STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Shoreland Health Care and Retirement Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Flower-Pridgen Drive Whiteville, NC 28472	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, staff, and Medical Director interviews, the facility failed to ensure a resident attended an oncology appointment for cancer-related care as scheduled. This deficient practice affected 1 of 1 resident reviewed for care to maintain wellbeing (Resident #62). Findings included: Resident #62 was admitted to the facility [DATE] with diagnoses including prostate cancer. A care plan dated [DATE] revealed Resident #62 had an activities of daily living self-care deficit related to disease process including malignant prostate cancer. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #62 was cognitively intact. He had no rejection of care, and he required staff assistance with activities of daily living. Record review revealed an after-visit summary from the cancer center dated [DATE] at 3:00 PM for Resident #62 to return to the cancer center on [DATE] at 1:15 PM for labs and 1:30 PM for an oncology appointment and Lupron injection (used to treat prostate cancer by lowering testosterone levels). During an interview on [DATE] at 12:32 PM Resident #62 stated he had prostate cancer and had to go to the cancer center every six months for Lupron injections. Resident #62 stated he had been receiving Lupron injections every six months for over five years. He stated he had an appointment scheduled by the cancer center on [DATE] for the Lupron injection but Transportation Aide #2 told him that day that she had a mandatory meeting and could not transport him to the cancer center and they would have to reschedule the appointment. He stated the appointment was rescheduled and he went a month later at the end of [DATE]. Resident #62 expressed concern about the delay in cancer treatment and stated he was not happy about having to miss an appointment and thought that other arrangements could have been made to get him there. Resident 62's medical record from [DATE] through [DATE] revealed no documentation in the medical record, or progress notes, regarding Resident #62's appointment on [DATE] at the cancer center. A follow up visit note from the cancer center dated [DATE] revealed Resident #62 was evaluated for prostate cancer and Lupron therapy. Resident #62 was high risk prostate cancer and was there for follow up and treatment. The treatment plan was for Leuprolide (Lupron) 45 milligram injections every six months with last injection on [DATE], noting that he was slightly overdue for his next dose. Resident #62 denied weight loss, fatigue, or changes in appetite. Resident #62's physical exam was unremarkable. The plan of treatment noted was to continue Lupron therapy every six months until [DATE], then shorten the interval to every four months to keep a closer eye on him and his tumor markers. Recheck labs in three months and follow up with oncologist in six months. There were no new labs listed on the [DATE] follow-up note. The next appointments were scheduled for labs on [DATE] and oncology and labs on [DATE]. During a phone interview on [DATE] at 3:00 PM Transportation Aide #2 stated that she and Transportation Aide #1 shared the responsibility for transporting residents to appointments. She stated if she could not take residents to their appointments, she would notify Transportation Aide #1 or reschedule the appointment. Transportation Aide #2 stated she did not take Resident #62 to his appointment at the cancer center (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE] because she had a CPR (cardiopulmonary resuscitation) class scheduled that day, but she did transport other residents after CPR class. Transportation Aide #2 stated that she notified Transportation Aide #1 that she was unable to transport Resident #62 to his appointment on [DATE]. She stated she did get Resident #62 to his appointment on [DATE] at the cancer center. Transportation Aide #2 stated they did not usually notify the nurses or Director of Nursing (DON) when appointments were rescheduled. She indicated that she and Transportation Aide #1 could reschedule appointments when they needed to in order to accommodate the residents' appointments. During a phone interview on [DATE] at 4:00 PM Transportation Aide #1 stated Transportation Aide #2 did let her know that she could not take Resident #62 to his appointment at the cancer center on [DATE]. Transportation Aide #1 stated she could not take Resident #62 to his appointment on [DATE] either because her transportation schedule could not accommodate getting Resident #62 to the cancer center, so she called and rescheduled the appointment, and the new appointment was scheduled for [DATE]. Transportation Aide #1 stated she did not notify the DON that she had to reschedule Resident #62's appointment. She stated since [DATE] they had a new process to where she emailed the clinical team including the DON every Friday to notify them of upcoming appointments for the following week. During a phone interview on [DATE] at 3:40 PM the Medical Director stated Resident #62 was followed by oncology for prostate cancer treatment. She stated there was no difference in getting the injection at seven months versus getting the injection at six months. The Medical Director stated the cancer center report on [DATE] read that Resident #62 was slightly overdue for the treatment. She stated if there had been a concern regarding a delay in treatment then oncology would have rescheduled the appointment sooner than four weeks. She stated she did not order testosterone or PSA levels (PSA - prostate specific antigen- a blood test used to monitor and guide treatment for prostate cancer) for Resident #62 and that was done at oncology, and she was not aware of what those levels were at this time. The Medical Director stated oncology didn't order a PSA to be drawn for three months following the [DATE] appointment indicating to her there was no acute concern, and Resident #62 has had no change in condition. She stated she did not need to be notified that his appointment had to be rescheduled.During an interview on [DATE] at 2:00 PM the Director of Nursing (DON) stated she was not made aware that Resident #62 had his cancer treatment appointment rescheduled with a four-week delay. She stated corporate changes became effective in [DATE] and now she and the clinical team get an email every Friday from the Transportation Aides that show what appointments were upcoming the following week for their residents. The DON stated she specifically reviewed the upcoming appointments when she received the email on Fridays. The DON stated the Transportation Aides should have notified her that they could not take Resident #62 to his appointment for cancer treatment on [DATE] and she would have made arrangements with an outside medical transport to get him to the appointment that day.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff, Nurse Practitioner and Physician interviews, the facility failed to maintain a medication error rate below 5%. Three (3) medication errors were observed out of 25 opportunities, resulting in a medication error rate of 8 %. This occurred for 2 of 5 residents reviewed during a medication pass observation (Residents #29 and #82). Findings included:A review of the facility's mealtime schedule showed that breakfast meal tray carts were delivered to the 200 Hall (the hall where Resident #29 and #82 resided) at 7:30 AM and 7:40 AM. 1. Resident #29 was admitted on [DATE] with diagnosis which included diabetes, diabetic retinopathy, and long-term use of insulin. A review of a physician order dated 2/16/26 in Resident #29's electronic health record read to administer Humalog insulin solution (100 units/milliliter) 10 units subcutaneously before meals for diabetes; hold for blood sugar less than 100. Resident #29 also had a separate order dated 2/16/26 for sliding-scale Humalog insulin solution (100 units/milliliter) to be administered subcutaneously before meals and at bedtime based on the following blood sugar readings: 70-150: 0 units 151-199: 1 unit 200-249: 2 units 250-299: 4 units 300-349: 6 units 350-399: 8 units 400-999: 10 unitsA review of Resident #29's quarterly Minimum Data Set assessment dated [DATE] indicated that the resident was cognitively intact, had a diagnosis of diabetes and received insulin daily.During a medication pass observation on 2/25/26 at 9:15 AM Nurse #1 obtained Resident #29's blood sugar with a result of 295. Nurse #1 administered a total of 14 units Humalog insulin to Resident #29, the 4 units of sliding scale insulin according to the blood sugar result and the scheduled dose that was ordered to be administered before the breakfast meal. Resident #29's breakfast tray was not observed in the room. An interview was conducted with Nurse #1 on 2/25/26 at 10:40 AM. Nurse #1 stated she worked at the facility through a temporary agency and had only worked there a few times. Nurse #1 stated that she was assigned to complete the blood sugar checks and administer insulin for all Residents on the 200 and 300 halls. Nurse # 1 indicated that she was not familiar with the residents or who required blood sugar checks or insulin, so she was late administering the insulin to the residents and did not administer the medication according to the physician order. An interview was conducted with Resident #29 on 2/25/26 at 3:15 PM. Resident #29 indicated that Nurse #1 administered her insulin after she finished her meal in the morning on 2/25/26. An interview with the Nurse Practitioner on 2/25/26 at 11:20 AM revealed that she expected that insulin be given as ordered prior to the meal. The Nurse Practitioner stated that it was important that insulin was administered accurately and this included the time. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 1:15 PM. The DON stated that the nurses should follow the physician orders and administer the insulin before the meals.An interview was conducted with the Physician on 2/25/26 at 3:48 PM. The Physician indicated that Humalog insulin was to be given prior to the meal and administering it after the meal was incorrect. The Physician stated that the resident could potentially have a hypoglycemic (low blood sugar) event when the medication was administered after the meal. 2). Resident #82 was admitted on [DATE] with diagnosis which included diabetes, chronic kidney disease and long-term use of hypoglycemic drugs. A physician order dated 9/19/25 in Resident #82's electronic health record indicated to administer sliding-scale Humalog insulin solution (100 units/milliliter) subcutaneously before meals and at bedtime based on the following blood sugar readings: 60-200 : 0 units 201-250 : 2 units 251-300: 4 units 301-350: 6 units 351-400: 8 units401-999: 10 units and call the physician immediately.A review of Resident #82's quarterly Minimum Data Set assessment dated [DATE] indicated the resident was cognitively intact, had a diagnosis of diabetes and received insulin daily.During a medication pass observation on 2/25/26 at 9:25 AM Nurse #1 obtained Resident #82's (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugar with a result of 256. Nurse #1 administered 4 units Humalog insulin to Resident #82. Resident #82's breakfast tray was not observed in the room. An interview was conducted with Nurse #1 on 2/25/26 at 10:45 AM. Nurse #1 stated that she was assigned from 7:00 AM to 3:00 PM on 2/25/26 to complete all blood sugar checks and administer insulin for the Residents on the 200 and 300 halls. She reported that she was not familiar with which residents required blood glucose monitoring or insulin administration, which resulted in delays in administering insulin and failure to administer the medication according to the physician's orders.An interview was conducted with Resident #82 on 2/25/26 at 3:10 PM. Resident #82 stated that his blood sugars were up and down, and that the nurses usually obtained his blood sugar before meals, but he typically received his insulin after he finished eating. Resident #82 reported that on 2/25/26 he ate his breakfast, and Nurse #1 administered his insulin after he finished his meal, and this was later than the usual time.An interview with the Nurse Practitioner on 2/25/26 at 11:20 AM revealed that she expected that insulin be administered as ordered prior to the meal. The Nurse Practitioner stated that it was important that insulin was administered accurately and this included the time. An interview was conducted with the Physician on 2/25/26 at 3:48 PM. The Physician stated that Humalog insulin was to be administered prior to meals and administering it after the meal was incorrect and could result in an adverse effect.An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 1:15 PM. The DON stated that nurses were expected to follow the physician's orders and administer insulin before meals. She explained that timing was one of the rights of medication administration, and she expected staff to adhere to this requirement.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Responsible Party interviews, the facility failed to arrange necessary dental services to replace a lower denture for a resident with a diagnosis of dysphagia (difficulty swallowing) after the denture was reported missing. This occurred for 1 of 1 resident reviewed for dental services (Resident #75). Findings included: Resident #75 was admitted to the facility on [DATE] with diagnoses including dysphagia and dementia. A physician's order dated 4/15/25 revealed Resident #75 was prescribed a modified texture diet of soft bite size food with mildly thick liquids. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #75 had severe cognitive impairment and moderately impaired vision. She required set up or clean up assistance with eating and with oral hygiene. Resident #75 received a mechanical and therapeutic diet and had no dental issues at the time of assessment. A grievance report dated 10/21/25 completed by the Social Worker revealed Resident #75's Responsible Party stated she was missing her bottom denture. The family brought in an extra pair of dentures and the family was filling out paperwork so that Resident #75 could get dental care in house. The resolution of the grievance was that in-house dental would come at the beginning of the year as this was the earliest time to get started on replacing dentures. The grievance form was signed by the Social Worker on 10/31/25. During an interview on 02/24/26 at 11:19 AM the Social Worker stated a grievance was filed on 10/21/25 by Resident #75's Responsible Party regarding the missing lower denture. She stated she gave Resident #75's Responsible Party the paperwork to complete for in-house dental services and did not get the paperwork back until 11/13/25. The Social Worker indicated she called on 11/13/25 to schedule an appointment with the in-house dental services for denture replacement after receiving the paperwork back and the earliest available appointment was scheduled for 3/16/25. The Social Worker indicated she did not attempt to call after that time to get a dental appointment scheduled sooner or call an outside dentist to get faster service due to Resident #75's diagnoses of dysphagia. During an interview on 2/24/26 at 2:00 PM Resident # 75's Responsible Party (RP) stated that Resident #75 was missing the lower denture since October 2025. The RP stated they brought in a lower denture from home for temporary use soon after her denture was lost in the facility. The RP stated the temporary lower denture brought in did not fit well and caused Resident #75 pain, and she did not like to wear it. The RP stated Resident #75 was able to voice when she was in pain. The RP stated they returned the paperwork for in-house dental within a couple of weeks of the grievance being filed but had no idea it would take six months to get an appointment. She stated she was told by someone at the facility that the appointment would be around the first of the year. She stated Resident #75 had difficulty chewing and swallowing and the facility had ordered a pureed diet earlier this year. The RP stated they signed a waiver to allow her to have soft bite size foods instead of pureed to maintain some quality of life. A care plan revised 12/18/25 revealed Resident #75 had oral and dental health problems with a risk for further decline and decline in nutritional intake related to wearing dentures. Interventions included to coordinate arrangements for dental care as needed. During an observation on 02/24/26 at 12:45 PM Resident #75 was observed in her room sitting in a wheelchair eating lunch independently. Resident #75 was oriented to self as evidenced by responding to her name. She was observed with a divided plate with spaghetti and green beans. She was not wearing the lower denture that was brought in by the RP. The observation further revealed Resident #75 was slow to chew her food, and had food smeared on the towel draped on her chest. During an interview on 02/24/26 at 1:00 PM Nurse Aide #2 stated she was Resident #75's assigned Nurse Aide today from 7:00 AM until 3:00 PM. She stated Resident #75 was able to feed herself, but she would go in the room during meals and (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offer assistance as needed. Nurse Aide #2 indicated she had not observed Resident #75 having difficulty chewing or swallowing her food. During an interview on 02/24/26 at 1:00 PM Nurse Aide #1 stated Resident #75 had a lower denture in her room that was brought in by the family (unable to specify a date) after the lower denture was reported missing, but Resident #75 did not like to wear it because it caused her pain. Nurse Aide #1 explained that Resident #75 was able to let you know if she had pain by grimacing or saying no when asked about wearing the dentures. Nurse Aide #1 indicated she had not observed Resident #75 having difficulty chewing or swallowing but stated it would be much easier for Resident #75 to chew her food if she had the bottom denture. During an interview on 02/24/26 at 1:19 PM the Speech Therapist stated Resident #75 was prescribed a soft bite size foods diet earlier this year following a FEES study (Fiberoptic Endoscopic Evaluation of Swallowing - a test used to evaluate how well someone can swallow) that was done in January 2025, which showed that Resident #75 was at high risk of choking. The Speech Therapist recommended a pureed diet, but the family wanted her to have soft foods and did not want her on a pureed diet. She stated a waiver was signed to allow soft foods. The Speech Therapist indicated Resident #75 was not currently on Speech Therapy services. During an interview on 02/25/26 at 2:45 PM the Occupational Therapist stated she was currently working with Resident #75. The Occupational Therapist stated she did not realize Resident #75 was waiting for so long for the lower denture, and it was important that she had a full set of dentures due to her risk of choking. The Occupational Therapist stated she would reevaluate Resident #75 to determine the need for increased assistance with eating since the resident continued to not have the lower denture. During an interview on 2/26/26 at 2:00 PM the Director of Nursing (DON) indicated she was aware of Resident #75's missing lower denture but stated she was not aware Resident #75 was not scheduled for new lower dentures until 3/16/26. She stated the RP brought in a lower denture to use while waiting for the appointment to replace the lost denture, but she was not aware that the lower denture caused the resident pain. The DON stated Resident #75 should have been scheduled with an outside dentist if the in-house dentist appointment was going to be six months out. She indicated the Social Worker called an outside dentist yesterday and Resident #75 went for her first fitting today and would be reevaluated by the Occupational Therapist to assess her need for increased assistance with eating while waiting on the lower denture to be replaced. The DON indicated there had been no reported episodes of Resident #75 choking on her food and her weight remained stable. The DON stated the Social Worker should have made attempts to get an appointment scheduled sooner than six months out for a resident with dysphagia, dementia and high risk of choking.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observations, and staff interviews, the facility failed to implement their infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to a resident with an indwelling urinary catheter (Resident #7) and a resident with a feeding tube (Resident #46). This occurred with 2 of 3 staff members who were observed for infection control practices (Nurse #2 and Nurse #3).Findings included: The Infection Control Policy dated 6/1/25 revealed Enhanced Barrier Precautions referred to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms (MDROs) to hands and clothing. High contact resident care activities that required enhanced barrier precautions included indwelling medical device care such as urinary catheters and feeding tubes. a.) During an observation on 2/23/26 at 11:30 AM Resident #7 was observed lying in bed. An Enhanced Barrier Precaution sign was observed by the door outside of Resident #7's room. A PPE (personal protective equipment) supply cart was in the hallway outside of the residents room with supplies including gloves and gowns. Nurse #2 was observed at Resident #7's bedside changing the urinary catheter bag. Nurse #2 was wearing gloves but did not don (put on) a gown prior to providing direct care to Resident #7. During an interview on 2/23/26 at 11:30 AM Nurse #2 stated she did not realize that Resident #7 was on enhanced barrier precautions, and she did not see the sign on the outside of Resident #7's room. Nurse #2 stated she did not know why Resident #7 was on enhanced barrier precautions. Nurse #2 stated she had received infection control training including training on enhanced barrier precautions and when to wear PPE. Nurse #2 stated she should have worn a gown along with gloves when changing the urinary catheter bag. b.) During an observation on 2/23/26 at 11:45 AM Resident #46 was observed lying in bed. An Enhanced Barrier Precaution sign was observed by the door outside of Resident #46's room. A PPE supply cart was in the hallway outside of the residents room with supplies including gloves and gowns. Nurse #3 was observed at Resident #46's bedside administering medications and water flushes through the feeding tube then replaced the blankets over Resident #46. Nurse #3 was wearing gloves but did not don a gown prior to providing direct care to Resident #46. During an interview on 2/23/26 at 11:50 AM Nurse #3 stated she did not see the sign on the outside of Resident #46's room, and she did not know why Resident #46 was on enhanced barrier precautions. Nurse #3 stated she had received infection control training including training on enhanced barrier precautions and when to wear PPE. Nurse #3 stated she should have read the sign and put on a gown along with the gloves when giving medications through a feeding tube. During an interview on 2/26/26 at 10:30 AM the Infection Control Preventionist Nurse stated staff had been trained on enhanced barrier precautions. She stated they provided in-service education on infection control including enhanced barrier precautions throughout the year, and she conducted random audits to ensure staff were adhering to PPE guidelines. She stated Nurse #2 and Nurse #3 should have donned a gown along with gloves when providing urinary catheter care and when administering medications through a feeding tube. She stated continued education would be provided to staff. During an interview on 2/26/26 at 2:00 PM the Director of Nursing (DON) stated staff received infection control training including training on enhanced barrier precautions annually. The DON indicated staff should be following the infection control guidelines and wearing PPE when providing direct care to residents on enhanced barrier precautions.