STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamance Health Care Center	1987 Hilton Road Burlington, NC 27217

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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 - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interviews, the facility failed to implement their infection control policy for Enhanced Barrier Precautions (EPB) when nurse aides failed to wear a gown while providing incontinence care for Resident #59 who was on EPB. The deficient practice was observed for 3 of 9 staff observed for infection control practices (Nurse Aide #1, Nurse Aide #2, and Nurse Aide #3).The findings included:A review of the facility's policy titled Enhanced Barrier Precautions, revised on 3/26/2024. The policy stated Employees providing high-contact patient care activities will follow EBP for patients who meet the criteria. This included indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy, etc.)An observation of Resident #59's room on 4/27/2026 at 10:27 AM revealed there was yellow signage outside the room indicating Personal Protective Equipment (PPE) were to be used. The signage advised staff to clean hands before and after entering Resident #59's room, wear gloves and gowns for high contact activities such as changing briefs. The PPE was hanging on the back of the door and included gowns and gloves.An observation and interview were conducted with Nurse Aide (NA) #1 and NA #2 on 4/28/2026 at 4:26 PM. NA #1 and NA #2 were in Resident #59's room completing incontinence care for Resident #59 wearing only gloves. Both NA #1 and NA #2 stated Resident #59 was on EBP because of his feeding tube. NA #1 stated she knew she should also have a gown on while providing personal care to Resident #59 but stated she forgot. NA #1 stated they use gloves with all personal care and she just did not remember to put a gown on for Resident #59. NA #2 stated she normally did not work with Resident #59 and did not remember to put the gown on. During this observation the PPE was observed to be hanging on the back of Resident #59's room door. An interview with Nurse #4 was completed on 4/29/2026 at 11:05 AM. She stated Resident #59 was on EBP due to his feeding tube and staff were aware of the precautions due to the EPB sign outside the room and the PPE on the door. An observation on 4/29/2026 at 11:15AM revealed NA #3 completing incontinence care for Resident #59 wearing only gloves. The EPB signage and PPE were observed at the time of the observation. An interview completed at the time of the observation revealed NA #3 was aware Resident #59 was on EBP. NA #3 stated she was in a hurry and forgot to put a gown on with the gloves. The Director of Nursing (DON) was interviewed 4/30/2026 at 12:29 PM. The DON stated she expected staff to follow the parameters that were listed on the EBP signage that was posted at the doors of residents who required EBP. She stated they were expected to put on the proper PPE that was provided for everyone's safety. The DON indicated she expected staff to intervene if they observed other staff not following the precautions. She was unable to explain why the nurse aides were not using the PPE. An interview with the Administrator was conducted on 4/30/2026 at 3:40 PM. She stated she expected staff to follow the guidelines for EBP. The Administrator indicated the staff were aware of the EBP signage at the residents' room doors and the PPE that was provided. She further stated she expected staff to follow through with the EBP requirements when providing activities of daily living and personal care. The interview further revealed staff were provided with training for EBP and she was unable to explain why staff were providing care without the appropriate PPE.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with family, facility staff, and Support Representative from the money transfer application company, the facility failed to protect the resident's right to be free from misappropriation of Resident #186's cell phone and an unauthorized transfer of funds from the resident's money transfer application (a financial platform that allows users to send, receive, and manage money directly from their smartphone) on his cell phone. This deficient practice affected 1 of 1 resident reviewed for misappropriation of property (Resident #186). The findings included:Resident #186 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #186 had moderate cognitive impairment and was dependent on staff for assistance with all activities of daily living. An initial allegation report dated 9/22/25 completed by the Staff Development Coordinator (who worked as the Assistant Director of Nursing at the time of the report) indicated on 9/20/25 Resident #186 reported his cell phone was missing. A search of Resident 186's room and surrounding facility areas was conducted, but the phone was not located. On 9/22/25, the resident also reported money was missing from his money transfer application account. Staff interviewed the resident to obtain details regarding when the phone was last seen and the timeframe of the missing funds. The resident's family/responsibly party was informed, and law enforcement and Adult Protective Services were contacted. A police report dated 9/22/25 revealed the facility staff reported a missing cell phone and equipment. The police report listed in the property description as: telephone/telephone equipment with the value of $600.00.An attempt to contact the local police department was made 4/30/26 at 9:00 AM and the detective handling the case was unavailable for interview.Review of disputed charges reported to Resident #186's money transfer application company revealed on 9/24/25 a claim was filed to dispute a transaction totaling $492.00.A telephone interview was conducted on 4/30/26 at 9:30 AM with Support Representative for Resident #186's money transfer application company. The Support Representative stated on 9/19/25 a transaction was made from Resident #186's account to a mobile payment service that did not belong to the resident in the amount of $492.00. She reported that they were unable to inform the Surveyor of the identity of the account holder for the mobile payment service due to legal reasons. She indicated a dispute was filed and initially Resident #186's account had been reimbursed $492.00 and an investigation was conducted. She explained that during the investigation, it was identified that the $492.00 transaction was withdrawn from Resident #186's money transfer application account and when sent to the mobile payment service it was declined/not accepted by the mobile payment service's account holder. She further explained that the $492.00 that was withdrawn was returned back to Resident #186's money transfer application account. A statement written on 9/24/25 by Nurse Aide #12 indicated on 9/20/25 she was called into Resident #186's room (statement did not indicate who called her into the room) and asked to look and see if Resident #186's phone could be found. Nurse Aide #12 searched the room and could not find the phone. She indicated she obtained Resident #186's family's phone number so they could be notified (the statement did not indicate the date of the notification). The family reported they had been trying to reach Resident #186 and last talked with the resident on 9/19/25 but was unable to reach him. Attempts were made to contact Nurse Aide #12 on 4/30/26 at 7:45 AM and 1:30 PM and she was unavailable for interview.A telephone interview was conducted on 4/30/26 at 7:45 AM with Nurse Aide #11 who stated she had assisted the resident with purchases from an on-demand delivery platform (utilized for purchases from local merchants such as restaurants) through his money transfer application account on his phone. She indicated on the evening of 9/19/25 she assisted Resident #186 with a purchase from the on-demand delivery platform and that was the last time she saw the resident with that cell phone. An interview was conducted on 4/29/26 at 8:09 AM with Nurse #7 who stated she believed it was on 9/21/25 that she received a call from Resident #186's family who reported the resident's cell phone and some (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	money was missing from Resident #186's money transfer application. She explained that Resident #186 was dependent on staff for all activities of daily living and using his cell phone. Nurse #7 revealed the resident used a voice communication application on his cell phone with the assistance of staff and he utilized his cell phone to access his personal contacts, bank accounts, and his money transfer application. She stated that Resident #186's family also had access to the resident's money transfer application account, and they would transfer funds to the account or order him food/snacks through the resident's on-demand delivery platform account. She stated a search for the cell phone throughout the facility was conducted and the cell phone was not found and she reported the incident to the Director of Nursing (DON) and Administrator (unable to recall specific date of the report). Nurse #7 indicated she helped the family reach out to the money transfer application company to track the transactions. She stated a transaction was identified transferring funds from the resident's money transfer application to a mobile payment service account that did not belong to the resident. A telephone interview was conducted on 4/29/26 at 11:16 AM with Resident #186's Family Member #1 who stated the resident was totally dependent on assistance with all activities of daily living and the use of his cell phone. Family Member #1 stated Resident #186 used a voice communication application on his cell phone to access his personal contacts and bank accounts. She added that Resident #186 had a money transfer application account on his cell phone that he needed staff assistance to access and his bank account was connected to this application. Family Member #1 explained that the resident's money transfer application was also connected to an on-demand delivery platform. She reported that the resident's family would transfer funds into his money transfer application. She stated that his cell phone was not password protected and was easily able to be accessed by anyone. Family Member #1 explained that on Friday 9/19/25 and Saturday morning 9/20/25 the family had been trying to reach Resident #186 and was not able to do so. She stated later in the day on 9/20/25 she received a call from the facility staff (unable to recall who) to let her know Resident #186's cell phone was missing. Family Member #1 stated the facility informed her they had searched the entire facility and were unable to locate the cell phone. She indicated that the incident was reported to the police. She stated the facility initially provided a temporary flip phone; however, Resident #186 did not have the ability to operate the phone as it did not have the same functions as his previous cell phone which was a smartphone. The facility then provided a check in the amount of $315.00 for a new phone. She indicated that on 9/22/25 the resident identified that funds were transferred out of his money transfer application without his authorization. She stated Nurse #7 and the local police department assisted with getting access to the money transfer application account to find out information on the transaction. It was identified that $492.00 was transferred out of Resident #186's money transfer application to a mobile payment service account. She explained that the mobile payment service company would not release the name of the account holder. She further stated the family disputed the $492.00 transaction with the money transfer application company on 9/24/25. Family Member #1 stated during the money transfer application investigation the $492.00 was initially refunded to Resident #186's account by the company, but on and later date (unable to recall the exact date) the refund was reversed (it was identified the $492.00 had been returned to the resident's account when the account holder for the mobile payment service declined/rejected the transfer). She indicated the local police still had the case opened. Family Member #1 stated Resident #186 had since passed away.The investigation report dated 9/26/25 (the summary did not note who completed it) related to the allegation of misappropriation of property for Resident #186 reiterated the information in the initial allegation report. The summary further indicated that interviews with staff and residents yielded no evidence. The facility replaced the resident's cell phone, and the money transfer application company confirmed reimbursement of the missing funds. The police investigation remained ongoing. A telephone interview was conducted on 4/29/25 at 10:45 AM with the Former Director of Nursing (DON) who indicated he recalled the allegations of Resident #186's missing cell phone and the unauthorized money transfer application transaction. He confirmed the cell phone was (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not recovered. During interviews and the investigation, it was discovered that multiple facility staff had used Resident #168's cell phone to make purchases for the resident with his permission via Resident #186's money transfer application account. He stated that following the incident staff were re-educated on the abuse, neglect and the misappropriation policy that included that staff were strictly prohibited from using residents' funds, cash, money transfer applications or any other digital payment platforms for transactions. He stated there were no other systemic measures implemented at that time to secure resident personal property/prevent further misappropriation. A telephone interview was conducted on 4/29/26 at 2:31 PM with the Former Administrator who indicated he recalled the allegations of Resident #186's missing cell phone and the unauthorized money transfer application transaction. He stated the initial investigation was started by Nurse #7 and when the original phone could not be found, a temporary flip phone was provided to the resident until a new phone could be purchased. The facility reimbursed Family Member #1 with $315 for a replacement phone. He indicated during the investigation Nurse #7 had communicated with the local police department and the money transfer application company to determine what transactions were made around the timeframe the cell phone was noticed to be missing. The money transfer application company and local police department indicated that they would also do an investigation. The Former Administrator indicated the facility's investigation revealed staff had been assisting Resident #186 with purchases for food and snacks on his cell phone utilizing his money transfer application and an on-demand delivery platform due to the resident's limited physical mobility. The Administrator stated an immediate in-service was done by Nurse #7 on the abuse, neglect and misappropriation of property policy at the time of incident. He stated there was no further action taken or implemented to ensure the situation did not occur in the future for other residents. An interview was conducted on 4/30/26 at 4:20 PM with the Regional Nurse Consultant who indicated she was not part of the investigation process related to the misappropriation of property allegation for Resident #186. She revealed she reviewed the facility's investigation and their plan of correction (POC) and verified the POC was not complete. She indicated she had zero tolerance of misappropriation of resident's property.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Ombudsman interviews, the facility failed to send a copy of the Notice of Transfer/Discharge to the Ombudsman for 3 of 3 residents reviewed for discharge process (Resident #117, Resident #182 and Resident # 179). The findings included: 1. Resident # 117 was admitted to the facility on [DATE]. Nursing documentation dated 11/1/25 noted Resident #117 had been sent to the hospital. Resident #117's discharge assessment-return anticipated Minimum Data Set assessment noted he was discharged to the hospital on [DATE]. Review of Resident #117's medical record revealed there was no documentation that the Regional Ombudsman had received a copy of the Notice of Transfer/Discharge. A telephone interview was conducted with the former Discharge Planner on 4/30/26 at 2:40 PM. She revealed she was the discharge planner in November of 2025 and was not aware that a copy of the Notice of Transfer/Discharge was required to be sent to the Regional Ombudsman. A telephone interview was conducted with the Regional Ombudsman on 4/29/26 at 3:13 PM and she indicated she did not receive a copy of Resident #117's Notice of Transfer/Discharge. An interview was conducted with the Administrator on 4/30/26 at 4:25 PM and indicated she was new to the facility, and she expected the facility to send the Ombudsman the Notices of Transfer/Discharge as stated in the regulations. 2. Resident # 182 was admitted to the facility on [DATE]. Review of the SNF/NF (skilled nursing facility/nursing facility) Hospital Transfer Form dated 7/14/25 indicated Resident #182 was transferred to the hospital on 7/14/25. Review of the Admission/Discharge To/From Report (a cumulative list of residents that have either transferred or discharged from the facility during the reporting period) for the period of 7/1/25 through 4/30/26 revealed Resident #182 was discharged on 7/14/25 to an acute care hospital. A telephone interview was conducted with the Ombudsman on 4/30/26 at 1:40 PM. The Ombudsman confirmed she did not receive a copy of the Notice of Transfer/Discharge for Resident #182's discharge to an acute hospital on 7/14/25. A telephone interview was conducted with the former Discharge Planner on 4/30/26 at 2:35 pm and she indicated she was responsible for sending the Notice of Transfer/Discharge to the Ombudsman; however, she reported she did not start sending any notices until August 2025. The Discharge Planner indicated she had just started in July 2025 and was not aware the facility was required to provide the Ombudsman with a copy of the Notice of Transfer/Discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 4/30/26 at 4:25 PM and indicated she was new to the facility, and she expected the facility to send the Ombudsman the Notices of Transfer/Discharge as stated in the regulations. 3. Resident #179 was admitted on [DATE]. Resident #179's admission Minimum Data Set (MDS) assessment dated [DATE] noted he had severe cognitive impairment, received skilled therapy services, and his diagnoses included muscle wasting and hypertension. Nursing documentation dated 2/14/26 noted Resident #179 had been discharged to home in the care of his Responsible Party (RP). Resident #179's discharge return not anticipated MDS noted he was discharged to home/community on 2/14/26. Review of Resident #179's medical record revealed there was no documentation the Ombudsman was notified of the transfer/discharge. An interview with the Social Worker (SW) was conducted on 4/28/26 at 4:12 PM. The SW stated Resident #179 would not have received a transfer/discharge notice because his RP had initiated the discharge. The SW explained she had been recently hired and the previous SW would have sent the February discharge information to the Ombudsman. A telephone interview with the Regional Ombudsman was conducted on 4/29/26 at 3:13 PM. After reviewing the facility's information, she indicated the facility had not sent in discharge notifications. A phone interview with the Administrator was conducted on 5/1/26 at 3:38 PM. The Administrator explained the SW verified that the February discharge information had not been sent to the regional Ombudsman as it should have been.

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F 0686 Level of Harm - Minimal harm or potential for 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 observation, record review, and staff, Wound Nurse Practitioner (NP), and Medical Director interviews, the facility failed to keep the resident's pressure ulcer wound vacuum device off the floor. The resident had sacral pressure ulcer and osteomyelitis (infection of the bone) of the sacral bone. The deficient practice affected 1 of 6 residents reviewed for pressure ulcer (Resident #14). The findings included:The National Institute for Health (NIH) defines a wound vacuum device as a method using negative pressure wound therapy with proper wound preparation, debridement, dressing placement, and airtight sealing. A porous foam dressing is placed into the wound to which continuous or intermittent suction is applied by tubing and connected to a suction device. An air-tight transparent film dressing is applied over the wound. The device may be placed using sterile technique when clinically indicated. (February 21, 2026).The NIH clinical guidelines for the wound vacuum usage were that you would emphasize keeping the pump and drainage system in a controlled, clean environment, often on a treatment table or in a designated care area, to maintain sterility and ensure proper function (February 21, 2026). Resident #14 was admitted to the facility on [DATE] with diagnoses including sacral pressure ulcer and osteomyelitis of the sacral bone. Resident #14's admission Minimum Data Set, dated [DATE] documented his cognition was intact. The resident was dependent for all his activities of daily living. The active diagnoses were quadriplegia, pressure ulcer, osteomyelitis of the vertebral/sacral/sacrococcygeal regions, and injury of the spinal cord unspecified level of the cervical spine. The resident had a stage 4 pressure ulcer that was present on admission. The care plan for Resident #14 dated 3/5/26 included areas to address the pressure ulcer and osteomyelitis requiring antibiotic administration.Resident #14 had an order for sacral pressure ulcer wound care to cleanse the wound with saline, apply wound vacuum at 125 millimeters of pressure continuous therapy and apply silver alginate to surrounding areas underneath the transparent film dated 4/13/26.Resident #14's had an order for Vancomycin (antibiotic) intravenous solution 1250 milligrams in 250 milliliters of fluids administered each morning related to osteomyelitis of the vertebral, sacral, and coccygeal region dated 4/27/26.NP #3's note dated 3/8/26 documented Resident #14 had a complex medical history including quadriplegia, chronic respiratory failure with tracheostomy, Stage 4 sacral pressure ulcer with known osteomyelitis, recent Clostridioides difficile infection of his stool, and diabetes on insulin. Resident #14 was seen today for follow-up to review lab results and provide recommendations per guidelines.On 04/28/26 at 9:35 AM an observation and interview with Resident #14 was completed. A wound vacuum was in place with tubing that went to the resident's sacrum. The vacuum device was covered in a case that had a strap with a tube attached with collection container to the resident's wound dressing. The wound vacuum device was on the floor. On 4/28/26 at 9:40 am the assigned Nurse #7 was interviewed after she entered Resident #14's room and observed the wound vacuum was on the floor. Nurse #7 commented she thought the wound vacuum may need to be lower for gravity but did not know why the device was on the floor, had not placed the device on the floor and had not noticed this morning during medication administration and tracheal suction. Nurse #7 stated she was unfamiliar with the resident and was usually assigned to another hall. On 4/28/26 at 11:05 am Nursing Assistant (NA) # 4 was interviewed. NA #4 stated she was assigned to Resident #14 on day shift 7:00 am to 7:00 pm (4/28/26). She noted the wound vacuum was on the floor and thought that was unusual but did not elevate the vacuum off the floor or report this to the nurse. NA #4 stated it was usually on a chair but not today.On 4/30/26 at 11:15 AM an interview was completed with NA #7. NA #7 stated Resident #14's wound vacuum was usually sitting on the floor. On 4/30/26 at 12:53 PM an interview was completed with NA #8. NA #8 stated she observed Resident #14's wound vacuum on the floor recently. On 4/30/26 at 4:19 PM an interview was completed with NA # 6. NA #6 stated she observed Resident #14's wound vacuum on the floor on different occasions. NA #6 commented she was not sure where it should be. On 04/28/26 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:52 am the Director of Nursing (DON) was interviewed. The DON was informed that Resident #14's wound vacuum was observed to be on the floor this morning. The DON frowned when she was informed the wound vacuum was on the floor and stated she would need to get back to me when the Wound Nurse was available. The DON commented that the wound vacuum device on the floor had the tubing directly connected into the resident's sacral pressure ulcer dressing which was a concern. On 4/28/26 at 1:15 pm the Wound Nurse was interviewed. The Wound Nurse thought the wound vacuum was sitting on a chair and not on the floor daily. The Wound Nurse stated the wound vacuum should be off the floor because it was attached to the resident's wound and was part of his sterile dressing and the collection container was part of the device. The floor was not a controlled environment and the device needed to be in a clean area. The Wound Nurse indicated the dressing was placed using sterile technique. On 4/28/26 at 1:32 pm an interview was completed with the Medical Director. The Medical Director reviewed Resident #14's record and commented that the resident had a sacral pressure ulcer with osteomyelitis and the wound vacuum should not be placed on the floor because it was connected to and part of his wound dressing. The Medical Director further stated no wound care items/dressings used for a wound that had high risk of infection should be placed on the floor. On 4/29/26 at 9:00 am an interview was conducted with the Wound Nurse and Wound NP. The Wound NP stated that Resident #14's wound vacuum should not be on the floor in case of contamination because it was attached to the resident's sacral pressure ulcer dressing. The Wound NP further commented that the pressure ulcer was not infected, but the resident had osteomyelitis of his sacral bone because of the pressure ulcer and was being actively treated.On 4/29/26 at 4:10 pm an observation was completed of Resident #14's sacral pressure ulcer wound care with replacement of the wound vacuum dressing and tubing by the Wound Nurse. The Wound Nurse removed the sacral dressing and then donned sterile gloves. The wound was cleaned with sterile saline. The wound vacuum kit was in an enclosed sterile package which included a foam dressing which was cut to fit inside the wound opening and placed, the vacuum tubing was placed into the foam and covered with a transparent film dressing using sterile technique. The wound vacuum was placed on the bed's headboard, off the floor. The Wound Nurse entered the settings in the vacuum device. The Infection Preventionist (IP) was interviewed on 4/30/26 at 11:50 AM. The IP stated the wound vacuum should not be on the floor exposed to potential contamination. The IP indicated the wound vacuum was attached to Resident #14's sterile dressing and he currently had osteomyelitis as a complication of the pressure ulcer.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 have an effective system in place for communicating a therapy order for a resting left hand splint to nursing staff for 1 of 1 resident reviewed for a contracture and limited range of motion (Resident #36).Findings included:Resident #36 was admitted to the facility on [DATE]. Diagnoses included contracture of the left hand, muscle weakness and cerebral infarction (stroke).Review of an Occupational Therapy note entered by Occupational Therapist (OT) #1 and dated 12/11/25 revealed Resident #36 was referred to occupational therapy for functional decline and reassessment of compliance with splinting. The musculoskeletal assessment revealed the range of motion (ROM) and strength of both the left and right upper extremities were impaired, functional limitations were present due to contractures, the location of the contractures were the left hand and elbow, and the current orthotic device was a resting hand splint. The long-term goal was for Resident #36 to safely wear a resting hand splint on left hand for up to 5 hours with no report of pain, swelling or redness in order to reduce progression of contracture and increase ease of hygiene.The discharge summary note written by OT #1 dated 1/23/26 revealed Resident #36 progress and response to treatment had demonstrated improved tolerance of left resting hand splint to 6 hours with no complaints of pain, redness, or skin irritation. The discharge summary further revealed OT #1 recommended Resident #36 to have 24-hour care and lifeline for safety and left resting hand splint.Review of Resident #36's physician orders from 1/23/26 through 4/28/26 revealed there were no orders in place to apply a resting left hand splint.Review of the Medication Administration Record (MAR) from 1/23/26 through 4/28/26 revealed there were no orders for nursing staff to sign off that a resting left hand splint for Resident #36 was applied.The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #36 was moderately cognitively impaired and demonstrated no behaviors. Resident #36 was dependent on staff for all activities of daily living assistance. The assessment indicated Resident #36 had limited range of motion in both the upper and lower extremities and had not received occupational therapy.A review of Resident #36's active care plan revealed there was no care plan for the use of left hand splint.An observation of Resident #36 on 4/28/26 at 9:20 AM and at 12:33 PM revealed there was no resting left hand splint applied. There was no splint in view in his room at any of these times. Resident #36's left hand was noted to be contracted.An interview was conducted with OT #1 on 4/29/26 at 9:42 AM. Upon review of Resident #36's Occupational Therapy discharge summary, OT #1 confirmed that she did recommend Resident #36 to continue to wear a left resident hand splint for 6 hours a day and she did not communicate the order. The OT initially stated that it was the rehabilitation staff's responsibility to enter the orders, and then she said she needed to check with her manager.An interview was conducted with Nurse # 5 on 4/29/26 at 9:47 AM and she indicated she was regularly assigned to Resident #36 and does not recall every seeing him with a splint in use and had no active physician order for the use of a splint.An observation of Resident #36 on 4/29/26 at 10:22 AM revealed there was no resting left hand splint applied. There was no splint in view in his room at that time. An interview conducted with Nurse Aide (NA) #6 on 4/29/26 at 12:00 PM revealed she had been regularly assigned to Resident #36 since December of 2025 and had not seen or applied a splint to his left hand.An interview was conducted with the Rehabilitation Manager on 4/29/26 at 2:50 PM. The Rehabilitation Manager indicated that OT #1 was responsible for entering Resident #36's OT recommendations into the orders.An interview was conducted with the Medical Director on 4/28/26 at 1:40 PM. The Medical Director stated he would have expected the therapist to follow through with her recommendation and communicate clear orders and instructions so the order could be implemented.An interview with the Director of Nursing (DON) on 4/30/26 at 2:57 PM indicated that she would have expected rehabilitation staff to enter all therapy recommendations into the orders so the recommendations could be implemented.

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	345420	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamance Health Care Center	1987 Hilton Road Burlington, NC 27217

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F 0689 Level of Harm - Minimal harm or potential for 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 observation, record review, and staff and Medical Director interviews, the facility failed to keep a dependent resident positioned in the center of his bed so when the air mattress rotated for offload it did not cause the resident to fall out of his bed. The resident sustained a laceration above his right eye and was sent to the Emergency Department (ED). The deficient practice affected 1 of 9 residents reviewed for accidents (Resident #14).The findings included:Resident #14 was admitted to the facility on [DATE] with a diagnosis of quadriplegia.Resident #14's admission Minimum Data Set, dated [DATE] documented his cognition was intact. The resident was dependent for all his activities of daily living. The active diagnoses were quadriplegia and injury of the spinal cord unspecified level of the cervical spine. The resident had a stage 4 pressure ulcer that was present on admission. The care plan for Resident #14 dated 3/5/26 included areas that addressed his high risk for a fall and he was dependent for all his activities of daily living. The interventions were to place items within reach and to remind the resident to use the call light. Resident #14's fall progress note description dated 4/15/26 at 11:00 pm and documented by Nurse #3 revealed Nursing Assistant (NA) #6 arrived at the desk and reported Resident #14 was on the floor. The NA heard the resident yelling for help. Upon entering, the resident was noted to the lying on the floor in between the beds on the left side of his body. The right side of his shoulder, back and hip were lying on top of the leg piece of the bedside table. The urinary catheter was intact and had become separated from the bag. Blood was noted to be rolling down the left side of the resident's face. The resident was placed back in his bed by 3 staff members. The blood was noted to be coming down from the left side of the resident's eye. His face was cleaned and a laceration was noted at the top lateral left eye and left lateral cheek. Both areas were cleaned with saline and covered with xeroform (non-stick dressing) and a dry sterile dressing. A full body assessment was completed, and no further impairments were noted. A hematoma was noted to form to the top left side of the forehead at the hairline. Emergency Medical Services were called (EMS). Neurological checks of the resident were initiated. The bed was in low position, and the call pad was within reach. The resident had been and was being repositioned often. On 4/30/26 at 4:14 PM an interview was completed with NA #6. NA #6 stated she was assigned to Resident #14 on 7/15/26 day shift from 7:00 am to 7:00 pm. NA #6 stated toward the end of the shift, she heard the resident call out and found him on the floor next to his bed. NA #6 indicated she reported this to Nurse #3 immediately. The resident was assessed by the nurse. NA #6 stated she believed the resident went out to the ED. NA #6 had adjusted the resident in the bed before the fall. The resident requested to sit up in bed and would slide over and requested staff to straighten him. That was the last time NA #6 saw the resident in bed. NA #6 was not sure how long from the last time she saw the resident until he called out for help. NA #6 further stated she straightened the resident several times that shift. NA #6 stated she was not sure how the resident fell out of bed but the resident's sitting up straight in bed. may have contributed to his sliding to one side. Nurse #3 was unable to be contacted for an interview. On 4/15/2026 at 7:37 pm a change in condition for Resident #14 nurses' note was documented by Nurse #3. Nurse #3 documented the resident fell and his vital signs were Blood Pressure: 109/71 (range 110-139/60-80); Pulse: 70 (range 60 to 100); Respiratory Rate: 20 (range 12-20); Temperature: 97.9 (range 97 - 99); Pulse Oximetry: oxygen level 94.0 % (range 90 to 100%). There were no changes in mental status observed. It was documented that Resident #14 was found lying on his left side on the floor facing the window with his face against the floor and blood was on the floor under his head. The primary care provider was contacted and gave the order to send the resident to the ED for further evaluation of the laceration to his left upper eye and cheek. Resident #14's ED record dated 4/15/26 documented he fell out of bed. The resident had x-rays and a CAT (diagnostic imaging procedure) scan which revealed he had no fracture. The resident had a one (1) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	centimeter laceration to the left eyelid/brow area. The laceration was cleaned and closed with tissue adhesive. There was no mention of an injury to Resident #1's cheek. The resident was sent back to the facility the same day with no new orders. On 4/28/26 at 10:20 AM an observation and interview were completed with Resident #14. Resident #14 stated about 3 days ago he fell out of bed. The resident commented he was a quad (quadriplegic) due to a recent motor vehicle accident. The resident was on a rotating air mattress for pressure relief. He stated the staff left him on the edge of the bed and not in the middle of the bed and he fell out when the rotating mattress rotated him out of the bed. The manufacturer sheet for the rotating mattress was noted to be slick to the touch and not cotton linen. The bed was observed and was operating by his weight setting. The resident was able to state the bed was rotating left and right to move his weight to offload his wound. Resident #14 was in the center of the bed at the time of the observation. On 4/28/26 at 3:16 pm an interview was completed with NA #4. NA #4 stated she had been assigned to Resident #14 frequently and knew him well. NA #4 indicated the resident could not move independently and would not be able to roll over. NA #4 thought the resident was sitting up and coughed hard and slid to the side and then out of bed. NA #4 stated she had seen the resident cough and start leaning to his right before and had to be straightened to the center of his bed. NA #4 commented that she has had to straighten the resident in bed frequently. NA #4 indicated she was informed about Resident #14's fall out of bed and the staff were educated to keep the bed low, resident in the middle of the bed, and the head of the bed lower to keep him from sliding out of bed. On 4/28/26 at 3:33 pm an interview was conducted with NA #5. NA #5 stated she worked nights and was assigned to Resident #14. NA #5 indicated she was assigned to the resident the night before he fell. NA #5 stated Resident #14 liked to sit up in his bed and would lean to the right. She further stated she was placing a pillow on his right side at the bedrail. NA #5 stated she reported the leaning to the nurse and in shift report. The next night the resident fell out of bed. After the fall, staff was instructed to keep the resident's bed in the low position. On 4/28/26 at 1:32 pm an interview was completed with the Medical Director. The Medical Director reviewed Resident #14's record and stated the resident had quadriplegia and cannot move. The Medical Director indicated this fall was a never event and should not have happened. The staff needed to place the resident appropriately in the center of his bed so when the mattress rotates for offload it does not cause a resident to fall out. The Medical Director stated staff cannot place a resident on the edge of the bed. On 4/29/28 at 9:52 am an interview was completed with the Director of Nursing (DON). The DON stated she was aware resident #14 had fallen out of bed and that he was dependent. She was not sure how he fell out and staff was to keep his bed low. There was an investigation after the unwitnessed fall, and the cause of the fall was not determined. On 4/30/26 at 3:40 pm, an interview was completed with the Administrator. The Administrator stated she was aware that Resident #14 had fallen out of bed and he was dependent. The Administrator had no further comments.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, and Quality Assurance Pharmacist interviews, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of medication to meet the resident's needs for 1 of 1 resident reviewed for medication administration (Resident #89). The findings included:Resident #89 was admitted to the facility on [DATE] with a diagnosis of atrophic vaginitis.Review of Resident #89's order summary revealed an order for Estrace Cream 0.1miligram(mg)/gram(gm) (a medication that restores hormone levels in vaginal tissue, insert 1gm vaginally one time of day for Atrophic vaginitis for 365 days written on 3/10/25 with an end date of 3/11/26. Estrace Cream 0.1mg/gm, insert 1 gm vaginally one time a day for atrophic vaginitis was reordered on 4/13/26.Review of Resident #89's Medication Administration Records (MAR) from May 2025 through April 2026 indicated 9 (refer to progress note) for the dates listed below: 5/26/25 and 5/27/258/4/25, 8/5/25, 8/8/25 and 8/17/259/11/2511/19/25, 11/20/25, and 11/21/251/14/26 and 1/15/262/2/26 and 2/3/26Review of a progress note dated 5/26/25 written by Nurse #6 indicated the Estrace cream was ordered due to no medication applicator.Review of a progress note dated 5/27/25 written by Nurse #6 indicated she was waiting on Estrace cream that was ordered on May 26th.Review of a progress note dated 8/4/25 written by Nurse #6 indicated Estrace cream was ordered from pharmacy.Review of a progress note dated 8/5/25 written by Nurse #6 indicated she followed up with the pharmacy regarding the Estrace cream. The progress note further indicated the medication would be delivered that day on night shift. Review of a progress note dated 8/8/25 written by Nurse #6 indicated Estrace cream was ordered from the pharmacy.Review of a progress note dated 8/17/25 written by Nurse #8 indicated Estrace cream was unavailable and ordered from the pharmacy.Review of a progress note dated 9/11/25 written by Nurse #6 indicated Estrace cream was ordered from the pharmacy because there was no medication applicator.Review of a progress note dated 11/19/25 written by Nurse #6 indicated the Estrace cream was on hold because there was no medication applicator.Review of a progress note dated 11/20/25 written by Nurse #6 indicated she followed up with pharmacy regarding the Estrace cream. The progress note further indicated that the medication would be delivered with the overnight delivery.Review of a progress note dated 1/14/26 written by Nurse #6 indicated the Estrace cream was on hold because there was no medication applicator.Review of a progress note dated 1/15/26 written by Nurse #6 indicated Estrace cream was ordered because there was no medication applicator.Review of a progress note dated 2/2/26 written by Nurse #6 indicated the Estrace cream was on hold.Review of a progress noted dated 2/3/26 written by Nurse #6 indicated the Estrace cream was on hold.Multiple attempts were made with no success to contact Nurse #6 and Nurse #8, the nurses responsible for Resident #89's care when the MAR indicated 9.An interview was conducted on 4/27/26 at 12:28pm with Resident #89 (Minimum Data Set, dated [DATE] indicated resident was cognitively intact). Resident #89 verified that she was not receiving her Estrace cream as ordered. She stated at times she still does not receive her Estrace cream but was unable to provide specific dates.An interview was conducted on 5/4/26 at 4:28 pm with Quality Assurance Pharmacist with the facilities pharmacy. The Quality Assurance Pharmacist indicated they delivered 42.5 grams of Estrace cream, a 42-day supply, to the facility. The Quality Assurance Pharmacist provided the dates and times when Resident #89's Estrace cream was delivered to the facility. The dates and times are listed below:4/29/25 at 5:10 am5/29/25 at 4:56 pm6/25/25 at 4:40 am7/13/25 at 9:12 pm8/8/25 at 5:23 am8/29/25 at 5:01 pm9/20/25 at 5:05 pm10/12/25 at 9:14 pm11/21/25 at 4:24 am1/14/26 at 4:27 pm2/10/26 at 4:09 pm4/14/26 at 3:12 [NAME] interview was conducted on 4/30/26 at 12:00 pm and 5/4/26 at 2:15 pm with the Director of Nursing (DON). The DON indicated the Estrace cream only came with one applicator in the box. When asked if the facility was ordering the applicators separate from the cream, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON was unable to answer. The DON indicated nurses should order the medication when they see that the supply is getting low. If the medication was not available in the facility, nurses were expected to make the provider aware that the medication was not available and follow the providers' recommendation.An interview was conducted with the Administrator on 5/1/26 at 11:11 am. The Administrator indicated she would expect staff to be aware of the medications and supplies that were needed and order them.