property for Resident #2 on 10/10/25. The police department was notified of suspicion of crime on 10/10/25 at 5:00 PM. The report did not indicate Adult Protective Services was notified. Record review of the Investigation Report, completed by the Administrator on 10/16/25, revealed that the allegation of misappropriation of resident property for Resident #2 was substantiated by the facility. The facility's investigation indicated that Resident #2 had one medication card, which contained 53 tablets of Oxycodone 5 mg, that was unable to be located in the facility. Nurse #1, named in the investigation report, was terminated. The Nursing Board and Law Enforcement were notified of the missing narcotics. On 1/23/26 at 1:10 PM, during an interview, the Administrator indicated that on 10/7/25, he was notified of the narcotic discrepancy with one of the medication carts at the facility, but it was not confirmed until 10/10/25. He continued the DON, SDC and nursing staff initiated the investigation to locate the missing medications and after pharmacy confirmation and full search of the facility, the missing narcotics were confirmed. The Administrator stated that the facility replaced the missing narcotics for the resident immediately to prevent medication treatment interruption. He did not report the allegation to the State until 10/10/25, because the facility was not sure if the narcotics were missing. The Administrator continued that the facility did not report the allegation to the Adult Protective Service (APS) because the resident was not affected by the situation. The facility reported the drug diversion to the Law Enforcement, North Carolina Board of Nursing, substantiated the allegation and terminated the accused employee Nurse #1. The facility was unable to speak with Nurse #1 about the missing narcotics. The Administrator confirmed that the facility was unable to locate Resident 2's missing narcotics, that the narcotics were removed from the facility, and that Nurse #1 was the named nurse in the allegation.