STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fleshers Fairview Health Care	3016 Cane Creek Road Fairview, NC 28730

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to serve a meal to all residents sitting at the same dining table, prior to serving other tables (Resident #42). Additionally, the facility failed to provide feeding assistance while sitting at eye level (Resident #30). This was for 2 of 22 residents reviewed for dignity (Residents #42 and #30). A reasonable person concept was utilized for Resident #42 and would want to have her meal served along with other residents at the dining table.Findings included: 1.Resident #42 was admitted on [DATE] with diagnoses that included dysphagia, type 2 diabetes and protein calorie malnutrition. Resident #42's admission Minimal Data Set (MDS) coded her with moderate cognitive impairment. The MDS review also found she needed setup or clean up assistance with eating. A review of Resident #42's care plan revealed she was care planned for nutrition on 8/14/25. Interventions included providing and serving her diet as ordered, monitoring her meal intake and recording the intake amount for every meal. A continuous observation in the dining room occurred on 9/15/2025 beginning at 12:21 PM. Three residents were observed at a dining room table, 2 of 3 residents sitting at the dining table were served meals. Resident #42 was observed raising her hand at 12:25 PM while saying she was hungry. The Hospitality Aide was observed reassuring Resident #42 her food was coming out soon. The observation continued at 12:29 PM and Resident #42 was observed raising her hand again and saying she was hungry. The Hospitality aide again reassured the resident her food was coming soon. At 12:37 PM, Resident #42 received her food and the Hospitality Aide apologized to the resident that her food was delivered to her late. The Hospitality Aide was interviewed on 9/15/25 at 12:45 PM. She stated normally all residents at the same table were served food at the same time, and she was unaware why Resident #42's meal was delayed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dietary Manager was interviewed on 9/15/25 at 1:08 PM. The Dietary Manager stated the kitchen had a staff call-out for the morning and another member of staff had come in late. She stated the resident meal tickets became disorganized, and Resident #42's meal tray was sent to her floor. The Dietary Manager said initially they did not realize Resident #42 did not have a meal in the dining room and were informed by a staff member from the dining room that her meal was missing. She stated the resident's meal needed to be retrieved from the hall and delivered to the dining room. The Dietary Manager said Resident #42 should have received her meal when the table was served and should not have waited so long to receive her meal. The Administrator was interviewed on 9/19/25 at 4:04 PM. The Administrator stated all residents eating at the same table should be served together within a couple minutes. She stated Resident #42 should not have to wait almost 20 minutes for her meal to be served to her. 2. Resident #30 was admitted to the facility on [DATE]. Her active diagnosis included Alzheimer's Dementia and dysphagia (difficulty swallowing). Resident #30's quarterly Minimum Data Set, dated [DATE] revealed she had severe cognitive impairment, and she required supervision/touching assistance for eating. Resident #30's care plan revised on 6/19/24 revealed a focus of impaired nutrition related to malnutrition, dementia, poor appetite and hypokalemia. Interventions included that the resident usually needs to be fed but sometimes will feed self. An observation on 9/15/25 at 12:56 PM revealed Nursing Assistant (NA) #1 standing on the side of Resident #30's bed feeding her lunch. NA #1 was not at eye level with the resident. A chair was available in the room, and the NA did not use it. An interview on 9/15/25 at 3:01 PM with NA #1 revealed she was aware she was supposed to sit to feed Resident #30 and did not know why she had not sat down. An interview on 9/19/25 at 2:39 PM with the Administrator revealed that staff were supposed to sit when feeding residents and she did not know why NA #1 had not sat down.

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (continued on next page)

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record reviews, and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns voiced by residents during the Resident Council meetings for 8 of 12 months reviewed (November 2024, December 2024, January 2025, March 2025, April 2025, May 2025, June 2026, and July 2025).The findings included:Review of the Resident Council minutes for the period of 09/23/2024 through 08/09/25 revealed the following:a. The Resident Council meeting minutes dated 11/25/24 noted the cell phone use while working was still an issue and the NAs (certified nursing assistants) on second shift were not answering call bells as fast as they could.The Resident Council Response form on the back of the 11/25/24 meeting minutes noted a resolution that they have addressed the cell phone usage and appropriate call bell times with the NAs and will continue to monitor.b. The Resident Council meeting minutes dated 12/14/24 noted the NAs were always on their phones while at work and the second shift NAs were still not answering the call bells as quickly as they should be.The Resident Council Response form dated 12/2024 and attached to the Resident Council meeting minutes noted a resolution that the cell phone usage had been addressed and was continuing to be monitored. The call bell response times have been monitored via the cameras and have been answered in a timely manner.c. The Resident Council meeting minutes dated 01/17/25 noted the call bells on second shift were still not being answered very quickly.The Resident Council Response form on the back of the 01/17/25 meeting minutes noted a resolution that they will continue to monitor.d. The Resident Council meeting minutes dated 03/26/25 noted NAs were still on their phones too much.The Resident Council response on the back of the 03/26/25 minutes noted a resolution that they will address the cell phone usage.e. The Resident Council meeting minutes dated 04/21/25 noted they were still on their cell phones too much.The Resident Council response on the back of the 04/21/25 minutes noted a resolution that they have addressed cell phone usage with the staff multiple times and will continue to monitor.f. The Resident Council meeting minutes dated 05/30/25 noted the NAs were still on their cell phones while sitting behind the desk and they should not be on their cell phones in the residents' rooms. The minutes also stated that 6:30 AM was too early to pass ice because it woke the residents up.The Resident Council response on the back of the 05/30/25 minutes noted a resolution that they will talk to the NAs about appropriate times to pass ice and they will continue to monitor cell phone usage.g. The Resident Council meeting minutes dated 06/26/25 noted the NAs were still passing ice too early. The residents do not want the ice passed before breakfast. The NAs were still on their cell phones.The Resident Council response on the back of the 06/26/25 meeting noted a resolution that they will talk with the staff about passing out ice a little later and they will continue to monitor the cell phone usage.h. The Resident Council meeting minutes dated 07/30/25 noted that ice passing was still waking the residents up in the mornings and the staff were still on their cell phones while they were feeding the residents.The Resident Council response on the back of the 07/30/25 meeting noted a resolution that they have discussed the concerns with the staff and were still monitoring for improvement.A Resident Council group interview was conducted on 09/17/25 at 2:00 PM with Residents #1, 7, 9, 14, 17, 19, 32, 39, 49 and #54 in attendance. Resident #17 was vocal about the ice being passed too early in the morning despite their repeated concerns about how it woke the residents up too early before breakfast. Resident #49 expressed that the wait time for his call bell to be answered, especially on second shift, was too long despite his repeated reporting of the concern. Residents #1, #17 and Resident #39 reported that NAs were still on their cell phones in the residents' rooms and in the dining rooms when they should be taking care of the residents. The Residents stated they felt the facility did not take their concerns seriously because they get the same response to their concerns every month like we are working on it, will continue to monitor and educate and nothing was resolved.During an interview with the Activity Director (AD) on 09/19/25 at 11:24 AM the AD explained the department managers took turns attending and recording the monthly Resident Council meetings and if the assigned department manager was unable to attend the Resident Council meeting it was up to the AD to attend the meeting in the place of that manager. The AD stated she has attended about 4 Resident Council meetings thus far this year. The AD continued to explain that the Resident Council meeting minutes were given to the department managers to investigate before the next meeting. The AD explained that there were months that the residents voiced the same repeated concerns during the meetings and voiced disappointment that their concerns were not taken seriously and resolved to their satisfaction.An interview was conducted with the Administrator on 09/19/25 at 6:00 PM. The Administrator explained that there were

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, and Resident Representative interviews, the facility failed to allow residents/representatives the opportunity to formulate an advance directive. Additionally, the facility failed to provide residents/representatives with written information regarding advance directives and the right to accept or refuse medical or surgical treatment for 2 of 4 residents reviewed for advance directives (Resident #11 and Resident #3). The findings included:Review of the facility's Advance Directive policy revised 3/17 revealed, the facility would at the time of admission give the following information to all resident's and/or responsible party. 1. provide written information to resident and/or responsible party regarding the resident's rights under state law to direct the course of their medical care, to refuse treatments, and to execute advance directives, 2. Will inform residents and/or responsible party in writing of the facilities policies regarding the implementation of these rights. a. Resident #11 was admitted to the facility on [DATE]. A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #11 had moderate cognitive impairment. Review of Resident #11's medical record revealed no advance directive checklist, or signed acknowledgment of receipt, or evidence the facility provided Resident #11's Resident Representative with written information pertaining to their right to accept or refuse treatment and to formulate an advance directive, on the resident's behalf. Review of the facility's admission packet revealed there was no written information included regarding advance directives or the right to accept or refuse medical treatment or to formulate an advance directive. The admission packet did not contain an advance directive acknowledgment check list. A telephone interview was attempted on 9/22/25 at 9:03 AM with Resident #11's Resident Representative. Resident #11's Resident Representative was not available for interview. b. Resident # 3 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #3 was cognitively intact. Review of Resident #3's medical record revealed no advance directive checklist, or signed acknowledgment of receipt, or evidence the facility provided Resident #3's or his Resident Representative with written information pertaining to their right to accept or refuse treatment and to formulate an advance directive, on the resident's behalf. Review of the facility's admission packet revealed there was no written information included regarding advance directives or the right to accept or refuse medical treatment or to formulate an advance directive. The admission packet did not contain an advance directive acknowledgment check list. An interview was conducted with Resident #3 on 9/19/25 at 4:00 PM. He did not know what an advanced directive was and stated he had not received any information from the facility about advance directives. An interview was conducted on 9/22/25 at 10:14 AM with Resident #3's Resident Representative. He stated he did not receive any written information from the facility about formulating an advanced directive. He reported he signed admission paperwork but did not remember what all was included specifically in the admission paperwork, he said he did not remember anything about advance directives other than the Medical Order for Scope of Treatment (MOST) form being discussed. He did not know exactly what an advance directive was. He stated Resident #3 had a regular will but did not think he had a living will and said he was not sure what the difference was between the two. An interview was conducted with the Social Worker (SW) who was also the facility's admission Coordinator on 9/18/25 at 1:30 PM. The SW stated when she reviewed advance directives on admission it was mostly the MOST form that she reviewed with the resident or family. The SW stated she did not give anything in writing to the residents or their representative about advance directives or the right to refuse medical or surgical care. She stated the facility did not include written literature in the admission packet about advance directives or right to refuse medical or surgical care. She stated if a resident did not have a living will or advance directive listed in their medical record then they did not have one. An interview was conducted with the Administrator on 9/18/25 at 5:11 PM. The Administrator stated she had spoken with the SW earlier today and the SW had told her about the Advance Directives information not being included in the admission packets. The Administrator stated the facility was not aware they needed to provide information in writing about advanced directives or the right to refuse medical or surgical care to residents or their Resident Representative or that the resident or Resident Representative needed to acknowledge they had been provided with the information verbally and in writing.

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F 0580 Level of Harm - 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 reviews, and staff, Nurse Practitioner and Medical Director interviews, the facility failed to consult with the physician about a new pressure ulcer that developed on 08/22/25 on Resident #8's right heel. The pressure ulcer was observed 08/22/25 with no notification to the physician until 09/09/25 when the pressure ulcer to Resident #8's right heel was assessed and documented as an unstageable wound to the right heel with black eschar (dry, black, or brown crust that forms on the surface of wounds) with foul odor and measuring 3.5 centimeters (cm) by 3.5 cm. The facility also failed to consult the physician when Resident #2's diabetic foot ulcer was identified on 09/10/25. In addition, the facility also failed to consult the physician when Resident #16's stage II pressure ulcer was identified on 08/31/25 and when Resident #29 experienced significant weight loss. This deficient practice affected 4 of 4 residents reviewed for notification (Resident #2, #8, 16 and #29). The findings included: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses that included history of cerebral vascular accident and diabetes mellitus. Resident #8's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident's cognition was severely impaired, required substantial to maximal assistance with most of her activities of daily living and she did not have pressure ulcers on admission. An interview was conducted with Nurse Aide (NA) #1 on 09/18/25 at 2:35 PM. The NA explained that on 08/22/25 she was preparing to give Resident #8 her shower when she tried to remove her right sock, but it was stuck to her heel and would not come off until she wet the sock first. The NA continued to explain that she noted a red raw area approximately the size of a quarter on her right heel with bloody dried hard drainage on the sock. The NA got Nurse #1 to come to the shower room where she observed Resident #8's right heel and put a dressing over the heel as well as obtained a heel protector to put on after she finished the shower. An interview was conducted with Nurse #1 on 09/18/25 at 4:10 PM and 09/18/25 at 5:30 PM. The Nurse explained that she remembered NA #1 asking her to come to the shower room on 08/22/25 where NA #1 showed her Resident #8's right heel. The wound was pink, and she could not remember if there was drainage. The Nurse continued to explain that she did not measure the pressure ulcer or notify the physician, but she did apply a dry foam dressing to the heel and put a note on the board in the medication room for the Wound Nurse to follow up on the next day. On 09/18/25 at 8:45 AM an interview was conducted with NA #5 who explained that on the night of 09/04/25 she noted an area of drainage on Resident #8's bed sheet while she was providing care to the Resident and when she tried to remove the Resident's right sock, the sock was stuck to her heel. The NA stated she got Nurse #7, and the Nurse cleansed Resident #8's right heel and applied a dressing on her heel. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview with Nurse #7 on 09/18/25 at 8:50 AM the Nurse explained that on the night of 09/04/25 NA #5 reported that she could not get Resident #8's sock off her right heel because it was stuck to her heel. The Nurse stated she had to soak the Resident's right heel with wound cleanser in order to remove the sock. The Nurse continued to explain that Resident #8's right heel had a blood-filled blister that was not open, and the area looked like the skin was layered. The Nurse reported that she did not measure the pressure ulcer or notify the physician, but she did apply a foam dressing to the Resident's right heel and applied heel protectors to Resident #8' feet. Nurse #7 also reported that she put a note in the wound communication book for follow up by the Wound Nurse. An interview was conducted with Wound Nurse on 09/16/25 at 2:39 PM, 09/18/25 at 11:45 AM and 09/19/25 at 7:30 AM. The Wound Nurse explained that she first became aware of Resident #8's right heel pressure ulcer on 09/09/25. The pressure ulcer was unstageable with black eschar, malodorous and measured 3.5 x 3.5 centimeters. The Wound Nurse continued to explain that the pressure ulcer had a treatment set up but when she noted that it was black with hard eschar and the drainage was malodorous, she decided to notify the Medical Director and asked for crushed metronidazole (antibiotic) which was what she normally did with a malodorous ulcer. The Medical Director also ordered an X-ray to rule out osteomyelitis which was negative. The Nurse stated she also obtained an order for a wound consult and Resident #8 was seen by the Wound Care Nurse Practitioner on 09/11/25. Nurse #4 reported that she did not see the note on the board in the medication room left by Nurse #1 on 08/22/25. She stated that 08/22/25 was a Friday and she did not work on Fridays and neither did she work on the weekends. Resident #8's medical record from 07/17/25 through 09/09/25 revealed there was no documentation in the medical record of the Medical Director being notified of pressure ulcer development. During interviews with the Medical Director on 09/18/25 at 10:25 AM and 09/19/25 at 3:08 PM. The Medical Director explained that he was first made aware of Resident #8's right heel pressure ulcer when the Wound Nurse #4 called and reported it on 09/09/25. He reported that he ordered crushed metronidazole to be applied to the wound daily for the malodor and to follow up with a wound consultation. The Medical Director also stated that based on the description by Wound Nurse he ordered an X-ray to rule out osteomyelitis which was negative. The Medical Director was not informed of the pressure ulcer first being discovered on 08/22/25 and no orders were obtained to follow up with treatment and the Medical Director stated that it was unfortunate because if the orders had been initiated then the pressure ulcer may not have gotten to the point it had. On 09/19/25 at 6:00 PM an interview was conducted with the Director of Nursing (DON) with the Administrator present. The DON explained that there were standing orders for wound care and when the pressure ulcer was first noted on Resident #8 the standing order should have been set up with specific treatment, and the Medical Director should have been notified in case there were further orders to be followed. 2. Resident #2 was admitted on [DATE] with diagnoses of vascular dementia and hemiparesis and hemiplegia of left side following a stroke. A progress note written by Wound Nurse dated 9/10/25 at 2:05 PM wrote she found an open area on Resident #2's left heel. The note read the open area was unstageable and measured 2 centimeters (cm) x 1.5(cm). The Wound Nurse wrote the area around the open area was red with blanchable redness. The wound did not contain an odor, and the area was cleaned, and a dressing was applied. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 9/18/25 at 1:15 PM the Wound Nurse was interviewed. The Wound Nurse stated she first saw the heel wound on 9/10/25 and documented the wound in a progress note. The left heel wound measured 2 (cm) x 1. 5 (cm) and did not contain an odor or drainage. The Wound Nurse said she treated the left heel wound with standing wound orders and notified the Wound Nurse Practitioner the following day. Additionally, she thought she had communicated the wound to the Nurse Practitioner (NP) when she found it 9/10/25. On 9/11/25 the Wound Nurse Practitioner evaluated the left heel dorsal wound. The Wound Nurse Practitioner treatment note read that given the dorsal location of this wound, it was consistent with a diabetic etiology. The wound was deep and full of necrotic slough (dead tissue) and suspected the wound had been present for some time. The treatment note also included the estimated depth to bone was less than 2 millimeters. Additionally, the Wound Nurse Practitioner wrote that a medically necessary sharp debridement was indicated and performed for the removal of excessive necrotic tissue and for the promotion of wound healing. The note continued with treatment orders to cleanse left heel wound with a full-strength antiseptic solution and then apply full strength (0.5%) antiseptic solution moistened gauze to the full depth of the wound bed. Finally, the wound was to be covered with a silicone bordered super absorbent dressing. The treatment was to be completed daily and PRN (as needed). An additional order was for a wound culture and sensitivity and x-ray of left heel for evaluation of evidence for presence of osteomyelitis (infection in a bone) and underlying pathology. The Wound Nurse Practitioner also wrote for labs of complete blood count, C reactive protein, and erythrocyte sedimentation rate. The Wound Nurse Practitioner also wrote that the resident was to always wear a podus boot (foot brace to prevent bedsores) for offloading. On 9/15/25 the Wound Nurse Practitioner treated the resident's left heel. A review of the treatment note found the measurements for the left heel diabetic ulcer were 2 cm x 1.5 cm x 1.5 cm. The wound contained 80% necrotic tissue with yellow seropurulent (discharge of serum and pus) drainage. The treatment note included the left heel wound had not improved from the previous treatment day, but the adherent slough that was present last week (9/11/25) was mostly liquefied and ran out of the wound when the dressing was removed. The Wound Nurse Practitioner assessed with certainty if the drainage included purulent drainage mixed with liquified yellow green slough. Furthermore, the Wound Nurse Practitioner's note wrote that a medically necessary sharp debridement was indicated for the removal of excessive necrotic tissue and for the promotion of wound healing. The wound was anesthetized, and debridement was performed. Resident #2's NP was interviewed on 9/17/25 at 11:00 AM. He stated Resident #2 had been placed on comfort measures due to an overall decline and Resident #2 had poor nutritional status and would refuse nutritional supplements. The NP stated he was aware that Resident #2 had wounds on her back and sacrum area but did not know she had a wound on her left heel. He stated he was not notified that Resident #2 had a wound on her left heel. The NP stated he was not notified of any lab results ordered by the Wound Nurse Practitioner on 9/11/25 and was not aware of her treatment orders. The NP stated it was important to be notified of new wounds and any interventions for Resident #2 so treatment could be started and to see what other interventions Resident #2 had in place. He stated Resident #2's left heel wound would be unavoidable due to her overall decline. The NP stated he should have been notified of Resident #2's left heel wound when it was found on 9/10/25. Additionally, the NP stated normally the Wound Nurse Practitioner would have been notified with results of any labs or diagnostics first because she had ordered them, and the results would be placed in his folder to review or would have been called in to him. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	The Medical Director was interviewed on 9/18/25 at 11:25 AM. The Medical Director stated he was notified by the nursing staff through the nursing communication book or by a phone call when a resident had a new wound. The Medical Director stated he was not notified that Resident #2 had a wound on her left heel. On 9/19/25 at 4:04 PM the DON stated the Medical Director and NP should have been notified for Resident #2's diabetic foot wound on 9/10/25 when found by the Wound Nurse. 3. Resident #29 was admitted to the facility on [DATE]. Her diagnoses included dementia, hypothyroidism, nutritional deficiency, protein-calorie malnutrition. Resident #29's electronic record documented the following weights -7/29/25- 132.1 pounds (lbs.) -8/26/25- 114.4 lbs. A progress note dated 8/31/25 by the Registered Dietitian (RD) #1 indicated Resident #29 was reviewed. The note indicated she had a significant weigh loss of 13.6 % in a month. The note indicated Resident #29 received a regular diet with mechanical soft texture and her intakes ranged from 0-50% of most meals. The note indicated she was receiving Med Pass (nutritional supplement) 60 milliliters (ml) twice daily and a mighty shake (nutritional supplement) three times daily. The note indicated the RD recommended obtaining a reweight for weigh loss verification and increasing her Med Pass to 90 ml twice daily to promote weight stability. RD #1 was not available for interview. A reweigh weight was not located in Resident #29's electronic medical record. An interview was conducted with the Director of Nursing (DON) on 9/18/20 at 10:20 AM. She said if a resident had significant weight loss it was the Assistant Director of Nursing (ADON) who was responsible for ensuring the provider was notified and said it should be documented somewhere. The DON stated when someone had significant weight loss the physician should be notified. Review of Resident #29's medical record revealed there was no documentation the physician was notified of the weight loss. An interview was conducted with the ADON on 9/18/25 at 11:01 AM. The ADON reported she was responsible for keeping up with the facility weights and ensuring they were completed. The ADON stated she had not notified the physician of Resident #29's significant weight loss. She said the Physician should be notified if a resident had significant weight loss so they could check the resident medically to see if there was a reason for the weight loss. The ADON stated Resident #29's reweight not being reported or entered until 9/18/25 by Unit Clerk #1 was a little late. The ADON said she noticed Resident #29's weight loss at the end of August but was waiting on the reweight before she notified the Physician. The ADON said she should have followed up on Resident #29's reweight but had gotten busy. The ADON thought she was the person who would be responsible for notifying the Physician of significant weight loss. She stated she had just got busy and forgot because she was working on the floor. (continued on next page)

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	345413	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fleshers Fairview Health Care	3016 Cane Creek Road Fairview, NC 28730

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F 0580 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 9/19/25 at 10:45 AM with RD #2. RD #2 reported that the Physician should also be notified if a resident had significant weight loss. RD #2 said she was not aware of who notified the physician at the facility. RD #2 stated she was not told by anyone at the facility the RD was the person who notified the Physician. RD #2 reported it was important to notify the Physician of significant weight loss so the Physician could review the resident from a medical standpoint. An interview was conducted with the Medical Director on 9/18/25 at 9:53 AM. He stated he was aware Resident #29 had some prior weight loss in the past but had not been notified in the last month about her having significant weight loss. He said if a resident had significant weight loss it would trigger for him to review and see them. The Medical Director said if he had been notified of Resident #29's significant weight loss he may have done labs and checked a TSH level because Resident #29 took Synthroid (thyroid medication). The Medical Director said the facility should have followed the RD recommendations and obtained a reweight to confirm her weight loss and ensured the weight was reported. The Medical Director said he would have asked for a reweight to be obtained too. The Medical Director explained there was no reason not to notify him immediately when the facility became aware someone had significant weight loss. He further explained if he was off, the facility could notify him through the provider's communication book, and the information would be there for him to review when he returned. The Medical Director stated he had not seen a note about Resident #29 having weight loss in the provider communication book. The Medical Director said he would expect to be notified within a week. An interview was conducted with the Administrator on 9/18/25 at 5:11 PM. The Administrator stated the ADON had notified her about Resident #29's weights today. The Administrator stated the Physician should be notified if a resident had significant weight loss. She said previously the RD notified the Physician if a resident had significant weight loss. She reported that it was still the process. The Administrator explained RD #1 went on medical leave at the end of August and said she thought that was why there was a breakdown in communication. 4. Resident #16 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle wasting and atrophy, muscle weakness. An interview was conducted on 9/15/25 at 9:23 AM with Resident #16. He reported he had a pressure ulcer to the back of his right thigh. A nursing note dated 8/31/25 by Nurse #8 read: “Nurse notified by resident of bleeding spot on the back of his thigh. Possible stage 2 pressure injury noted to right outer back thigh. Wound bed pink, scant red drainage noted on resident's reusable chuck on his manual wheelchair. No signs of infection. Nurse cleansed wound with wound cleanser, covered wound bed with silver alginate and covered with adhesive dressing. Resident will be added to acute book for this issue and nurse will enter wound care orders until wound care nurse can assess.” An order dated 8/31/25 was entered by Nurse #8 and read: Cleanse wound with wound cleanser, cover wound bed with silver alginate (highly absorbent wound dressing embedded with silver particles to fight infection), place dry adhesive dressing over wound, two times a day for pressure injury for 7 days. The order ended on 9/7/25. There were no additional wound care orders after 9/7/25. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Nurse #8 on 9/17/25 at 2:57 PM. She recalled finding the stage 2 pressure ulcer to the back of Resident #16's right thigh on 8/31/25. Nurse #8 stated she had not notified the Physician when she found Resident #16's wound to obtain treatment orders, she said that was not the process. Nurse #8 explained what she understood was the facility's process when a wound was found. She said the nurse entered a treatment order for the wound, made a nursing note, and entered a note in the nursing “acute book” so everyone would know about the wound and document on the wound for 72 hours. An interview was conducted with the ADON on 9/17/25 at 11:00 AM. The ADON reported she reviewed Resident #16's orders and stated Resident #16 had a treatment order for the stage 2 pressure ulcer entered on 8/31/25. She said when a wound was found the nurse was supposed to notify the provider by placing a note in the provider's communication book or by calling them. The ADON reviewed the provider's communication books and stated there was not a note left to notify the provider about Resident #16's wound. An interview was conducted on 9/17/25 at 12:11 PM with the Nurse Practitioner (NP). He said he was not aware Resident #16 had a wound and that he had not been asked to look at the area. He said Nurse #8 should have notified a provider when the wound was found to obtain wound care orders. He stated if he had been notified, he would have ordered Resident #16 to be seen by the Wound Care Provider. An interview was conducted with the Medical Director on 9/18/25 at 9:46 AM. The Medical Director stated he was not aware that Resident #16 had developed a wound. He stated the nurse should have notified him or the NP of Resident #16's wound and to get wound care orders when the wound was identified. An interview was conducted with the Director of Nursing (DON) and Administrator on 9/19/25 at 6:00 PM. The Administrator reported that Nurse #8 should have notified the provider when she found Resident #16's wound. The Administrator stated she did not know why Nurse #8 did not notify the Physician about the wound.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on record review, observations and staff interviews, the facility failed to protect residents' personal health information by leaving confidential medical information unattended, visible and accessible to others on top of the medication cart for 1of 4 medication carts observed for privacy and confidentiality (500 hall). Findings included:On 09/16/25 at 8:48 AM an observation was made of the unattended 500 hall medication cart with the narcotic book which was open to a resident's narcotic sheet for a controlled medication. The narcotic sheet noted the resident's name, name of medication, directions of use, how often the resident had used the medication, the indication of use and the count left in the medication card. The observation also included 2 empty medication cards of 2 additional residents with residents' names, names of the medications and the directions of use for the medication. There was no nurse attending the medication cart. Two staff members and one resident walked by the unattended medication cart while the medical information was visible.On 09/19/25 at 8:54 AM Nurse #3 arrived at the 500-hall medication cart. The Nurse was asked about the open narcotic book and 2 medication cards left on top of the medication cart and immediately closed the book and stated she forgot to close the narcotic book, and she was going to reorder the medication from the pharmacy. The Nurse explained that she should not have left the medical information on top of the medication cart for the public to see because it was a violation of the residents' privacy and confidentiality.An interview was conducted with the Director of Nursing (DON) with the Administrator present at 6:00 PM on 09/19/25. The DON indicated that it was a HIPAA (health insurance portability and accountability act) violation to leave the residents' medical information unattended and accessible for the public to see. The staff were educated on HIPAA during orientation and yearly afterwards and Nurse #3 should not have left the information visible to the public on top of the medication cart.

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure the residents' clothing was stored in a sanitary manner in the laundry room inside the facility and failed to ensure the laundry room outside the facility was free of dust. Additionally, the facility failed to ensure a pill crusher's surfaces were free from what appeared to be a dried light brown liquid substance on the end of the pill crusher and had dark brown particles embedded in the dried liquid. The deficient practice affected 2 of 2 laundry rooms and 1 of 4 pill crushers (100 hall) reviewed for safe, clean and homelike environment.The findings included:1a. On [DATE] at 4:00 PM an observation was made of the laundry room that was in a building separate from the facility where the facility laundered the linen and residents' personal clothing. The observation yielded strings of dust hanging off dryer #2 and the tops of the two washers were dusty as evidence by fingerprints being left on the tops of the washers when touched. The clean side of the laundry room had linens and residents' personal clothing stored on the worktable with a stack of base board trim thick with dust being stored on a shelf above the worktable that the residents' personal clothing was stored on.An interview was conducted with the Environmental Services Supervisor on [DATE] at 4:00 PM. The Supervisor explained that the laundry room should be cleaned every day by the laundry aid on duty which included dusting the equipment in the laundry room. The Supervisor stated the separate laundry room tended to be a storage place for the facility and old furniture and personal items of residents that have expired and stated the items should not be stored near the clean laundry.An interview was conducted with the Administrator on [DATE] at 6:00 PM. The Administrator explained that she expected the laundry room separate from the facility to be cleaned the same as the laundry room inside the facility. She stated she did not routinely tour the laundry room in the separate building, but she would make that a routine.b. On [DATE] at 4:10 PM an observation was made of the laundry room inside the facility accompanied by the Environmental Services Supervisor. The observation yielded a housekeeping cart stored next to a rack of residents' personal clothing that had been laundered and ready for transport. The Supervisor explained that the housekeepers store their housekeeping carts in the space next to the rack of residents' personal clothes after they were finished with their housekeeping duties for their shift. The Supervisor stated the housekeeping carts were not deep cleaned every day but if they were visibly soiled then they were wiped down. The Supervisor stated she would wash the residents' clothing again and put a cover over them until they were ready to be taken to the residents.During an interview with the Administrator on [DATE] at 6:00 PM the Administrator explained that she did not routinely tour the laundry room enough to notice the housekeeping carts being parked next to the residents' personal clothing, but she would increase her surveillance of the laundry rooms. The Administrator indicated that the housekeeping carts should not have been stored near the residents clean clothing. She stated the rack of clothes should have been put in another room or the rack of clothing should have been covered to prevent them coming in contact with the housekeeping cart. 2. On [DATE] at 9:16 AM an observation was made of the pill crusher on the 100-hall medication cart. The pill crusher had what appeared to be a dried light brown liquid substance on the end of the pill crusher and had dark brown particles embedded in the dried liquid. On both sides of the crusher there was dark brown debris deep in the crevices that looked like dirt. An interview was conducted with the Wound Nurse on [DATE] at 2:20 PM. The Wound Nurse who was assigned to the 100-hall medication cart on [DATE] first shift was asked who was responsible for cleaning the medication carts and pill crushers and the Wound Nurse stated the nurse on the hall was responsible for cleaning the pill crushers. The Wound Nurse was shown the pill crusher on the 100-hall medication cart and stated it looked like it had been a long time since it was cleaned and needed to be cleaned. She stated every nurse should wipe down the pill crushers along with the medication cart before they leave the shift.An interview was conducted with Nurse #1 on [DATE] at 11:50 AM who was scheduled to work on 100-hall medication cart. Nurse #1 was asked who was responsible for cleaning the medication carts and pill crushers and the Nurse explained that each nurse should keep the medication carts clean. The Nurse was shown the pill crusher on the 100-hall medication cart, and she stated that it looked like it had not been cleaned in a long time. Nurse #1 stated she would clean the pill crusher.An interview was conducted with the Director of Nursing (DON) on [DATE] at 6:00 PM. The DON indicated that cleaning the pill crusher was part of cleaning the medication cart and it should be done by the weekend supervisor.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 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 observation, record review, and staff and Medical Director interviews, the facility failed to protect a resident's right to be free from physical abuse when an employee (Staff #13) slapped Resident #44 on the hand with an open hand during care. This deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #44).Findings included:Resident #44 was admitted to the facility on [DATE]. Her diagnoses included dementia, anxiety.A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #44 had severe cognitive impairment. The MDS documented that she did not have behaviors or rejection of care. The MDS reported she was incontinent of bladder, required staff assistance with activities of daily living (ADL), and was dependent on staff for personal hygiene and toileting. A care plan revised on 4/9/25 for impaired mobility, Activity of Daily Living (ADL) deficit related to dementia and debility was in place. The care plan interventions included Resident #44 required assistance with most ADL and that the amount of assistance needed varied from task to task and day to day. The care plan included that Resident #44 was usually combative and frequently refused care. A care plan revised on 4/9/25 for potential for impaired skin integrity was in place. The care plan interventions included cleanse peri-area in the morning and evening and following each episode of incontinence episode. A care plan revised on 4/9/25 was in place for behavior problems, refusing care, screaming related to dementia. The care plan interventions included explaining all procedures before starting and allow to adjust to changes. Approach/ speak in a calm manner, divert attention, remove from situation and take to alternate location as needed. Praise for appropriate behavior. Caregivers to provide opportunities for positive interaction, attention. A care plan revised on 4/9/25 was in place for impaired thought process related to dementia, anxiety, depression with behaviors, and combative with care. The care plan interventions included offer verbal reassurance, use touch for reassurance as appropriate, reassure that situation must be difficult, talk to resident during care.Review of a facility reportable incident indicated on 5/28/25 Nurse Aide (NA) #12 reported to Nurse #13 during shift change at 11:00 PM that she witnessed Staff #13 hit Resident #44 during care. The report did not state what time the alleged abuse occurred on 5/28/25 or what type of care was being provided when it occurred. The report stated Nurse #13 reported the abuse allegation to the Director of Nursing the following morning on 5/29/25. The facility reported the incident to the local police department and state agency on 5/29/25 after they became aware of the alleged abuse allegation. The facility investigation revealed NA #12, Staff #13, and Nurse #13 were interviewed by the Director of Nursing. The investigation revealed Staff #13 admitted to hitting Resident #44 during care. The abuse allegation was substantiated by the facility and Staff #13 was terminated on 6/2/25. The report indicated the facility reported Staff #13 to the health care personnel investigations.An interview was conducted on 9/16/25 at 3:02 PM with Nurse Aide (NA) #12. She recalled the incident from 5/28/25 with Resident #44 and Staff #13. NA #12 stated between 8:00 and 9:00 PM she and Staff #13 entered Resident #44's room to provide incontinence care. She said they were in her room for about 10 minutes providing care. NA #12 reported she was on one side of Resident #44's bed and Staff #13 was on the other side of the bed. She reported Resident #44 had been sleeping when they entered the room and had just been woken up. She said when they began to provide incontinence care Resident #44 started saying stop, no, and was pushing their hands away. She stated Staff #13 got really angry at Resident #44 and she was not sure why Staff #13 had gotten angry. NA #12 reported Staff #13 grabbed both of Resident #44's wrists and yelled at her to stop and then slapped Resident #44 on the hand. She did not remember which one of Resident #44's hands Staff #13 slapped but said she had slapped her with an open hand. She reported she did not remember seeing any mark on Resident #44's hand after Staff #13 slapped her but said she had not looked. NA #12 said Resident #44 acted startled when Staff #13 slapped her on the hand, she said she thought Resident #44 had yelled out when Staff #13 slapped her. NA #12 said she was not sure if Resident #44 was scared in the moment but afterwards Resident #44 acted differently and scared when people came into her room. She explained Resident #44 would ask a lot of questions like what are you going to do, what are you doing in here and acted suspicious of what staff were doing or going to do. NA #12 said they had been about halfway through care when the incident occurred. She reported they had finished providing incontinence care and then left the room. She did not know what Staff #13 did after leaving the room or where she went. NA #12 said she reported the incident to Nurse #13 at the end of her shift at 11:00 PM.An interview was conducted on 9/16/25 at 3:10 PM with Nurse #13. She recalled the incident on 5/28/25

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 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 staff interviews, the facility failed to implement their abuse policy and procedure in the areas of prevention, protection, reporting, and investigating. The facility failed to immediately implement protection and report abuse when Nurse Aide (NA) #12 witnessed Staff #13 grab both of Resident #44's wrists followed by slapping the resident's hand during care on 5/28/25 between 8:00 PM and 9:00 PM and did not immediately intervene and report the abuse to administration. Staff #13 continued to provide resident care to Resident #44 and worked on the floor for the remainder of her shift. On 5/28/25 at approximately 11:00 PM NA #12 reported the incident to Nurse #13 and Nurse #7 and the administration was not notified of the incident until the following morning (5/29/25) when Nurse #13 reported the allegation to the Director of Nursing (DON). The facility failed to thoroughly investigate the allegation of abuse when they did not interview or assess other residents who had the potential to be abused by Staff #13. This deficient practice affected 1 of 3 residents reviewed for abuse and had the potential to affect other facility residents (Resident #44). Findings included: A policy and procedure dated 3/17 entitled Resident Rights, Resident Abuse indicated the policy prohibited abuse neglect, and exploitation of residents and misappropriation of resident property. The policy included the following information:- Physical abuse included hitting, slapping, pinching, and kicking. -Prevention: the facility tries to identify, correct, and intervene in situations in which abuse is more likely to occur by having trained, qualified, registered, licensed, and certified staff in sufficient numbers to meet the needs of the residents. -Investigation: anyone who witnesses or has knowledge of an act or suspected act of abuse shall notify his/ her charge nurse, immediate supervisor, Director of Nursing, Social Services, Administrator, or any other management personnel that they feel comfortable reporting to. Once management personnel have received such a report they shall go immediately to the Administrator, DON, or Social Service Director, who will start the investigation process.- The facility will report allegations of resident abuse immediately but not later than 2 hours after the allegation is made. - The facility will collect statements from each witness, resident victim, and alleged perpetrator; and interview other residents in the same location where the alleged violation occurred.-Protection: The facility will protect the residents and other residents from further acts of abuse; protection could include responding immediately to protect the alleged victim. Resident #44 was admitted to the facility on [DATE]. Her diagnoses included dementia. A facility reportable incident investigation report dated 6/4/25 had been prepared by the Assistant Director of Nursing (ADON). The investigation report indicated the facility had become aware of the abuse allegation on 5/29/25 and submitted an initial allegation report to the State agency. The investigation stated on 5/28/25 NA #12 reported to Nurse #13 during shift change at 11:00 PM that she witnessed Staff #13 hit Resident #44 during care. The report did not state what time the alleged abuse occurred on 5/28/25. The report stated Nurse #13 reported the abuse allegation to the DON the following morning on 5/29/25. The facility reported the incident to the local police department and State Agency on 5/29/25 after they became aware of the alleged abuse allegation. The investigation revealed NA #12, Staff #13, and Nurse #13 were interviewed by the DON. The facility investigation did not indicate if the facility assessed or interviewed other residents regarding abuse that Staff #13 had provided care for. The investigation revealed Staff #13 admitted to hitting Resident #44 during care. The abuse allegation was substantiated by the facility and Staff #13 was terminated on 6/2/25. The allegation was reported to the local department of social services on 6/2/25.Review of Staff #13's time record indicated she left at the end of her shift on 5/28/25 at 11:05 PM. There were no recorded time punches after 5/28/25. Staff #13 was not available for interview. An interview was conducted on 9/16/25 at 3:02 PM with Nurse Aide (NA) #12. She recalled the incident from 5/28/25 with Resident #44 and Staff #13. NA #12 stated between 8:00 and 9:00 PM she and Staff #13 entered Resident #44's room to provide incontinence care. She said they were in her room for about 10 minutes providing care. She said when they began to provide incontinence care Resident #44 started saying stop, no, and was pushing their hands away. NA #12 reported Staff #13 grabbed both of Resident #44's wrists and yelled at her to stop and then slapped Resident #44 on the hand. She did not remember which one of Resident #44's hands Staff #13 slapped but said she had slapped her with an open hand. NA #12 said they had been about halfway through care when the incident occurred. She reported they finished providing incontinence care and then left the room. She did not know what Staff #13 did after leaving the room or where she went. NA #12 said she reported the incident to Nurse #13 at the end of her shift at 11:00 PM. She stated the oncoming shift nurse

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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) in the areas of Preadmission Screening and Resident Review (PASRR) Level II (Resident #4 and Resident #2) and Pressure Wound (Resident #2) for 2 of 19 residents reviewed for MDS accuracy (Resident #2 and Resident #4). The findings included: 1. Resident #4 was admitted to the facility on [DATE]. Her active diagnoses included bipolar disorder. Resident #4's electronic health record contained a PASRR Level II determination notification dated 12/07/23 with no end date. The annual MDS dated [DATE] indicated Resident #4 was not coded for Level II PASRR. An interview on 9/17/25 at 8:21 AM with MDS Nurse #1 revealed Resident #4's PASRR was coded as Level I and should have been coded as Level II. She stated it was a human error mistake. An interview on 9/18/25 at 11:40 AM with the Administrator revealed she did not know why Resident #4's PASRR was coded as Level I when it should have been coded as Level II. She stated it must have been a coding error. 2.Resident #2 was admitted on [DATE] with an active diagnosis of bipolar disorder. A review of Resident #2's electronic health record found a PASRR Level II determination notification dated 6/12/23 with no end date. A review of Resident #2's Annual Minimum Data Set (MDS) dated [DATE] found she was not coded for Level II PASRR. An interview with MDS Nurse #1 was conducted on 9/19/25 at 12:41 PM. MDS Nurse #1 stated Resident #2 has a level II PASARR determination and should have been coded for a level II PASARR on her annual MDS assessment. The Administrator was interviewed on 9/19/25 at 4:40 PM. The Administrator stated Resident #2's annual MDS should have coded the level II PASARR. The Administrator said the level I PASARR was coded in error. 3.Resident #2 was admitted on [DATE] with diagnoses of vascular dementia and hemiparesis and hemiplegia of left side following a stroke. A review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] coded Resident #2 as having 1 stage 1 pressure ulcer. A review of Resident #2's electronic health record found Resident #2 developed a pressure ulcer on 9/5/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MDS Nurse #1 was conducted on 9/19/25 at 12:41 PM. MDS Nurse #1 stated Resident #2 did not have a pressure wound when the quarterly MDS was completed 9/2/25. She stated Resident #2 should not have been coded for a pressure wound and it was an input error. The Administrator stated on 9/19/25 at 4:40 PM Resident #2's MDS should accurately reflect her conditions. The Administrator stated Resident #2 should not have been coded for a pressure wound, and it was an error.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation, and staff interviews, the facility failed to revise the care plan in the area of pressure ulcers (Resident #8) for 1 of 3 residents reviewed for pressure ulcers. The findings included:Resident #8 was admitted to the facility on [DATE] with diagnoses that included history of cerebral vascular accident (CVA) and diabetes mellitus.Review of Resident #8's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident's cognition was severely impaired, required substantial to maximal assistance with most of her activities of daily living and she did not have pressure ulcers on admission.Review of Resident #8's care plan dated 07/31/25 revealed Resident #8 had the potential for impaired skin integrity related to decreased mobility, incontinence and poor appetite. The goal that Resident #8 would maintain skin integrity as evidence by no development of pressure ulcers or peri area excoriation through the next review. The goal would be attained by utilizing interventions such as assisting and turning frequently, monitoring her skin for any open areas and notifying the nurse immediately and providing treatments as ordered.Review of Resident #8's medical record revealed a progress note dated 09/09/25 at 11:56 AM written by the Wound Nurse read in part.an unstageable wound was found to Resident #8's right heel of black eschar and measuring 3.5 centimeters (cm) x 3.5 cm with foul smelling odor. Obtained new treatment orders and to wear soft boot at all times. The note also revealed the Medical Director was notified and orders were received to start an antibiotic, obtain an X-ray on the right heel and to obtain a Wound Consult.There was no revised care plan for the development of the unstageable pressure ulcer to Resident #8's right heel.An interview was conducted with the Minimum Data Set (MDS) Nurse # 1 on 09/19/25 at 2:25 PM. The MDS Nurse explained that the care plans were updated quarterly and as needed when situations arise. She continued to explain that pressure ulcer development was an issue that was care planned pretty quick because the nurses were good to inform us on those developments and we will revise the care plan. She also indicated that she was informed of new pressure ulcer developments in the morning clinical meeting and she will update the care plan when she returned to her office. The MDS Nurse continued to explain that she vaguely remembered learning of Resident #8's new pressure ulcer in the morning clinical meeting but somewhere between the meeting room and her office she had forgotten to update the care plan. The MDS Nurse stated it was important for the care plan to be updated to reflect the Resident's status so that appropriate care can be delivered.On 09/19/25 at 6:00 PM an interview was conducted with the Administrator who explained that it was the MDS Nurses' responsibility to revise the care plans for new developments including new pressure ulcers right away in order to deliver quality care to the residents. The Administrator indicated it was her expectation that the care plans be revised as soon as issues arise.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and resident interviews, the facility failed to provide activity of daily living (ADL) care for dependent residents when Resident #28 and Resident #11 did not receive showers. This deficient practice affected 2 of 4 residents reviewed for ADL care (Resident #28 and Resident #11). Findings included:a. Resident #28 was admitted to the facility on [DATE]. His diagnoses included muscle weakness, difficulty walking, age related physical disability, osteoarthritis, cerebral infarction (stroke), and intervertebral disc disorder (spine disorder that can lead to back problems that can cause pain, numbness and weakness in the legs or arms). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #28 was cognitively intact. The MDS stated he required supervision and touching assistance with showers. He used a wheelchair and needed setup/ clean up assistance with feeding and oral hygiene. The MDS documented Resident #28 did not have behaviors or rejection of care. A care plan last revised on 6/25/25 was in place for impaired mobility and ADL deficit related to debility and muscle weakness. The care plan goal was for Resident #28 to maintain current mobility and ADL status through the next review. The care plan interventions included assisting with hygiene by setting up supplies and assisting as needed to complete tasks. The care plan included he used a wheelchair for mobility and could usually dress himself. He had a fall risk care plan last revised on 6/25/25 in place related to debility, weakness, and cardiac medications that said to give verbal reminders to not transfer without assist when feeling weak and unsteady. Resident #28's scheduled shower days were on Monday and Thursday. The last time a shower was documented as provided was 9/11/25. Review of shower sheets revealed there was no documentation Resident #28 received a shower on 8/4/25, 8/18/25, 8/21/25, 9/8/25.An interview and observation were conducted on 9/15/25 at 3:49 PM with Resident #28. He stated that he did not receive showers often at the facility because they were short of help. He explained that the shower team Nurse Aides (NAs) were pulled to work on the floor when the facility was short staffed or there were call outs. Resident #28 stated this happened frequently and when it happened showers were not given, and he did not get his showers. He said the facility did not give showers the next day to make up the shower if it was missed. He explained if he missed a shower he had to wait until his next scheduled shower day to get a shower if they had staff to do it. Resident #28's hair was trimmed short; there was no body odor noted. b. Resident #11 was admitted to the facility on [DATE]. With diagnoses that included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle weakness, need for assistance with personal care, abnormalities of gait and mobility, transient ischemic attack (TIA) (temporary episode of stroke-like symptoms)A significant change MDS assessment dated [DATE] indicated Resident #11 had moderate cognitive impairment. The MDS recorded she was dependent on staff for showers. The MDS documented Resident #11 did not have behaviors or rejection of care.A care plan revised on 7/25/25 was in place for impaired mobility and ADL deficit related to TIA with right sided weakness, debility, and fractured left ankle. The care plan interventions included Resident will do as able, if unable to complete task assist resident to finish them.Resident #11 was supposed to receive a shower on Mondays and Thursdays. The last time a shower was documented as provided was 8/25/25. Review of shower sheets revealed there was no documentation Resident #11 received a shower on 8/4/25, 8/14/25, 8/18/25, 8/21/25, 9/1/25, 9/4/25, 9/8/25, 9/11/25An observation and interview were conducted with Resident #11 9/15/25 at 11:30 AM she stated recently she had not been getting showers. She was observed in her bed, her hair was uncombed and greasy, there was no odor noted. An interview was conducted on 9/16/25 at 11:26 AM with the shower team, NA #1 and NA #3. They explained the facility had one shower team and they were the only shower team NAs. They further explained they both worked Monday, Tuesday, Thursday, and Friday from 7:00 AM to 5:00 PM. They said residents were supposed to receive two showers a week. The shower team NAs reported all the residents on halls 100, 200, and 300 were supposed to receive a shower every Tuesday and Friday and all the residents on halls 400, 500, and 600 were supposed to receive a shower every Monday and Thursday. NA #1 and NA #3 stated on average they each gave 15 to 17 showers every shower day. NA #1 and NA #3 reported last week they had been pulled 3 out of 4 of the days they were supposed to give showers to work on the floor and that over the last couple of weeks it had been the same. NA #1 said yesterday (9/15/25) both her and NA #3 had been pulled to the floor to work, and no showers were given. NA #1 stated today (9/16/25) one of them was

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with staff, Wound Nurse Practitioner, Nurse Practitioner (NP), and Medical Diractor the facility failed to provide skin assessments, failed to identify a new wound on the heel at the onset, and failed to ensure necessary medical treatment when positive culture and sensitivity results were available Resident #2. This delayed the treatment for an infected wound. This was for 1 of 2 residents (Resident #2) reviewed for quality of care. Findings included:The findings included:Resident #2 was admitted on [DATE] with diagnoses of vascular dementia and hemiparesis (one-sided muscle weakness) and hemiplegia (one-sided paralysis or weakness of the face, arm and leg) of left side following a stroke. A review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] coded her with severe cognitive impairment. Resident #2 was coded for one (1) stage one pressure ulcer, needing maximal assist with rolling, and total dependence on transfers. Resident #2 was care planned for do not resuscitate with comfort measures(1/24/25). Interventions included to notify the residents family and MD if resident condition worsened (7/4/24). A care plan for skin related to hemiplegia and wound on bottom (4/24/25). Interventions included excoriation on buttocks treated with zinc (3/27/25), air overlay discontinued per resident request (3/27/25), assist and turn frequently (7/9/24), cleanse peri area in AM and PM following each episode of incontinence episode (7/9/24), follow in- house wound care(7/9/24), cushion to chair and panacea mattress(pressure reducing mattress) to bed (1/2/25), monitor nutrition (7/9/24), and monitor skin for any redden or open areas. Notify nurse immediately (7/9/24). A review of Resident #2's medical record found there were no weekly skin assessments documented for Resident #2. On 9/5/25 the Medical Director saw Resident #2 and his progress note was reviewed. The Medical Director wrote there was a 5-centimeter (cm) erythematous plaque (raised, flat skin area that is red in color) on Resident #2's upper left back and a similar wound on her sacrum. The Medical Director wrote the chronicity and characteristics of the wounds suggested a potential for infection and poor healing. The plan from the Medical Director was to consult wound care specialist for further evaluation and treatment recommendations and ordered alginate (dressing used to keep wound moist for healing) dressing for wound management on both wounds. A review of Resident #2's September 2025 physician orders included an order dated 9/8/25 to float heels every shift. On 9/18/25 at 4:10 PM a Nurse Aide (NA) #3 who was on the shower team was interviewed. She stated Resident #2 had received a shower on 9/9/25, and she completed a skin assessment for Resident #2. NA #3 said Resident #2 did not have an open wound on her left heel, but only a red area on it. NA #3 stated she communicated the red area to Resident #2's assigned nurse on the second shift. Resident #2's assigned second shift nurse on 9/9/25, Nurse #6, was interviewed on 9/18/25 at 5:12 PM. Nurse # 6 stated she did not recall NA #3 telling her about a red area on Resident #2's left heel on 9/9/25. Nurse #6 stated she became aware of the left heel wound on 9/10/25 from the Wound Nurse. A progress note written by Wound Nurse dated 9/10/25 at 2:05 PM wrote she found an open area on Resident #2's left heel. The note read the open area was unstageable and measured 2 (cm) x 1.5 (cm). The Wound Nurse wrote the area around the open area was red with blanchable redness. The wound did not contain an odor, and the area was cleaned and a dressing was applied. On 9/18/25 at 1:15 PM the Wound Nurse was interviewed. The Wound Nurse stated she first saw Resident #2's heel wound on 9/10/25 and documented the wound in a progress note. The left heel wound measured 2(cm) x 1.5 (cm) and did not contain an odor or drainage. The Wound Nurse said she treated the left heel wound with standing wound orders and notified the Wound Nurse Practitioner the following day, as she was scheduled to be in the facility. Additionally, she thought she had communicated the wound to the medical provider when she found it 9/10/25.On 9/11/25 the Wound Nurse Practitioner evaluated the left heel dorsal wound. The Wound Nurse Practitioner treatment note read that given the dorsal location of this wound, it was consistent with a diabetic etiology. The wound was deep and full of necrotic slough (dead tissue) and suspected the wound had been present for some time. The treatment note also included the estimated depth to bone was less than 2 millimeters. Additionally, the Wound Nurse Practitioner wrote that a medically necessary sharp debridement was indicated and performed for the removal of excessive necrotic tissue and for the promotion of wound healing. The note continued with treatment orders to cleanse left heel wound with a full-strength antiseptic solution and then apply full strength (0.5%) antiseptic solution moistened gauze to the full depth of the wound bed. Finally, the wound was to be covered with a silicone bordered super absorbent dressing. The treatment was to be completed daily and

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews with the Wound Care Nurse Practitioner, Medical Director and staff, the facility failed to obtain treatment orders for two (2) pressures ulcers (Resident #8 and Resident #16) when first identified resulting in numerous days that the pressure ulcers went without treatment and worsening to unstageable for Resident #8 and a stage 2 for Resident #16. Resident #8's pressure ulcer was first identified on 08/22/25 as a red open area but an assessment or treatment was not documented. The pressure ulcer was later identified on 09/04/25 and treatment was initiated but no assessment was documented. The pressure ulcer was assessed and documented on 09/09/25 as unstageable wound to the right heel with black eschar (dry, black, or brown crust that forms on the surface of wounds) with foul odor and measuring 3.5 centimeters (cm) by 3.5 cm. The facility failed to routinely assess Resident #16 for being at risk of pressure ulcer, failed to implement measures to prevent Resident #16 from developing a pressure ulcer and then failed to provide ongoing assessment and treatment for Resident #16's pressure ulcer. Resident #16 was identified on 8/31/25 to have a stage 2 pressure wound to the back of his right thigh, there were no wound measurements completed until 9/3/25. After 9/3/25 there was no assessment or measurement documented for the wound. Resident #16 had an initial treatment order entered on 8/31/25 for his stage 2 pressure ulcer that was for 7 days and stopped on 9/7/25. After 9/7/25 there were no additional treatment orders for the wound. The facility failed to complete accurate head to toe skin assessments to identify new or existing pressure ulcers that include the location, type of wound, length, width, depth, and stage of pressure ulcers. This deficient practice occurred for 2 of 3 residents reviewed for pressure ulcers (Resident #8 and Resident #16). The findings included: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses that included history of cerebral vascular accident (CVA) and diabetes mellitus. Review of Resident #8's admission Nursing assessment dated [DATE] written by Nurse #5 revealed there were no pressure ulcers identified on the assessment. An interview was conducted with Nurse #5 on 09/19/25 at 5:10 PM. The Nurse confirmed that he conducted the admission nursing assessment on Resident #8 on 07/17/25 and explained that he did not recall any issues with pressure ulcers on her heels or anywhere on her body. Review of Resident #8's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident's cognition was severely impaired, required substantial to maximal assistance with most of her activities of daily living and she did not have pressure ulcers on admission. Review of Resident #8's care plan dated 07/31/25 revealed Resident #8 had the potential for impaired skin integrity related to decreased mobility, incontinence and poor appetite. The goal that Resident #8 would maintain skin integrity as evidence by no development of pressure ulcers or peri area excoriation through the next review. The goal would be attained by utilizing interventions such as assisting and turning frequently, monitoring her skin for any open areas and notifying the nurse immediately and providing treatments as ordered. Review of Resident #8's medical record for skin assessment documentation from admission on [DATE] to present 09/19/25 revealed there were no skin assessments documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #8's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for July 2025 and August 2025 revealed there were no treatments set up for pressure ulcers on the MARs or TARs. An interview was conducted with Nurse Aide (NA) #1 on 09/18/25 at 2:35 PM. The NA explained that on 08/22/25 she was preparing to give Resident #8 her shower when she tried to remove her right sock, but it was stuck to her heel and would not come off until she wet the sock first. She noted a red raw area approximately the size of a quarter on her right heel and there was bloody hard (dried) drainage on the sock. The NA remarked she showered Resident #8 on 08/15/25 and there were no issues with her heels. The NA got Nurse #1 to come to the shower room where she observed Resident #8's right heel and put a dressing over the heel as well as obtained a heel protector to put on after she finished the shower which the NA completed. An interview was conducted with Nurse #1 on 09/18/25 at 4:10 PM and 09/18/25 at 5:30 PM. The Nurse explained that she remembered NA #1 asking her to come to the shower room on 08/22/25 where NA #1 showed her Resident #8's right heel. The wound was pink, and she could not remember if there was drainage. The Nurse continued to explain that she applied a dry foam dressing to the heel and put a note on the board in the medication room for the Wound Nurse #4 to see the next day. The Nurse stated she did not put a note in the wound communication book because she did not know about the wound communication book. The Nurse continued to explain that she did not assess, measure the pressure ulcer or notify the Medical Director of the pressure ulcer because she thought the Wound Nurse would do it on her follow up. On 09/18/25 at 8:45 AM an interview was conducted with NA #5 who explained that on the night of 09/04/25 she noted an area of drainage on Resident #8's bed sheet while she was providing care to the Resident and when she tried to remove the Resident's right sock, the sock was stuck to her heel. The NA stated she got Nurse #7, and the Nurse cleansed Resident #8's right heel and applied a dressing on her heel. During an interview with Nurse #7 on 09/18/25 at 8:50 AM the Nurse explained that on the night of 09/04/25 NA #5 reported that she could not get Resident #8's sock off her right heel because it was stuck to her heel. The Nurse stated she had to soak the Resident's right heel with wound cleanser in order to remove the sock. The Nurse continued to explain that Resident #8's right heel had a blood-filled blister that was not open, and the area looked like the skin was layered. The Nurse reported that she applied a foam dressing to the Resident's right heel and applied heel protectors to Resident #8' feet and wrote orders to clean open area to right heel with wound cleanser and apply border foam every two days and apply heel protectors while in bed. Nurse #7 also reported that she put a note in the wound communication book for follow up and reported the pressure ulcer to the Assistant Director of Nursing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with the Assistant Director of Nursing (ADON) on 09/19/25 at 5:43 PM the ADON explained that she could not remember the exact day she found out about Resident #8's pressure ulcer but when she did become aware of it she went to see it and before she got to the Resident's door she could smell the foul odor coming from the Resident's room. The ADON stated that she obtained an order from the MD for an antibiotic, and the Wound Nurse came in the next day (09/09/25) and got an order for crushed metronidazole (antibiotic) to be applied to the pressure ulcer to control the odor. The ADON continued to explain that the nurses do not do routine skin assessments, but the Wound Nurse used to do them quarterly and she would inform the management team about them in the morning meeting if she knew about them. the ADON indicated the nurses depended on the shower team to inform them of the skin issues, and the nurses should follow up on them. An interview was conducted with the Wound Nurse on 09/18/25 at 11:45 AM and 09/19/25 at 7:30 AM. The Wound Nurse explained that she first became aware of Resident #8's right heel pressure ulcer on 09/09/25. The pressure ulcer was unstageable with black eschar, malodorous and measured 3.5 cm x 3.5 cm. The Wound Nurse continued to explain that the pressure ulcer had a treatment set up but when she noted that it was black with hard eschar and the drainage was malodorous, she decided to notify the MD and asked for crushed metronidazole which was what she normally did with a malodorous ulcer. The MD also ordered an X-ray to rule out osteomyelitis which was negative. The Wound Nurse stated she also obtained an order for a wound consult and Resident #8 was seen by the Wound Care Nurse Practitioner on 09/11/25. The Wound Nurse reported that she did not see the note on the board in the medication room left by Nurse #1 on 08/22/25. She stated that 08/22/25 was a Friday and she did not work on Fridays and neither did she work on the weekends. The Wound Nurse stated the next time she would have seen the note would be on 08/25/25 and that was if she worked on the medication cart that was parked in front of the board in the medication room. She indicated the best place to put notes about pressure ulcers was in the wound communication book and she would see them when she worked as the Wound Nurse. Review of Resident #8's MAR and TAR for September 2025 revealed orders for: -09/09/25 ceftriaxone sodium (antibiotic) 1 gram intramuscularly one time a day for 7 days for wound infection. -09/10/25 metronidazole (antibiotic) 500 milligrams (mg) crush tablet and apply to right heel wound bed every day for wound infection. Review of Resident #8's September 2025 MAR and TAR revealed the orders for the heel protector and foam boarder dressing were initialed as completed. Review of a Wound Care Consult dated 09/11/25 provided by the Wound Care Nurse Practitioner revealed Resident #8 had a pressure ulcer to her right heel measuring 3.5 cm x 3.0 cm x 1.0 cm with 30% black necrotic tissue that was unstageable and had no drainage and no odor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview conducted with the Wound Care Nurse Practitioner 09/19/25 at 1:30 PM. The Wound Care Nurse Practitioner explained that she had consulted on Resident #8's right heel twice with the first time being on 09/11/25 and she found the wound having black necrotic tissue and no drainage that she could recall. She stated that the pressure ulcer was not at the point of needing debridement (surgical removal of dead tissue), but she anticipated that would need to occur. The Wound Care Nurse Practitioner reported she could not say if the pressure ulcer was avoidable or unavoidable because of company policy but she did disclose that she did not feel the pressure ulcer was chronic. On 09/16/25 at 2:49 PM an observation of Resident #8's right heel pressure ulcer treatment was conducted and performed by the Wound Nurse. The pressure ulcer was approximately the size of a fifty-cent piece with black eschar. A raw area approximately the size of a pea was noted in the eschar. On 09/19/25 at 6:00 PM an interview was conducted with the Director of Nursing (DON) with the Administrator present. The DON explained that there were standing orders for wound care and when the pressure ulcer was first noted on Resident #8 the standing order should have been set up with specific treatment, and the physician should have been notified in case there were further orders to be followed. She stated the pressure ulcer should have been assessed, measured and documented on weekly through wound assessments in order to follow whether the pressure ulcer improved or worsened in case the treatment needed to be changed. The DON indicated skin assessments were done monthly on normal skin and the shower team should notify the nurses if they discovered any skin issues in between. The DON stated she did not know why Nurse #1 did not initiate the standing orders for the pressure ulcer because she had been at the facility for a number of years. The Administrator also stated Nurse #1 should have initiated the standing orders for the pressure ulcer because if she had, it was possible that the pressure ulcer would not have gotten to the point it was and if Resident #8 had gotten the services she needed the pressure ulcer could have been healed by now. During interviews with the Medical Director on 09/18/25 at 10:25 AM and 09/19/25 at 3:08 PM. The Medical Director explained that he was first made aware of Resident #8's right heel pressure ulcer when the Wound Nurse called and reported it on 09/09/25. He reported that he ordered crushed metronidazole to be applied to the wound daily for the malodor and to follow up with a wound consultation. The Medical Director also stated that based on the description by the Wound Nurse he ordered an X-ray to rule out osteomyelitis (infection in the bone) which was negative. The Medical Director was not informed of the pressure ulcer first being discovered on 08/22/25 and no orders were obtained to follow up with treatment and the Medical Director stated that it was unfortunate because if the orders had been initiated then the pressure ulcer may not have gotten to the point it had. The Medical Director remarked that he considered the pressure ulcer to be considered avoidable. 2. Resident #16 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle wasting and atrophy, muscle weakness. A care plan dated 7/1/24 for skin was in place. The care plan goals were for Resident #16 to maintain skin integrity as evidence by no development of pressure ulcers or peri-excoriation through the next review date. The care plan interventions included: float heels while sleeping, pressure relief cushion to wheelchair or recliner, monitor skin for any reddened open areas, monitor nutrition, use recliner for sleep and to reduce pressure, treatments as/if ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Braden scale assessment (assessment for predicting pressure ulcer risk) dated 2/18/25 indicated Resident #16 was at risk for developing pressure ulcers. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 was cognitively intact. The MDS documented he had impairment of his upper and lower extremities on one side. The MDS indicated he was independent with his activity of daily living (ADL) tasks and mobility but required partial/ moderate assistance with showers. The MDS documented that he did not have a pressure ulcer but that he was at risk for developing a pressure ulcer. The MDS further documented that he had a pressure relieving device to his chair. An interview was conducted on 9/15/25 at 9:23 AM with Resident #16. He was observed resting in a recliner chair in his room. The recliner chair was observed in the reclined position and Resident #16 was positioned lying on his right side. The recliner chair was covered with a sheet and had a folded pad in the recliner seat. There was no cushion noted in the seat of his recliner. His wheelchair was positioned next to the recliner; a cushion was present in his wheelchair. Resident #16 stated he slept in his recliner chair and that was his preference. He reported he had a pressure ulcer to the back of his right thigh. A review of Resident #16's electronic medical record revealed that weekly skin assessments had not been completed. There were no skin assessments documented. A nursing note dated 8/31/25 by Nurse #8 read: “Nurse notified by resident of bleeding spot on the back of his thigh. Possible stage 2 pressure injury noted to right outer back thigh. Wound bed pink, scant red drainage noted on resident's reusable chuck on his manual wheelchair. No signs of infection. Nurse cleansed wound with wound cleanser, covered wound bed with silver alginate and covered with adhesive dressing. Resident will be added to acute book for this issue and nurse will enter wound care orders until wound care nurse can assess.” An order dated 8/31/25 was entered by Nurse #8 and read: Cleanse wound with wound cleanser, cover wound bed with silver alginate (highly absorbent wound dressing embedded with silver particles to fight infection), place dry adhesive dressing over wound, two times a day for pressure injury for 7 days. The order ended on 9/7/25. There were no additional wound care orders after 9/7/25. Review of the Treatment Administration Record (TAR) dated September 2025 revealed a twice daily treatment order that read, cleanse wound with wound cleanser, cover wound bed with silver alginate, place dry adhesive dressing over wound. for 7 days, started 8/31. The treatment was signed to indicate it was administered as ordered. The order stopped on 9/7/25. There was no additional treatment orders present on the TAR for the stage 2 pressure ulcer after 9/7/25. Review of the Wound Care communication book revealed on 8/31/25 Nurse #8 made a note about Resident #16 that read: “right posterior thigh stage 2 pressure injury”. There was a column labeled Wound Care Nurse initials. The notation was not initialed by the Wound Care Nurse. Facility wound care standing orders for a stage 2 pressure ulcer read, cleanse open area with wound cleanser and apply bordered foam dressing, change every 2 days and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nursing note dated 9/1/25 by Nurse #8 read: “Resident in acute book for stage 2 pressure injury to left posterior thigh. Dressing was removed. Wound bed is pink/beefy, scant dry drainage noted on dressing. No signs of infection present. Wound cleansed with wound cleanser, silver alginate placed on wound bed and wound covered with dry adhesive dressing. Will continue to monitor.” An additional nursing note dated 9/3/25 by Nurse # 8 read: Right posterior thigh pressure injury wound care completed as ordered: dressing removed, moderate amount of drainage present on dressing. Wound bed appears pink, beefy. No signs of infection present. Wound bed cleansed with wound cleanser. Wound measures 2 centimeters (cm) (length) x 1 cm (width). Wound bed covered with silver alginate and secured in place with adhesive dressing. Resident tolerated well.” There was no additional documentation in the medical record about Resident #16's pressure ulcer being assessed after 9/3/25. Resident #16 was not followed by the Wound Care Provider. An interview was conducted with Nurse #8 on 9/17/25 at 2:57 PM. She recalled finding the stage 2 pressure ulcer to the back of Resident #16's right thigh on 8/31/25. Nurse #8 stated Resident #16 told her he had a wound, and that the back of his leg was hurting. She remembered he had some bloody colored drainage on the pad in his chair. Nurse #8 reported she looked at the wound and recalled it was an open area to back of his right thigh. She remembered the wound bed was pink and the area was moist with a small amount of drainage. Nurse #8 stated she assumed the wound had come from the pad on his chair being folded and creating pressure. She said Resident #16 always slept in his recliner chair and had a folded pad in his recliner chair. Nurse #8 stated she did not measure the wound when she found it but had documented in a nursing note what she had seen. She explained she had planned to talk to the Wound Care Nurse (Nurse #4) the next day and that the Wound Care Nurse would assess the wound when she looked at it. Nurse #8 reported she did not talk to the Wound Care Nurse the next day but had left a note about Resident #16's wound in “the wound book” at the nursing station. Nurse #8 could not remember if she entered treatment orders for Resident #16's wound but said she probably did. Nurse #8 explained the facility protocol was for the nurse to enter an order for whatever was being used to treat the wound at that time until the Wound Care Nurse looked at the wound to see if it needed something else or a different treatment. Nurse #8 explained silver alginate was part of the facility's wound care standing order for stage 2 pressure ulcers and it was what she had seen other nurses put on those types of wounds. Nurse #8 further explained, there were not really standing orders for each piece of material that was used to treat a wound and that the standing orders were vague and not specific. Nurse #8 explained what she understood was the facility's process for wound care orders, she said nurses used their prior knowledge of what treatments they had seen work for wounds and from what wound care supplies the facility had on hand for wound dressings and then entered an order for that. She reported then the Wound Care Nurse would assess the wound and if she thought the treatment needed to be changed then she would change it. Nurse #8 stated there was not a weekly skin assessment scheduled or completed by staff. She reported there was not a process or schedule for nurses to perform routine skin assessments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Wound Care Nurse (Nurse #4) on 9/17/25 at 9:48 AM. The Wound Care stated she was supposed to do wounds but was usually not able to do them because she was being pulled to the floor/medication cart to work due to the facility being short staffed. The Wound Care stated over the last month she had been pulled almost every day she worked to work a medication cart on the floor. The Wound Care stated when she was pulled to work a floor assignment the nurse on the hall was responsible for doing wounds and the treatments for their assigned group of residents. She reported there was not a process in place at the facility where nurses did routine resident skin assessments. The Wound Care explained there was not a schedule or assigned skin assessments for residents that were done on a routine basis by the nurses. The Wound Care said other than the NAs looking at skin during showers and care there were no skin assessments and that the NAs were supposed to tell the nurses if they saw something. The Wound Care said she was not aware of Resident #16 having a pressure ulcer because she had been working on the floor/medication cart. She reported that she heard he may have a wound and said the nurse was going to look at it but that she had not looked at the wound. She did not remember who the nurse was. An interview was conducted with Assistant Director of Nursing (ADON) on 9/17/25 at 10:00 AM. She reported she was not aware of Resident #16 having a pressure ulcer or wound and that Wound Nurse was responsible for keeping up with who had wounds. An observation was completed on 9/17/25 at 10:49 AM with the ADON of Resident #16's wound. Resident #16 was observed in his room in his recliner chair. The chair was in the reclined position, and he was lying on his right side. The recliner chair was covered by a sheet, and a folded pad was in the seat the recliner. There was no cushion in the recliner seat. The ADON asked Resident #16 if he had a wound and he stated, “yes it's on the back side of my leg”. Resident #16 rolled onto his left side and pulled down his pants exposing the back of his right upper thigh. There was a dressing in place dated 9/14/25. The ADON removed the dressing and confirmed the dressing in place was xeroform (wound treatment) covered with a border gauze dressing. Resident #16 was observed to have an open area to the back of his right thigh, the wound bed was pink, the wound edges appeared rolled and thick, there was a small amount of yellow/ tan colored drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the ADON on 9/17/25 at 11:00 AM. The ADON reviewed the wound care communication book at the nursing station and reported Nurse #8 had made a note on 8/31/25 that Resident #16 had a stage 2 pressure ulcer to his right posterior (back) thigh. The ADON stated the note had not been reviewed by the Wound Care Nurse because it had not been initialed. The ADON reported she reviewed Resident #16's orders and stated Resident #16 had a treatment order for the stage 2 pressure ulcer entered on 8/31/25 for 7 days but that it had been discontinued after the 7 days. She did not know why the order was only for 7 days. The ADON explained the process for what was supposed to be done when a wound was found. She said the facility had standing orders for wound care. She stated when a wound was found the nurse was supposed to use the standing orders for wound care according to the type of wound that was identified. She said the nurse who found the wound was supposed to enter the order into the electronic computer system according to the standing orders, place a note about the wound in the wound communication book so the Wound Care Nurse could follow up on the wound, and notify the provider by placing a note in the provider communication book. The ADON reviewed the provider's communication books and stated there was not a note left to notify the provider about Resident #16's wound. The ADON reported the wound care standing orders for a stage 2 pressure ulcer were to clean the wound with wound cleanser, apply a boarder foam dressing, and change the dressing every 2 days and as needed. She said the wound care orders entered on 8/31/25 for Resident #16's stage 2 pressure ulcer did not follow the facility wound care standing orders. The ADON stated she did not know about Resident #16's wound specifically but had heard in the morning meeting that “he had a spot there”. The ADON said she had asked the wound Care Nurse to look at Resident #16 and see what was going on and what was there. She did not remember the day it was mentioned in the morning meeting or that she had asked the wound Nurse to look at Resident #16. The ADON stated wounds should be measured and assessed once a week. She explained if a resident was not being followed by the Wound Care Provider, then the Wound Nurse was responsible for measuring, assessing, and documenting on the wound weekly. The ADON said Resident #16's wound was last measured on 9/3/25 and that it should have been measured and assessed before today (9/17/25). The ADON acknowledged The Wound Care Nurse was pulled to work on the floor most days but said on Thursdays, if no one called out she only worked on the floor from 7:00 am to 11:00 am and then was pulled off the floor from 11:00 am to 3:00 pm to do rounds with the Wound Care Provider and follow up on “other wound care stuff”. The ADON said the NAs looked at resident skin during showers/ care and if they saw something then they were supposed to alert the nurse. The ADON stated NAs could not assess a resident's skin but could see if something was open or if there was a rash. The ADON reported there was no schedule or process for the nurses to do routine skin assessments on residents. The ADON said skin assessments were important to identify new skin issues. The ADON could not say why there was no formal process or documented scheduled skin assessments completed by the nurses, she said they had never really done it like that. The ADON said she thought normally it would be the Wound Care Nurse who was responsible for doing resident Braden assessments. She reported the Wound Nurse would not do the Braden assessments when she was working on the floor and said she was not sure who would do them but thought it might be the MDS nurse. The ADON said she saw today where Resident #16 had not had a Braden assessment completed since February 2025, she reported they were supposed to be completed quarterly, and she was not sure why his had not been done. An order was entered on 9/17/25 at 1:30 PM by the ADON for a foam boarder dressing, apply to back of right upper thigh every day shift every two days for wound and as needed for wound soiling. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 9/17/25 at 1:40 PM with Nurse #3. Nurse #3 stated she was the floor nurse assigned to Resident #16's wing. She reported that when she measured Resident #16's wound today it measured 1.5 cm x 0.75 cm x 0.25 cm. She said she would not have known Resident #16 had wound unless he had treatment order in place for the wound. She reported wound care orders were entered today for Resident #16's wound according to the wound care standing orders for stage 2 pressure ulcer. An interview was conducted on 9/17/25 at 12:11 PM with the Nurse Practitioner (NP). He said he was not aware Resident #16 had a wound and that he had not been asked to see the area. The NP said the normal protocol was for wounds to be measured and assessed weekly to see if they were improving or healing. He reported skin assessments were important because they could identify skin issues such as infection and wounds early so there could be an intervention. He said it was hard to say if the initial treatment (silver alginate) put into place for Resident #16 was an appropriate wound care order for his stage 2 wound because he had not seen the wound. An interview was conducted with the Medical Director on 9/18/25 at 9:46 AM. The Medical Director said treatment orders should be in place if a resident has a wound and that there should be a standard protocol for wound orders. He stated wound assessments should be completed weekly. He said the wound assessment should include the characteristics of the wound and wound measurements. The Medical Director explained wound assessments were important to determine if a wound was improving and to guide treatment. He thought basic standard of care was that nurses should do skin assessments at least weekly to identify skin issues. The Medical Director said NAs could help look at resident skin during care and report to the nurse if they saw something but that the facility should have a process in place for nurses to assess residents' skin and not rely on NAs only. The Medical Director stated he was not aware that Resident #16 had developed a wound. An interview was conducted with the MDS nurse on 9/19/25 at 5:30 PM. She stated she did not complete the Braden assessments. She was unsure who completed the Braden assessments but said she thought it might be the ADON. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) and Administrator on 9/19/25 at 6:00 PM. The Administrator stated when Resident #16's pressure ulcer was found the nurse should have initiated the standing orders, assessed the wound, and documented the wound assessment in the nursing notes. The Administrator stated the wound assessment should include measuring the wound. She reported that the nurse should notify the provider about the wound and obtain wound care orders from the provider if the wound needed a different treatment from the wound care standing orders. The Administrator stated wounds should be assessed and monitored weekly to see if the wound was improving or worsening and so the treatment plan could be changed if needed. The Administrator stated the weekly assessment should include what the wound looked like, if there was any draining, any signs of infection, and the wound measurements. The Administrator stated she did not know why Nurse #8 did not follow the wound care standing orders or put ongoing treatment orders in for Resident #16's wound. The Administrator and DON reported the shower team NAs looked the residents' skin when they did showers. The DON said the NAs could not assess resident skin but could notify the nurse if they saw something. The Administrator stated NA skin checks during showers should not replace skin assessments completed by a nurse. The Administrator stated if a resident was assessed to be at risk for skin breakdown, then they should have skin assessments completed weekly. The Administrator explained the Braden assessment identified if a resident was at risk. The Administrator stated the Braden assessment should be done quarterly. The DON said the Wound Nurse was responsible for doing the Braden assessments but if she could not get to them the MDS nurse should do them. The DON said the MDS Nurse should have been checking and auditing to ensure the Braden assessments were completed quarterly. The Administrator said she had spoken with the MDS Nurse earlier today and the MDS Nurse had not known she was supposed to be checking that the Braden assessments were done and doing them if they had not been completed. The Administrator stated Resident #16 should have had a Braden assessment completed since February. The DON and Administrator reported they w

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to provide supervision to prevent a fall with injury and failed to implement effective fall interventions for a resident (Resident #11) who had repeated falls. Resident #11 experienced 12 falls from 1/22/25 to 7/24/25. On 7/24/25 Resident #11 sustained a left ankle fracture when she was left unsupervised in the bathroom and fell. Additionally, the facility failed to supervise a cognitively impaired resident (Resident #10) who wandered and exited the facility unsupervised on two separate occasions. This deficient practice occurred for 2 of 3 residents reviewed for supervision to prevent accidents.Findings included: Resident #11 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle weakness, need for assistance with personal care, abnormalities of gait and mobility, transient ischemic attack (TIA) (temporary episode of stroke-like symptoms). A progress note dated 7/6/25 indicated Resident #11 had a change in level of consciousness, elevated blood pressure, and was sent to the emergency room. A hospital Discharge summary dated [DATE] indicated Resident #11 was admitted to the hospital on [DATE]. Her discharge diagnoses included stroke like symptoms and acute renal failure. A progress note dated 7/12/25 indicated Resident #11 was readmitted to the facility from the hospital on 7/12/25. A significant change MDS assessment dated [DATE] indicated Resident #11 had moderate cognitive impairment. The MDS reported she used a wheelchair and was dependent on staff for showers and toileting. She required partial/moderate assistance with dressing and transfers. The MDS documented Resident #11 did not have behaviors or rejection of care. She was not documented on the MDS for falls. A care plan dated 1/25/25 was in place for impaired mobility and ADL deficit related to TIA with right sided weakness, and debility. The care plan interventions included “Resident will do as able, if unable to complete task assist resident to finish them”. A care plan dated 1/15/25 was in place for fall risk related to TIA, right sided weakness, and history of falls. The care plan goal was for Resident #11 to not sustain significant fall related injury as evidence by no injury more serious than a bruise, abrasion, or skin tear. The care plan included the following interventions dated 1/25/25, attempt to maintain environment adequate lightening, free of clutter, free of safety hazards, and free of glare. Encourage to use appropriate assistive devices, wear non-skid soled shoes when out of bed, give reminders to not transfer without assistance if feeling weak or unsteady, observe for adverse effects of medications, administer anticonvulsant as ordered, place frequently used items in reach. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	An incident report dated 7/24/25 at 12:38 PM was completed by Nurse #2. The incident report stated therapy assisted Resident #11 onto the toilet. Resident attempting to transfer from toilet to wheelchair independently, her legs buckled and she was sitting with her left ankle twisted beneath her. Head to toe assessment completed. The left foot started to swell within 20 minutes. She was able to rotate the ankle but stated it was painful. Three staff assisted Resident #11 into her wheelchair. The incident report indicated the provider was notified and an x-ray was ordered. A nurse note dated 7/24/25 entered at 2:11 PM by Nurse #2 said Resident #11 “was on the floor in front of the toilet. Therapy assisted Resident onto the toilet. Resident attempting to transfer from toilet to wheelchair (w/c) independently, her legs buckled, and she was sitting with her left ankle twisted beneath her. Head to toe assessment completed. The left foot started to swell within 10 mins. She was able to rotate the ankle, she did state it was painful. 3 staff assisted Resident into w/c”. The note indicated that Resident #11's family member was notified of the fall, the MD was informed, and an X-ray had been ordered. An Occupational Therapy treatment note dated 7/24/25 at 1:07 PM by Occupational Therapy Assistant (OTA) #1 was reviewed. Under precautions the note stated “one to one (1:1) supervision required (falls). Fall risk and confusion”. Under the response to treatment section the note read, “At end of therapy toileting ADL session notified NA on duty of patient need for assist to transfer off toilet once done defecating, NA verbally confirmed understanding of patient need for assist. This therapist instructed patient to pull alert cord when ready for assistance and placed cord in patient's hand.” An interview was conducted on 9/18/25 at 2:27 PM with Occupational Therapy Assistant (OTA) #1. She reported she had been working with Resident #11 on 7/24/25. OTA #1 reported she assisted Resident #11 to transfer to the toilet. She stated she needed about 50 % assistance with the transfer. OTA #1 explained that included hand placement on the grab bars, foot placement, weight shifting over, and clothing assistance. OTA #1 stated Resident #11 needed more time on the toilet. She explained she was out of occupational therapy treatment time and needed to leave. OTA #1 reported she put the call light in Resident #11's hand and reiterated to her not to transfer on her own and to use the call light. OTA #1 said she then found the NA on the hallway, she could not remember who the NA was. OTA #1 stated she told the NA Resident #11 was on the toilet, she would need assistance, and she had the call light to call for assistance when she was done. OTA #1 reported the NA was right outside of Resident #11's room door and confirmed understanding. OTA #1 said Resident #11's balance and strength was okay for her to be able to safely sit on the toilet by herself. She stated she thought Resident #11 was physically able to pull the call bell string and said she thought Resident #11 seemed to have the mental ability to use it. OTA #1 explained at the time she was not sure if she was supposed to stay there with Resident #11 if she was over her treatment time and had thought she would get in trouble if she stayed. OTA #1 said she knew Resident #11 had falls that occurred from the bed but did not think she had falls in the bathroom before this fall. An interview was conducted on 9/18/25 at 12:19 PM with the Director of Rehabilitation (Rehab). The Director of Rehab said OTA #1 had notified the NA at the time that she had taken Resident #11 to the bathroom and instructed Resident #11 to use the call bell. She did not remember who the NA was. The Director of Rehab stated Resident #11 had balance deficits, but the NA was outside of the room and said there was intended to be an immediate transference of care and observation for Resident #11. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with NA #9 on 9/18/25 at 3:26 PM. NA #9 said she was the assigned NA for Resident #11 on 7/24/25 when she fell. NA #9 explained she recalled the fall because she had been upset about what had happened. NA #9 reported a therapist had left Resident #11 on the toilet unattended without notifying her or any NA that she was on the toilet. She could not remember the therapist's name. NA #9 said the fall happened between 11:00 AM and 12:00 PM. NA #9 said she had been on a different hallway helping residents get up for lunch. NA #9 remembered Resident #11's roommate was yelling for help. She said when she went to the room, she found Resident #11 on the bathroom floor. She recalled Resident #11 was sitting on the bathroom floor with her leg bent under her and she was sitting on her ankle. She thought it had been her right ankle but was not sure. NA #9 stated she did not move Resident #11 but had asked her if she was in pain and Resident #11 said she had hurt her ankle. NA #9 stated she notified Nurse #14 and she came first to assess Resident #11. NA #9 stated three staff members assisted Resident #11 back into her wheelchair after the fall. She said Resident #11 wanted to stay up in her wheelchair so she could go smoke. NA #9 reported Resident #11 was not okay to be left in the bathroom alone. She reported Resident #11 needed supervision because she was shaky when she stood and did not always ring the call bell. She said Resident #11 did not ring the call bell on 7/24/25, she stated when she went to Resident #11's room the call light had not been on. An interview was conducted on 9/19/25 at 11:13 AM with Nurse #14. She recalled Resident #11's fall on 7/24/25. Nurse #14 stated that it was the fall where the OTA had put her on the toilet and then told her to ring the call when she was done. Nurse #14 said someone came and told her Resident #11 had fallen, she could not remember who had told her. Nurse #14 stated Nurse #2 came to the room and they had assessed Resident #11 together. Nurse #14 said Resident #11 had not acted like she was in pain at all. She recalled Resident #11 was sitting on the bathroom floor and one of her ankles was under her. She said it looked odd how she was positioned on her leg on floor. Nurse #14 said after they assessed her and got her back into her wheelchair they had asked if her ankle was hurting and Resident #11 had said “no”. Nurse #14 stated Resident #11 had not remembered what happened when they asked her. Nurse #14 was unsure if Resident #11 should be left alone in bathroom and said that she did not usually take care of her. Nurse #14 said staff did not usually leave residents in the bathroom alone if they could not be left unsupervised and that was a question that day. She remembered the NA was upset that day because the OTA had left Resident #11 in the bathroom and had not told her. She stated the NA had said she did not know Resident #11 was in the bathroom. Nurse #14 did not remember the NAs name. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 9/18/25 at 12:01 PM with Nurse #2. She was the assigned nurse for Resident #11 on the 7/24/25 day shift (7:00 am to 3:00 pm). Nurse #2 recalled Resident #11's fall on 7/24/25 she stated therapy had assisted her to the toilet that day, she did not remember the exact time or if she had gone to Resident #11's room first or if Nurse #14 had. She said Resident #11 had not called for assistance, had tried to transfer herself, and fell. Nurse #2 stated cognitively Resident #11 was able to use the call light at the time of the fall. She reported she had asked Resident #11 why she did not ring the call bell for assistance and Resident #11 had told her she “thought she could do it herself”. Nurse #2 said she asked Resident #11 about pain when she assessed her after the fall and she said Resident #11 had said her ankle hurt. Nurse #2 stated Resident #11 had swelling to her left ankle and that was why she had gotten the x-ray ordered. Nurse #2 said she did not remember if the x-ray results came back on her shift or if she had called the physician about the results. Nurse #2 reported after the fall Resident #11 had stayed up in her wheelchair and had not wanted to lay down in bed. She stated Resident #11 had propelled herself in her wheelchair and continued to go out to smoke. Nurse #2 said she remembered Resident #11 had other falls before the fall on 7/24/25 and she stated most of Resident #11's were related to her not calling for assistance and trying to transfer herself. An order dated 7/24/25 was entered at 11:00 AM by the DON that read, left ankle X-ray. The order indicated it had been ordered by the Medical Director. An X-Ray report dated 7/24/25 of Resident #11's left ankle read, “acute nondisplaced fracture at distal fibula, proximal to the lateral malleolus.” An additional progress note dated 7/24/25 entered at 5:17 PM by the DON read, “new order per [Medical Director] refer to [local orthopedic office] ortho for left ankle fracture. Daughter made aware of fracture.” An order dated 7/24/25 was entered at 5:30 PM by the DON that read, refer to [local orthopedic office] orthopedic for left ankle fracture. An interview was conducted on 9/18/25 at 3:56 PM with Nurse #9. Nurse #9 was the 3:00 PM to 11:00 PM nurse on 7/24/25 for Resident #11. Nurse #9 reported Resident #11 had been up in her wheelchair when she arrived at work on 7/24/25. Nurse #9 stated the x-ray results had already been called to the Physician from her earlier fall before she arrived at work. Nurse #9 said Resident #11 had a lot of falls and was a high fall risk. She reported she did not know what fall interventions had been put in place for Resident #11. She said staff tried to keep an eye on her when she was in bed and tried to encourage her to use the call bell. An orthopedic progress note dated 7/25/25 indicated Resident #11 had been seen for a closed displaced fracture of the lateral malleolus of left fibula. The note indicated a repeat X-Ray was completed at the office visit with results showing she had a “minimally displaced oblique (angle) lateral (side) malleolus (ankle bone) fracture that extends to the level of the tibial plafond (bottom of the shin bone). She had no widening of the ankle mortise (were the leg bones and ankle bones come together at the joint) or medial (middle) malleolus fracture”. The note indicated the treatment plan included a short leg walking boot. The note reported a “cam boot (short walking boot) was prescribed” and said the boot could be removed for bathing and sleeping and that she may wear the boot as tolerated. Acetaminophen was recommended for pain. The note said to recheck in 6 weeks for repeat ankle x-rays or sooner if symptoms worsen. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A combined interview was conducted with the Administrator and Director of Nursing (DON) on 9/19/25 at 6:00 PM. The Administrator and Director of Nursing stated Resident #11 should not have been left unassisted and unsupervised in the bathroom alone. 2. Resident #10 was admitted to the facility on [DATE]. Her active diagnoses included Alzheimer's dementia. The quarterly MDS dated [DATE] indicated Resident #10 had not exhibited any wandering behavior. Resident #10's care plan with the focus revised on 9/13/24 revealed a risk for elopement related to dementia. Interventions included frequent checks on whereabouts and make sure hallway doors were alarmed at all times. a. Review of the facility incident log revealed there was no incident event for Resident #10 dated 2/02/25. Review of Resident #10's nursing progress note dated 2/02/25 at 3:58 PM entered by Nurse #3 read that the resident was noted outside of the building walking past the 200-hall door. Resident redirected and brought back in the building. An interview on 9/17/25 at 12:51 PM with the Nurse Practitioner (NP) revealed he had been notified of Resident #10's elopement and she was assessed to have no injuries. An interview on 9/18/25 at 10:53 AM with Receptionist #2 revealed she had been on duty at the front desk on 2/02/25 when Resident #10 eloped. She believed that Resident #10 exited the building when she opened the front door for a group of visitors to exit. She stated she did not know the resident had gotten out until Nurse #3 came and told her that Resident #10 had gotten outside. She did not know what time this incident occurred. An interview on 9/18/25 at 2:14 PM with the Business Office Manager revealed Receptionist #1 trained Receptionist #2. She stated she was informed that Receptionist #2 accidentally let Resident #10 out when she opened the door for a group of visitors to leave. She stated there was a book at the receptionist's desk with pictures of the residents. An observation on 9/18/25 at 2:30 PM with the Business Office Manager of the resident book at the receptionist's desk revealed the book contained a printed face sheet for all the facility residents. The face sheet contained a picture of each resident with their name. There was no indication of who was an elopement risk in the book. The Business Office Manager stated the elopement risk residents were verbally communicated to the receptionists and she did not know how the weekend receptionist (Receptionist #2) would become aware of elopement seeking residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 9/18/25 at 4:09 PM with Nurse #3 revealed she was walking down the 200-hall when she observed through the glass hall exit door that Resident #10 was walking independently outside the facility. She stated she went out the 200-hall door and escorted Resident #10 back into the facility. She stated that Resident #10 was fully dressed and wearing shoes. She assessed the resident who appeared clean, dry and without injury. Nurse #3 stated she talked to the receptionist, and it appeared the receptionist had let Resident #10 out accidentally when she let a group of visitors out. She stated she did not remember notifying any administrative or supervisory staff. Nurse #3 was unaware Resident #10 had gotten outside until she saw her through the door. She was unable to say the last time she had seen the resident. Resident #10 was known to pace the facility and ask staff how to get out of the facility. An interview on 9/19/25 at 8:51 AM with Receptionist #1 revealed she had trained Receptionist #2 who worked weekends at the facility. She stated she had told Receptionist #2 who the elopement risk residents were but did not remember if she had shown her what the resident looked like or if Resident #10 was specifically included in the conversation. An observation and interview on 9/19/25 at 9:01 AM with the Director of Nursing (DON) revealed from the facility front door around the outside of the facility to the 200-hall door was between 105 to 123 steps depending on if you walked in the grass (105 steps) or the parking lot (123 steps). An interview on 9/19/25 at 10:14 AM with the Director of Nursing (DON) revealed she was unable to say when she became aware of Resident #10's elopement on 2/02/25 and did not have any incident or investigation paperwork. An unsuccessful interview was attempted on 9/19/25 at 1:04 PM with the NA #6 who was on duty on 2/02/25. An interview on 9/19/25 at 2:39 PM with the Administrator revealed Resident #10 had gotten out of the building on 2/02/25. She stated she reviewed the security camera footage, and the resident was outside for ‘minutes'. She stated there was a facility investigation, but she was unable to locate the documentation. She stated that Receptionist #2 was educated on the elopement risk residents. Per wunderground.com reported the weather that day at 3:54 PM was 51 degrees with no rain. b. Review of the facility incident log revealed an elopement incident event dated 3/11/25 at 00:00 for Resident #10. The elopement incident report revealed an incident description that read Resident #10 was observed out front of building by receptionist, assisted back inside by receptionist and business office staff. No injuries were observed at the time of the incident. Resident #10's family member was notified on 3/11/25 at 3:47 PM and the physician was notified on 3/11/25 at 3:44 PM. Review of Resident #10's nursing progress note dated 3/11/25 at 3:53 PM entered by Nurse #6 read that resident was observed out front of building by receptionist, assisted back inside by receptionist and business office staff without incident. No fall; no apparent injury. Sister informed and note to MD. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 9/19/25 at 1:14 PM with Nurse #6 revealed she was on duty and assigned to Resident #10 on 3/11/25. She stated she remembered Receptionist #1 bringing Resident #10 to the nurses' station around 3:45 PM and informing her she found the resident outside the front door. Nurse #6 assessed the resident with no injuries noted. She did not recall if she notified Administration or a Supervisor or if they had already been notified. She stated she completed the incident report but had not entered the correct time of the incident which should have been documented as around 3:45 PM. She was unaware the resident had gotten outside and unable to say the last time she had observed the resident on the unit. An interview on 9/19/25 at 9:38 AM with Receptionist #1 revealed she was on duty at the facility front door on 3/11/25. She stated she observed Resident #10 outside the front door on 3/11/25 around 3:45 PM and went outside and escorted her back into the building and to a nurse at the 200-hall nurses' station. She also stated that Resident #10 was fully dressed and wearing shoes with no visible distress. Receptionist #1 stated no one from the business office assisted her with getting Resident #10 back into the facility. An interview on 9/17/25 at 12:51 PM with the Nurse Practitioner (NP) revealed he had been notified of Resident #10's elopement and she was assessed to have no injuries. An interview on 9/19/25 at 1:29 PM with Nursing Assistant #2 revealed she worked with Resident #10 frequently and was assigned to her hall on 3/11/25. She stated on 3/11/25 before her elopement, Resident #10 was behaving as usual which included pacing inside the facility, exit seeking, and checking doors. She was unable to say the last time she had observed Resident #10 on the unit. An interview on 9/19/25 at 10:14 AM with the Director of Nursing (DON) revealed she was unable to say when she became aware of Resident #10's elopement on 3/11/25. She stated that maintenance monitors the hallway door alarms. An interview on 9/19/25 at 11:15 AM with the Maintenance Director revealed he checked the hall doorway alarms monthly and as needed. An interview on 9/19/25 at 2:39 PM with the Administrator revealed Resident #10 had gotten out of the building on 3/11/25 around 3:45 PM. She stated that the facility power had been off and, in the restoration process around 3:45 PM, the hall door became unlocked. She stated that Resident #10 had not eloped since this incident, and she felt the interventions were effective. Per wunderground.com reported the weather that day at 3:54 PM was 71 degrees with no rain.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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 0692 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 observations, record review, and staff, and Medical Director interviews, the facility failed to act on the Registered Dietitian's (RD) recommendation of 8/31/25 to reweigh a resident (Resident #29) after a monthly weight triggered a significant weight change. The diet order was revised to add more calories, and the volume of the nutritional supplement was increased as recommended by the RD. The facility failed to reweigh Resident #29 until 9/3/25 and then staff did not document the weight or report it to nursing management until 9/18/25. The reweight confirmed a significant weight loss. During meal observation on 9/19/25, Resident #29 did not consume any food on her own and staff did not provide any cues or encouragement to eat. The interdisciplinary team did not discuss Resident #29's weight loss or lack of eating in the clinical meeting, nor was it reported to the physician. This deficient practice occurred for 1 of 2 residents reviewed for nutritional care.Findings included:Resident #29 was admitted to the facility on [DATE]. Her diagnoses included dementia, hypothyroidism, nutritional deficiency, and protein-calorie malnutrition. Resident #29's active physician orders revealed an order dated 6/5/24 for Remeron 7.5 milligrams (mg), give one tablet by mouth at bedtime related to primary insomnia. Remeron is an antidepressant medication that can be used to stimulate appetite.A care plan revised on 3/17/25 was in place for impaired nutrition related to malnutrition, hypothyroidism, and nutritional deficiencies. The care plan interventions included using remeron (antidepressant medication) to stimulate appetite, monitor weights as indicated, obtain and monitor lab work as ordered, provide and serve diet as ordered, provide and serve supplements as ordered, Registered Dietician (RD) to evaluate and make diet change recommendations.Resident #29's medical record indicated a thyroid stimulating hormone (TSH) level was checked on 4/23/25 with normal results. The medical record indicated a complete blood count (CBC) (lab test that counts the type/ type/ number of cells in your blood and is an indicator of health) was also checked in April 2025. Resident #29 last had a complete metabolic panel (CMP) (lab that shows glucose, electrolytes, protein, and indicators for kidney and liver function) completed in February 2025. The Medical Record revealed she had not had any additional lab work completed since April. On 6/25/25, the electronic record documented Resident #29's weight was 134.4 pounds (lbs.)On 7/29/25, the electronic record documented Resident #29's weight as 132.1 lbs. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #29 had severe cognitive impairment. She was not documented for behaviors or rejection of care. The MDS documented she needed setup/ clean up assistance with eating The MDS did not document she had weight loss or difficulty swallowing. The MDS documented she received a mechanically altered diet. The MDS documented her weight was 132 lbs. A quarterly mini nutritional assessment dated [DATE] indicated Resident #29's most recent weight was 132.1 lbs. on 7/29/25. The assessment documented she had no decrease in her food intake and had weight loss between 2.2 and 6.6 lbs. The assessment documented that she had normal nutritional status. A revised diet order on 8/21/25 read, regular diet mechanical soft texture, regular thin liquid consistency, extra gravy with dry meats, mighty shake (supplement) with meals. On 8/26/25, the electronic record documented Resident #29's weight as 114.4 lbs. A progress note dated 8/31/25 by Registered Dietitian (RD) #1 indicated Resident #29 was reviewed. The note indicated she had a significant weight loss of 13.6% in a month. The note indicated Resident #29 received a regular diet with mechanical soft texture and her intakes ranged from 0-50% of most meals. The note indicated she was receiving Med Pass (nutritional supplement) 60 milliliters (ml) twice daily and a mighty shake (nutritional supplement) three times daily. The note indicated the RD recommended obtaining a reweight for weight loss verification and increasing her Med Pass to 90 ml twice daily to promote weight stability. A medical nutrition therapy recommendation log by RD #1 dated 8/31/25 included Resident #29. The recommendations stated reweigh resident for verification of weight loss. Increase Med Pass to 90 ML twice daily to promote weight stability RD #1 was not available for interview.A reweight was not located in Resident #29's electronic medical record. A physician's order revised on 9/1/25 by the Assistant Director of Nursing (ADON) read, Med Pass 90 ml two times a day related to protein calorie malnutrition. An interview was conducted with ADON on 9/18/25 at 11:01 AM. The ADON reported she was responsible for keeping up with residents' weights and ensuring they were completed. The ADON explained that the Unit Clerk was responsible for obtaining resident weights. She further explained only a couple of residents, including Resident #29 had weights obtained for the month of August because the former Unit Clerk had not obtained them before her last day of work at the end of

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 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, observations and staff interviews, the facility failed to clean oxygen concentrator filters (Resident #1 and Resident #2) and provide oxygen in use signage on resident room entrances (Resident #1, Resident #2, and Resident #9) for 3 of 3 residents reviewed for respiratory care (Resident #1 and Resident #2, Resident #9). In addition, the facility failed to secure an oxygen tank stored upright in a resident's room (Resident #1) and failed to secure an oxygen tank while being transported for 1 of 1 staff member observed carrying an oxygen tank (Nurse Aide #2). Findings Included:1a. Resident #1 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). Resident #1 had active physician order dated 8/7/25 for oxygen via nasal cannula at 2 liters per minute every shift.Resident #1 was care planned for impaired breathing patterns related to COPD (8/22/24). Interventions included oxygen as ordered (8/22/24).Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] coded her cognitively intact and for oxygen use. On 9/16/25 at 11:20 AM an observation of Resident #1's room found her oxygen concentrator filter contained debris build-up that was fluffy in appearance and crumbled when touched. Furthermore, Resident #1's room door was missing oxygen in use signage. Resident #1's in room observation found an oxygen tank that was not empty sitting vertically on the floor near the corner of Resident #1's room. The oxygen tank was not in a secure oxygen tank holder. Resident #1 stated during the observation a staff member removed the oxygen tank earlier that day from her wheelchair, and placed it over by the corner, she could not remember who the staff was. The oxygen tank pressure gauge revealed the tank to be 50% full.The Wound Nurse who was working as a floor nurse was interviewed on 9/19/25 at 11:21AM. The Wound Nurse stated Nurse Aide (NA) #10 was responsible for cleaning the concentrator filters weekly.On 9/16/25 at 11:34 AM Nurse #3 was notified the oxygen tank was stored in Resident #1's room and then observed the stored oxygen tank in the room.Nurse #3 stated on 9/16/25 at 11:36 AM she did not know who had stored the tank in the room and that the oxygen tank needed to be stored in a secure stand. Nurse #3 then placed the oxygen tank in a secure oxygen tank holder.1b. Resident #2 was admitted on [DATE] with diagnoses including vascular dementia, Chronic Obstructive Pulmonary Disease (COPD), and respiratory failure.Resident #2 was care planned for impaired breathing patterns related to COPD and respiratory failure dated 7/4/24. Interventions included administering oxygen as ordered, monitor signs of respiratory distress, and monitor vitals and oxygen saturations as indicated (7/4/24).Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was severely cognitively impaired and coded for oxygen use.On 9/16/2025 at 11:27 AM an in-room observation of Resident #2's room found her oxygen concentrator contained a light brown colored substance uniformly covering the top of the concentrator. The debris was easy to remove when touched. The concentrator's filter was found to contain a thick and fluffy debris that was crumbly to touch. There was no signage for oxygen in use observed.1c. Resident #9 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure and hypoxemia. Resident #9 had a physician's order dated 8/7/25 for oxygen via nasal cannula at 2 liters per minute as needed (PRN).Resident #9's annual MDS assessment dated [DATE] coded her with moderate cognitive impairment and oxygen use. On 9/16/25 at 11:44 AM an observation of Resident #9's room found an oxygen concentrator and no oxygen in use signage. On 9/17/2025 at 2:57 PM Resident #9's room entrance was observed to not contain an oxygen in use sign. 1d. An observation on 9/16/25 at 11:50 AM found NA #2 carrying an oxygen tank cradled in both arms against her torso and switched to carrying it with one hand on the handle of the tank used for grabbing and protection. NA #2 was walking from the oxygen storage room down a hallway and into the main dining room. NA #2 stated on 9/16/25 at 11:51AM she was taking the full oxygen tank to replace an empty tank on a wheelchair. NA #2 stated she was being careful carrying the oxygen tank when transporting it. NA #2 said she thought there was a small cart to transport the oxygen tank but was unsure where it was located. Furthermore, NA #2 said if the tank was dropped or hitting something hard, it could possibly blow-up or fly into a resident or staff.A follow-up interview with NA #2 was conducted on 9/16/25 at 2:26 PM. NA #2 stated she had spoken with the Administrator, and the facility did have a cart to use for oxygen transportation. Na #2 said the cart should be used when transporting a full oxygen tank long distance.NA #10 was interviewed on 9/19/25 at 11:30 AM. NA #10 stated she was responsible for changing oxygen tubing every week on Wednesday. She stated she also cleaned oxygen concentrators including filters, and nebulizers. NA #10 stated she documented a progress note every time the oxygen

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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 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Based on observations, record reviews and resident and staff interviews, the facility failed to maintain sufficient staff to provide activities of daily living (ADL) care for dependent residents, to obtain treatment orders for residents with pressure ulcers when the pressure ulcers were first identified, to routinely assess a resident for being at risk of a pressure ulcer, to implement measures to prevent a resident from developing a pressure ulcer and then failed to provide an ongoing assessment, treatment, and necessary medical care for a resident's diabetic and pressure ulcer. Additionally, the facility failed to complete accurate head to toe assessments to identify new or existing pressure ulcers. This was for 5 of 9 residents reviewed for sufficient staffing (Resident #2, Resident #8, Resident #11, Resident #6 and Resident #28). The findings included:This tag was cross referred to:F 677 Based on observation, record review, staff, and resident interviews, the facility failed to provide activity of daily living (ADL) care for dependent residents when Resident #28 and Resident #11 did not receive showers. This deficient practice affected 2 of 4 residents reviewed for ADL care (Residents #28 and #11). F 684 Based on record review, observations, staff wound provider, and physician interviews, the facility failed to provide skin assessments, failed to identify a new wound on the heel at the onset, and failed to ensure necessary medical treatment when positive culture and sensitivity results were available Resident #2. This delayed the treatment for an infected wound. This was for 1 of 2 residents reviewed for quality of care. F 686 Based on observations, record reviews, interviews with the Wound Care Nurse Practitioner, Medical Director (MD) and staff, the facility failed to obtain treatment orders for two (2) pressures ulcers (Resident #8 and Resident #16) when first identified resulting in numerous days that the pressure ulcers went without treatment and worsening to unstageable for Resident #8 and a stage 2 for Resident #16. Resident #8's pressure ulcer was first identified on 08/22/25 as a red open area but an assessment or treatment was not documented. The pressure ulcer was later identified on 09/04/25 and treatment was initiated but no assessment was documented. The pressure ulcer was assessed and documented on 09/09/25 as unstageable wound to the right heel with black eschar (dry, black, or brown crust that forms on the surface of wounds) with foul odor and measuring 3.5 centimeters (cm) by 3.5 cm. The facility failed to routinely assess Resident #16 for being at risk of pressure ulcer, failed to implement measures to prevent Resident #16 from developing a pressure ulcer and then failed to provide ongoing assessment and treatment for Resident #16's pressure ulcer. Resident #16 was identified on 8/31/25 to have a stage 2 pressure wound to the back of his right thigh, there were no wound measurements completed until 9/3/25. After 9/3/25 there was no assessment or measurement documented for the wound. Resident #16 had an initial treatment order entered on 8/31/25 for his stage 2 pressure ulcer that was for 7 days and stopped on 9/7/25. After 9/7/25 there were no additional treatment orders for the wound. The facility failed to complete accurate head to toe skin assessments to identify new or existing pressure ulcers that include the location, type of wound, length, width, depth, and stage of pressure ulcers. This deficient practice occurred for 2 of 3 residents reviewed for pressure ulcers (Resident #8 and Resident #16).During an interview with the Wound Nurse on 09/16/25 at 2:39 PM the Wound Nurse explained that she was pulled to the hall to work as the hall nurse about every day and she could not stay caught up with her wound care responsibilities. She stated that the facility tried to give her half a day a week to catch up on all the documentation that pertained to the wounds in the facility but that was not enough time to keep caught up on the documentation. She continued to explain that when the Wound Care Nurse Practitioner made rounds at the facility which was usually one day a week and if she happened to be on the hall that day, one of the administrative nurses would cover her hall while she made rounds with the Wound Care Nurse Practitioner. The Wound Nurse reported it was hard to monitor the wounds in the facility because she was often pulled to the hall to work as the nurse, and she was unable to be consistent in providing the wound care. The Wound Nurse stated that it was not unusual for her not to see a wound for two weeks or longer because of having to be pulled to the hall to work. On 9/18/25 at 5:11 PM during an interview, the shower sheets were reviewed with the Administrator, DON and ADON for the month of September. There were 8 days residents were supposed to receive showers from 9/1/25 through 9/12/25 and 4 out of 8 of the days no showers were given.- The DON reviewed the shower sheet dated 9/1/25 and stated not all residents received showers because one of the shower team NAs (NA #1) was pulled to work on the floor.- There was no shower sheet dated 9/2/25, the DON, ADON, and Administrator explained if there was not a shower sheet then there would be no showers given on that day.- The DON and Administrator reviewed the shower sheet dated 9/5/25 and both stated there was

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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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. (continued on next page)

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F 0728 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 staff interviews, the facility failed to provide staff that met minimum competency requirements when they employed a staff member to work in the capacity of a nurse aide (NA) and were assigned NA tasks who had not completed a state-approved nurse aide training program, certification exam, or competency evaluation prior to providing direct care to residents. This deficient practice occurred for 1 of 8 staff reviewed for minimum competency requirements (Staff #17). Findings included:The North Carolina (NC) Department of Health and Human Services (DHHS) Health Care Personnel Education and Credentialing Section's website indicated under the section of Nurse Aide I, last updated [DATE], that in accordance with federal law, a facility may employ a nurse aide (NA) for a period of up to 4 months under the following conditions: -During the 4-month grace period, an individual must be deemed competent to provide nursing or nursing-related services by a Registered Nurse and work toward meeting the training and testing requirements by participating in a state-approved Nurse Aide I training and competency evaluation program or a state-approved competency evaluation program. The website clarified that the individual must be actively participating in a state-approved Nurse Aide I training and competency evaluation program during the 4-month grace period. It further indicated the NC Nurse Aide I Registry was a registry of all people who met the state and federal training and testing requirements to perform Nurse Aide I tasks. Staff #17's employee file stated her date of hire was [DATE]. She was hired to work full time in the capacity of a nurse aide but had not completed a state approved training program or passed a certification exam. In addition, Staff #17 had not completed a skills competency check list.On [DATE] at 4:00 PM the DON reported Staff #17 was not currently enrolled in a state approved training program. The DON stated Staff #17 had been enrolled in a hybrid online program a week ago but was told by the program instructor she needed an in-person program and to return in December. Review of nursing schedules from [DATE] through [DATE] revealed Staff #17 was scheduled to work and was assigned NA tasks on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE].A telephone interview was attempted on [DATE] at 11:55 AM and Staff #17 was unavailable for interview. A joint interview was conducted on [DATE] at 5:11 PM with the Administrator and DON. The Administrator stated the facility hired Staff in to eventually become a Nurse Aide. The Administrator stated the facility did not have an in-house state approved nurse aide training program. She explained that Staff were basically hired as an NA without certification and they were able to do direct patient care. The Administrator said Staff were not enrolled in a state approved training program when hired. She explained Staff were hired and then the facility tried to get them enrolled in a program during their first four months. The Administrator stated the facility paid for the Staff to go to NA school and that the Staff had to complete the NA program and pass NA certification exam within four months. The Administrator reported during the four-month period Staff could work anywhere in the building taking care of residents and doing everything a certified NA could do. The Administrator explained after four months if the Staff had not completed an NA program and became certified, then they could only work on the hallway with uncertified rest home beds and take care of those residents. The Administrator stated they had started hiring Staff during the pandemic as part of a waiver that allowed the use of Temporary Nurse Aides. The Administrator explained the waiver allowed staff to take an online class, receive on the job NA training, and then be checked off on skills through return demonstration by the facility. She reported that during the waiver Staff could challenge the NA certification exam (take the NA certification exam without completing a state approved training program). The Administrator explained when the waiver went away when the pandemic ended, she thought Staff could still work for the 4 months and the only part that had changed was that staff could not challenge the certification exam anymore. The Administrator stated that the waiver had expired and the facility had switched to the model they were currently using. She explained that the current model was hiring Staff and then having them enroll in an NA program and the facility paying for the program, she said it was a scholarship program. The Administrator stated she had not been aware that for staff working in the capacity of an NA for less than 4 months the regulation said Staff needed to actively be participating in a state approved NA program or have completed a state approved NA program and be waiting to take the competency exam.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. (continued on next page)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Based on observations, record reviews and interviews, the facility failed to ensure the Nurse Staffing Information was posted in a prominent place that was readily accessible to residents, staff and visitors. The facility also failed to ensure the posted Nurse Staffing Information accurately reflected the facility census and staffing for 4 of 4 days (09/16/25, 09/17/25, 09/18/25 and 09/19/25).The findings included:A. A review of the Nurse Staffing Information sheets for 09/16/25 at 9:45 AM, 09/17/25 at 9:26 AM, 09/18/25 at 4:56 PM and 09/19/25 at 11:42 AM revealed the staffing sheets were observed posted on counter of the receptionist desk in the front lobby which was approximately two and a half feet tall. The staffing sheets were posted flat on the counter, and the observer had to stand over the desk and look down to view the staffing sheets.On 09/19/25 at 2:10 PM an interview was conducted with the Receptionist who explained that she was given the Nurse Staffing Information sheets by the Scheduler either the day before or the morning of the day she posted them. She explained that lately the Scheduler had been out, so the Director of Nursing gave them to her to post.An interview was conducted with the Administrator on 09/19/25 at 6:00 PM with the Director of Nursing present. The Administrator explained that the facility had been posting the Nurse Staffing Information sheets in the lobby for a long time, and no one had made her aware that it was not readily accessible.B. A review of the Nurse Staffing Information sheet for 09/16/25 at 9:45 AM revealed the resident census section was left blank. A review of the Nurse Staffing Information sheet for 09/17/25 at 9:26 AM revealed the census total included both the skilled residents and assisted living residents. The posted census was 61 when the actual resident census for the skilled residents was 55.A review of the Nurse Staffing Information sheet for 09/18/25 at 4:56 PM revealed the census total included both the skilled residents and assisted living residents. The posted census was 61 when the actual resident census for the skilled residents was 55.A review of the Nurse Staffing Information sheet for 09/19/25 at 11:42 AM revealed the census total included both the skilled residents and assisted living residents. The posted census was 60 when the actual resident census for the skilled residents was 54.An interview was conducted with the Administrator on 09/19/25 at 6:00 PM with the Director of Nursing present. The Administrator explained that the facility had included the census of the whole facility for as long as she could remember and no one had ever told her anything different. The Administrator stated she had reviewed the regulations and now understood that the census for the assisted living part of the facility should not be included in the census of the skilled residents.C. A review of the nursing assignment sheet dated 09/16/25 for first shift (7:00 AM - 3:00 PM) had 2 Registered Nurses (RNs) for 16 hours and 6 Nurse Aides (NAs) for 43 hours scheduled to work. The Nurse Staffing Information sheet indicated there were 4 RNs for 32 hours and 8 NAs for 69 hours. There were 2 Temporary Nurse Aides (TNA) for 16 hours scheduled to work on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet.A review of the nursing assignment sheet dated 09/16/25 for second shift (3:00 PM - 11:00 PM) had 1 RN for 4 hours and 7 NAs for 46 hours scheduled to work. The Nurse Staffing Information sheet dated 09/16/25 indicated there were no RNs and 7 NAs for 40 hours. There were 3 TNAs for 24 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet dated 09/16/25 for third shift (11:00 PM - 7:00 AM) had 4 NAs for 24 hours scheduled to work and the Nurse Staffing Information sheet had 4 NAs for 32 hours.A review of the nursing assignment sheet dated 09/17/25 for first shift had 3 RNs for 24 hours and 6 NAs for 41 hours scheduled to work. The 9/17/25 Nurse Staffing Information sheet indicated there were 4 RNs for 32 hours and 9 NAs for 61 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet dated 09/17/25 for second shift had 2 RNs for 16 hours, 1 LPN for 8 hours and 4 NAs for 24 hours scheduled to work. The Nurse Staffing Information sheet indicated there was 1 RN for 8 hours, 2 LPNs for 16 hours and 5 NAs for 32 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet dated 09/17/25 for third shift had 2 NAs for 16 hours scheduled to work and the Nurse Staffing Information sheet had 3 NAs for 24 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet.A review of the nursing assignment sheet dated 09/18/25 for first shift had 2 RNs for 12 hours, 1 LPN for 8 hours and 7 NAs for 61 hours scheduled to work. The Nurse Staffing Information sheet dated 9/18/25 indicated there were 3 RNs for 32 hours, 1 LPN for 4 hours and 8 NAs for 69 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing

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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 manufacturer guidelines, observations and staff interviews, the facility failed to remove loose and unsecured pills of various shapes, sizes and colors from 1 of 3 medication carts (200 Hall) and failed to label and store inhalation breathing solutions (Budesonide, Albuterol Sulfate, DuoNeb) according to manufacturers' guidelines for 2 of 3 medication carts (200 and 500 hall) reviewed for medication storage.The findings included:a. Review of manufacturers' guidelines for budesonide solution revealed after opening the foil pouch the vials are only good for 2 weeks. Review of the manufacturers' guidelines for DuoNeb solution revealed that after opening the foil pouch the individual vials of DuoNeb solution should be used within 7 days.An observation was made of the 200-hall medication cart on 09/19/25 at 11:50 AM accompanied by Nurse #1. The cart yielded 13 loose pills of various shapes, colors and sizes from the bottom of the medication cart drawers. Further review of the 200-hall medication cart revealed an open and undated box of budesonide solutions that contained multiple vials of budesonide solutions available for use in the medication cart drawer. The medication cart also yielded 2 open and undated boxes of DuoNeb solutions that were available for use in the medication cart drawer.An interview was conducted with Nurse #1 at 11:50 AM on 09/19/25. The Nurse explained that it was each nurse's responsibility to keep the medication carts clean and orderly. She stated that she had not cleaned the medication cart yet, but she doubted that the 13 loose pills had happened since the beginning of her shift at 7:00 AM. She stated that she had not used the budesonide nebulizing solution yet that shift. The Nurse indicated that she did not know how long the budesonide or DuoNeb solution could be used after the foil pouch was opened.b. Review of the manufacturers' guidelines for DuoNeb solution revealed that after opening the foil pouch the individual vials of DuoNeb solution should be used within 7 days.Review of the manufacturers' guidelines for albuterol sulfate solution revealed the solution should be stored in the foil pouch to protect them from light.On 09/19/25 at 12:38 AM an observation was made of the 500-hall medication cart accompanied by Nurse #2. The medication cart yielded 4 loose albuterol sulfate solutions vials laying in the bottom of the medication cart drawer. The medication cart also yielded 1 open and undated box of DuoNeb solutions that was in the medication cart drawer and available for use.An interview was conducted with Nurse #2 at 12:38 AM on 09/19/25. The Nurse explained that it was each nurse's responsibility to keep the medication carts clean and orderly. She indicated that she had not cleaned the medication cart yet and that she had not used the albuterol sulfate nebulizing solution. The Nurse indicated that she did not know how long the DuoNeb solution could be used after opening the foil pouch.During an interview with the Director of Nursing (DON) on 09/19/25 at 6:00 PM the DON explained that it was each nurse's responsibility to keep the medication carts clean, but it was the weekend supervisor's responsibility to clean and organize the medication carts which included removing loose pills and ensuring that nebulizing solutions were stored and labeled appropriately.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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F 0773 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 staff, Wound Provider, Nurse Practitioner, and Medical Director interviews, the facility failed to notify the Wound Provider of a positive wound culture and sensitivity lab result when the results were received. This resulted in a delay of antibiotic treatment for 1 of 1 resident reviewed for notifying a physician of laboratory results (Resident #2). Findings Included:Resident #2 was admitted on [DATE] with diagnoses of vascular dementia and hemiparesis (weakness of a limb) and hemiplegia (side of body paralyzed) of left side following a stroke.A progress note written by the Wound Nurse dated 9/10/25 at 2:05 PM read she found an open area on Resident #2's left heel. The note read the open area was unstageable and measured 2 centimeters (cm) x 1.5 (cm). On 9/11/25 the Wound Provider evaluated the left heel dorsal wound. The Wound Provider treatment note read; given the dorsal location of this wound, it was consistent with a diabetic etiology. The wound was deep and full of necrotic slough (dead tissue) and suspected the wound had been present for some time. The recommendations included: wound culture and sensitivity. On 9/11/25 at 12:48 PM the Unit Clerk wrote a progress note. The note read: Resident # 2's wound culture of left heel was collected by the Wound Provider and awaiting pick up.A laboratory report dated 09/11/25 and a final report dated 09/14/25 read in part: Wound culture left heel-moderate proteus mirabilis (bacteria) and scant staphylococcus aureus (bacteria).The Wound Provider was interviewed via phone on 9/18/25 at 1:30 PM and stated Resident #2 was evaluated by her on 9/11/25 for the first time. Resident #2 was evaluated for 3 wounds with one being the left heel diabetic wound. The Wound Provider stated the left heel wound had yellow necrotic slough and it was difficult to measure the depth but suspected it was to the bone. Furthermore, the Wound Provider stated she had ordered and obtained a culture and sensitivity for the left heel wound for suspected wound infection on 9/11/25. On 9/15/25 the Wound Provider documented the Wound Nurse reported the wound culture obtained last Thursday (9/11/25) was negative. The Wound Provider noted a subsequent culture was obtained today because she had a high suspicion that the previous culture result was inaccurate.On 9/15/25 at 12:09 PM the Wound Nurse wrote a progress note for order to repeat the wound culture and sensitivity (left heel wound).Resident #2's Nurse Practitioner (NP) was interviewed on 9/17/25 at 11:00 AM. The NP stated he was aware that Resident #2 had wounds on her back and sacrum area but did not know she had a wound on her left heel. The NP stated he was not notified of any laboratory results ordered by the Wound Provider on 9/11/25 and was not aware of her treatment orders. Additionally, the NP stated normally the Wound Provider should have been notified with results of any labs or diagnostics first because she had ordered them and then results would be placed in his folder to review or would have been called in to him. A follow-up interview was conducted with the NP 9/17/25 at 2:30 PM. He stated Resident #2's culture and sensitivity laboratory results from 09/11/25 had been reviewed by him today (09/17/25). The NP stated the culture and sensitivity for the wound on Resident #2's left heel was positive for moderate proteus mirabilis and scant staphylococcus aureus on the results dated 9/14/25. He then added orders for 2 antibiotics (Bactrim 400/80 milligrams by mouth twice daily for 14 days, Ceflin 250 milligrams by mouth one time daily for 14 days) for the infected heel wound, based on the culture and sensitivity results obtained on 09/11/25.The Medical Director was interviewed on 9/18/25 at 11:25 AM. The Medical Director stated the culture and sensitivity laboratory report was verified on 9/14/25 and the facility should have notified the Wound Provider or the NP on 9/15/25 of the results. The Medical Director said Resident #2's labs had indicated an infection of the left heel, and Resident #2 had missed 1 day of antibiotic treatment due to the Wound Provider not receiving the wound culture and sensitivity results promptly.A follow up interview with the Wound provider was conducted on 9/18/25 at 1:30 PM. The Wound Provider stated on 9/15/25, she evaluated and treated Resident #2 and was told by the Wound Nurse that the culture and sensitivity from 09/11/25 had come back negative. The Wound Provider stated she had not seen the results of the culture and sensitivity, nor had they been called or communicated to her prior to the Wound Nurse's report that they were negative. The Wound Provider went on to state she had suspected an infection of the left heel wound and was surprised the culture and sensitivity results were negative (as stated by the Wound Nurse). She ordered another culture and sensitivity to be sent to the lab for confirmation. The Wound Provider said she was only able to see laboratory results if they were uploaded to the resident's electronic chart or handed to her in person. The surveyor informed the Wound Provider the wound culture and sensitivity was completed on 9/14/25 and had been sent to the facility. Resident #2's NP had seen the results on 9/17/25 and had

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	345413	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fleshers Fairview Health Care	3016 Cane Creek Road Fairview, NC 28730

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 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 observations, record reviews and staff interviews, the facility failed to follow their Hand Hygiene and Enhanced Barrier Precautions (EBP) policy and procedures when the Wound Nurse did not don a gown, doff her gloves, perform hand hygiene and don clean gloves after removing the soiled dressing and after cleansing the wound and before applying the new dressing during wound care to Resident #8. The Wound Nurse also did not don a gown, use hand hygiene after doffing gloves after removing soiled dressing and before donning clean gloves, and did not doff gloves and use hand hygiene after cleansing the wound and before applying the new dressing during wound care to Resident #2 for 1 of 7 staff observed for infection control practices (Wound Nurse).The findings included:Review of the facility's undated policy for Enhanced Barrier Precautions (EBP) revealed: EBP are used to prevent the transmission of multidrug resistant organisms. EBP will be used when contact precautions do not apply. EBP will be used for high contact resident care involving wounds or any medical indwelling devices including central line, urinary catheter, feeding tube, tracheostomy/ventilator. High contact care including dressing, bathing, transferring, changing linens, providing hygiene, incontinent care, device care and wound care. Policy: Gloves and Hand Hygiene 1) Hand hygiene should be complete prior to donning gloves 2) Gloves should be worn when entering the room and while providing care for a resident 3) Gloves should be changed after having contact with infective material like fecal matter and wound drainage 4) Gloves should be removed before leaving the residents' room and hand hygiene should be performed immediately 5) After removing the gloves and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items. Gowns: 1) A gown should be worn when providing high contact resident care 2) If a gown is worn it should be removed before leaving the resident's room [ROOM NUMBER]) After removing the gown, clothing should not contact potentially contaminated environmental surfaces.Review of the facility's undated policy for Hand Hygiene read in part: Handwashing is the single most important thing you can do to prevent the spread of infection. Thorough handwashing removes pathogens from the skin. In order to perform hand hygiene appropriately, soap, water, alcohol-based hand rub, and a sink should be readily accessible. Staff must perform hand hygiene even if gloves are used: before and after contact with the residents, before performing an aseptic task, after contact with blood, body fluids, visible contaminated surfaces or after contact with objects in the residents' room, after removing personal protective equipment (gloves, gown and mask).1a. On 09/16/25 at 2:49 PM an observation was conducted of the Wound Nurse performing a wound treatment on an unstageable right heel of Resident #8. The Wound Nurse gathered the supplies and went to the Resident's room (there was no EBP signage on the door) where she prepared the supplies on the over bed table. The Wound Nurse did not don a gown for the treatment and proceeded to wash her hands and don gloves before she removed the soiled dressing from the unstageable right heel pressure ulcer. Then without changing her gloves and sanitizing her hands the Wound Nurse then cleansed the pressure ulcer and again without changing her gloves and sanitizing her hands she applied the ordered medication and border dressing. The Wound Nurse then removed her gloves and washed her hands.An interview was conducted with the Wound Nurse on 09/18/25 at 2:20 PM. The Wound Nurse explained that she knew she had messed up while doing wound care on Resident #8 because she did not change her gloves and wash her hands when she should have which was after she removed the old dressing and after she cleansed the wound and applied the new dressing. The Wound Nurse stated she just forgot. The Wound Nurse also explained that she did not wear a gown because she questioned the Assistant Director of Nursing (ADON) about if Resident #8 should be on Enhanced Barrier Precautions (EBP) because she had a chronic wound and she was told Resident #8 did not require EBP.1b. An observation was made on 09/18/25 at 2:12 PM of the Wound Nurse performing a wound treatment on Resident #2 who had a diabetic foot ulcer on her left heel. The Wound Nurse gathered her supplies and went to the Resident's room (there was no EBP signage on the door) where she placed the supplies on the bedside table. The Wound Nurse washed her hands and donned gloves but did not don a gown for the procedure. The Wound Nurse removed the soiled dressing from the Resident's heel and doffed her gloves and without sanitizing her hands she applied a new pair of gloves. She then cleansed the wound and without removing her gloves and using hand sanitizer she picked up the gauze soaked with a liquid used to kill bacteria and packed the wound with the gauze before she applied a border dressing to the wound. The Wound Nurse then doffed her gloves and washed her hands On 09/18/2025 at 2:20 PM an interview was

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and staff interviews, the facility failed to keep essential equipment clean and in safe operating order for 2 of 2 dryers (dryer #1 and dryer #2) observed for safe operating conditions.The findings included: On 09/18/25 at 4:00 PM an observation was made of the laundry room which was in a building separate from the facility accompanied by the Environmental Services Supervisor. Laundry Aide #1 was asked to open the dryer doors to be able to observe the dryer lint traps. The observation yielded dryer #1 and dryer #2 with copious amount of dark colored dust balls in the bottom of the dryers and both lint traps of the dryers had a sheet of lint that fell from the traps when touched that appeared to be approximately 1/4 inch thick.An interview was conducted with Laundry Aide #1 on 09/18/25 at 4:05 PM who explained that he worked on first shift and that he cleaned the dryer vents and filters every shift. The Laundry Aide could not explain the buildup lint and dust in the dryers.During the interview with the Environmental Services Supervisor on 09/18/25 at 4:05 PM the Supervisor explained that the dryer vents and lint traps should be cleaned every day, but she indicated if cleaning them every day had a buildup of lint and dust remaining like what was found then the cleaning would need to be changed to a more frequent occurrence.