STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345433	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clay County Health and Rehabilitation	86 Valley Hideaway Drive Hayesville, NC 28904

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on staff interviews, the facility failed to designate a qualified Infection Preventionist (IP) who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. This had the potential to affect all the residents residing in the facility.Findings included:During the Entrance Conference with the Administrator on 4/27/26 at 11:02 AM, he revealed the facility's Infection Preventionist position was currently vacant and the Assistant Director of Nursing (ADON) and Director of Nursing (DON) were performing those duties. He also stated that neither the ADON or DON had completed the Statewide Program for Infection Control and Epidemiology (SPICE) training or any other specialized infection prevention and control training.An interview on 4/30/26 at 10:30 AM with the DON revealed the previous IP left the facility the first part of March 2026. She stated that currently she and the new ADON were performing the IP functions but neither of them were SPICE trained and had not had any other specialized infection prevention and control training.An interview on 4/30/26 at 12:27 PM with the Administrator revealed the facility was attempting to hire an IP.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Pharmacist, and Medical Director interview, the facility failed to transcribe and implement orders for diabetes care according to the hospital discharge summary for a resident with diabetes. Additionally, the facility failed to transcribe and implement orders for the same resident's Coreg (used to treat heart failure and hypertension) according to the hospital discharge summary. This deficient practice occurred for 1 of 5 residents reviewed for significant medication errors (Resident #23).Findings included.Resident #23 was re-admitted to the facility on [DATE]. His diagnoses included type-2 diabetes mellitus with hyperglycemia, atherosclerotic (buildup of plaque in artery) heart disease of native coronary artery (blood vessels in the heart) without angina (chest pain), heart failure, hypertension.An admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #23 was cognitively intact. The MDS further documented that he had orders for insulin, received insulin injections, and hypoglycemic medication.1a. A hospital Discharge summary dated [DATE] discharge medication list included the following orders:- Insulin aspart (NovoLog) (short acting insulin) 100 units/ milliliter (ml) inject 10 units under the skin 3 times a day with meals.-Insulin aspart 100 units/ ml sliding scale insulin to be administered before meals and at bedtime. Usual correction to be used between 6:01 AM-10:59 PMBlood glucose (BG) less than 70-hypoglycemia protocol70-150-no correction insulin151-200-2 units201-250-3 units251-300-4 units301-350-6 units351-399-7 unitsGreater than 399-7 units and initiate BG greater than 399 protocol Usual correction to be used between 9:00 PM- 6:00 AMBlood glucose (BG) less than 70-hypoglycemia protocol70-200-no insulin201-250-1 units251-300-2 units301-399-3 unitsGreater than 399-3 units and initiate BG greater than 399 protocol -Insulin glargine (Lantus) (long-acting insulin) 100 units/ml inject 15 units under the skin two times a day. Resident #23's electronic record indicated his medications were entered into the electronic computer system by the Assistant Director of Nursing (ADON) when he was re-admitted on [DATE].Resident #23's electronic medical record contained active orders dated 4/14/26 for:-Insulin Aspart 100 units/ml sliding scale insulin, inject per sliding scale before meals and at bedtime.If 200-250-2 unit251-300-4 unit351-400-8 unit401-450-10 unit451-500-12 unitGreater than 500 call MD -Glargine insulin 15 units twice daily.Review of Resident #23's electronic record, active physician orders, and Medication Administration Record (MAR) for April 2026, revealed there was not an order for aspart insulin 10 units three times daily with meals that had been entered. The electronic medical record documented Resident #23's BG was monitored four times daily. His BG results were documented most frequently ranging in the 200's and 300's. From 4/14/15-4/29/26 the medical documented Resident #23's BG results were greater than 400 on 9 occasions on the following dates 4/16/26, 4/17/26, 4/18/26, 4/19/26, 4/22/26,4/25/26, and 4/26/26. Review of the April 2026 Medication Administration Record (MAR) documented Resident #23's insulin aspart sliding scale insulin and glargine insulin were administered as ordered.1b. A hospital Discharge summary dated [DATE] discharge medication list included an order for:-Carvedilol (heart medication) 12.5 mg by mouth twice daily. Review of Resident #23's active physician orders included an order dated 4/14/26 that read, Coreg (Carvedilol) oral table 12.5 mg give one table by mouth twice daily for hypertension.Review of the April 2026 Medication Administration Record (MAR) revealed Coreg was only scheduled on the MAR to be given one time a day in the morning. The MAR documented Resident #23 had only received his Coreg once daily in the morning from 4/15/26 through 4/30/26. The electronic medical record documented from 4/14/26 to 4/28/26 Resident #23's blood pressure was monitored at least daily. Resident #23's systolic blood pressure (top number in blood pressure reading, measures the maximum pressure in your arteries when the heart beats) ranged from 130-180 (normal systolic blood pressure is 120 or less). His systolic blood pressure was documented at greater than 160 on 7 occasions. Resident #23's diastolic blood (bottom number in blood pressure reading, measures pressure in your arteries when your heart is resting) pressure ranged from 68-108 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(normal diastolic blood pressure is less than 80). His diastolic blood pressure was documented at greater than 90 on 4 occasions.The electronic medical record documented from 4/14/26 to 4/28/26 Resident #23's pulse was monitored at least daily. Resident #23's pulse ranged from 73-112 (normal pulse range is 60-100). His pulse was documented at greater than 100 on 7 occasions.A care plan dated 4/16/26 was in place for hypertension. The care plan goal was to remain free of complications related to hypertension. The care plan interventions included giving anti-hypertensive medications as ordered.An interview was conducted with the Assistant Director of Nursing (ADON) on 4/30/26 at 9:33AM. The ADON said he did not recall Resident #23's 4/14/26 admission orders specifically but that he had entered the orders. The ADON stated he did not verify orders from the discharge summary with the physician on admission for residents because he was not aware he needed to do so. The ADON reviewed Resident #23's hospital Discharge summary dated [DATE]. He said he had missed entering the order for routine aspart insulin 10 unit with meals. The ADON confirmed the discharge summary orders were for Coreg 12.5 mg to be given twice daily. He reviewed the Coreg order he entered in the electronic computer system. The ADON said he had entered the time code incorrectly for Resident #23's Coreg order. He explained he had entered a once a day time code instead of a twice a day time code for Resident #23's Coreg. The ADON explained that the aspart insulin sliding scale entered was the default insulin sliding scale insulin used by the facility. The ADON said it was typically the DON or the Unit Manager (UM) who did the second check on admission orders after he entered them. He did not know who had completed the second check.An interview was conducted with the UM on 4/30/26 at 10:21 AM. The UM stated she had worked at the facility for about 6 weeks. When asked about the process for new admission orders, the UM stated she did not usually do them. The UM explained that the ADON typically entered the new admission orders and then passed the admission paperwork on to her to do all the assessments when the resident arrived at the facility. The UM said she did not perform a second check of the admission orders and said she was not sure who did the second check of the orders. The UM stated she had not been told she needed to check the admission orders. The UM said she probably should have known she needed to do so but that no one had told her she needed to.An interview was conducted with the pharmacist on 4/30/26 at 3:43 PM. The pharmacist would not comment if Resident #23's missed order for routine aspart insulin was significant or if Resident #23 receiving Coreg once a day instead of twice a day as ordered was a significant medication. The Pharmacist said medications were given for a clinical reason and Resident #23 needed the medications for that clinical reason.An interview was conducted with the Director of Nursing (DON) on 4/30/26 at 9:52 AM. The DON reported the facility performed new admission audits and said reviewing the orders was part of that audit. The DON said she recalled reviewing Resident #23's orders and discharge summary in the clinical meeting. The DON stated during the morning clinical meeting they checked the discharge summary orders against the orders entered in the electronic computer system. The DON explained she printed a copy of the orders from the electronic computer system and used the paper copy to check the orders against the discharge summary but did not open each order in the electronic computer system to ensure the time codes were accurate. The DON said orders were supposed to have a second check by a nurse. She reported the UM and ADON who were supposed to check the new admission orders. The DON explained that previously she had entered the new admission orders but during the last month that had changed because the facility had filled the ADON and UM positions and she had turned that over to them to do. The DON stated the ADON and UM had been trained and told what was expected. She reported if the orders were put in by one then the other should do the second check of the admission orders. The DON explained that outside of business hours the floor nurses were responsible for verifying and entering the new admission orders, and then ADON or UM were supposed to perform the second check. The DON stated orders should be entered accurately from the discharge summary unless the provider changed something when the orders were verified. She said if the provider did change something then it should be noted on the discharge summary. She stated if the provider was not in the building, then the nurse (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was supposed to call and verify the orders with the provider over the phone and note on the discharge summary who the orders were verified with and the date. The DON said she was unable to locate a verified or facility provider signed copy of Resident #23's 4/14/26 discharge summary. The DON stated the ADON and UM positions were recent positions that had been filled and additional training was needed. The DON did not think the missed order for Resident #23's routine aspart insulin was a significant medication error because his blood sugars were being monitored and he had an order for sliding scale insulin. The DON did not think Resident #23 receiving Coreg once a day instead of twice daily was a significant medication error because he was still receiving the medication.An interview was conducted with the Medical Director on 4/30/26 at 12:47 PM. The Medical Director stated the facility should follow the discharge summary orders and enter them accurately. The Medical Director indicated the facility should verify discharge summary orders for new admissions with a provider. The Medical Director stated he did not want the sliding scale insulin scale on Resident #23's discharge summary used. He explained that the sliding scale insulin orders in place for Resident #23 was the default sliding scale used at the facility when sliding scale insulin was ordered and that was what he wanted to be in place. The Medical Director did not think Resident #23's order for routine aspart insulin 10 units before meals being missed was a significant medication error because he was receiving sliding scale insulin and his blood sugars were being monitored. The Medical Director stated Resident #23 not receiving his Coreg twice daily as ordered could be significant because it could affect the heart. He said Resident #23 should have received his Coreg as ordered. The Medical Director said the potential for the medication error to be significant was high because Coreg was a heart medication and by default, he would consider it a significant medication error.An interview was conducted with the Administrator on 4/30/26 at 5:34 PM. The Administrator stated admission orders should be entered accurately and according to the hospital discharge summary.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Registered Dietitian (RD) interviews, the facility failed to follow Registered Dietitian recommendations for nutritional supplement for a resident with significant weight loss for 1 of 5 residents reviewed for nutrition (Resident #44).The findings included:Resident #4 was admitted to the facility on [DATE]. Her diagnoses included dementia. A care plan last revised on 3/26/25 was in place indicating Resident #44 had a nutritional problem/ potential nutritional problem. The care plan goal was for her to maintain adequate nutritional status as evidenced by maintaining weight within 5% of body weight, not having symptoms of malnutrition, and consuming at least 50 % of meals daily. The care plan interventions included for the Registered Dietitian to evaluate and make diet change recommendations as needed, provide and serve diet as ordered, weight per facility guidelines, and monitor/ report symptoms of malnutrition. Resident #44's electronic medical record documented on 12/5/25 her weight was 120 poundsA quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had severe cognitive impairment. She was documented for behaviors or rejection of care. The MDS indicated she was able to feed herself after meal set up, her weight was 120 pounds, and that she did not have weight loss.Resident #44's electronic medical record documented on 1/5/26 her weight was 110 poundsAn order by the Medical Director dated 1/14/26 read, health shake (nutritional supplement) one time daily.An RD note dated 2/5/26 indicated Resident #44's current weight was 110 pounds and noted she had signification weight loss at the 30-day mark. The RD note indicated Resident #44 was started on a supplement and Remeron (antidepressant used to treat appetite) in response to the weight loss. The RD note recommended continuing the current nutritional intervention.Resident #44's electronic medical record documented on 2/11/26 her weight was 109.6 pounds and on 3/4/26 her weight was 109 pounds.A diet order dated 3/22/26 read: Regular diet, mechanical soft texture, regular/ thin liquid consistency. Resident #44's electronic medical record documented on 4/1/26 her weight was 101.8 poundsResident #44's electronic medical record under progress notes contained a significant weight change assessment progress note dated 4/14/26 by RD #1. The note indicated Resident #1 had a 6.6 % weight loss over 1 month reported for the month of April. The note stated she received health shakes daily and the RD recommended increasing her health shakes to three times a day for support of continued weight loss.Review of Resident #44's physician orders revealed there was no order for the health shakes to be increased to three times a day.An interview with Nurse #1 was conducted on 4/29/26 at 11:00 AM. Nurse #1 stated she was Resident #44's routine nurse. She reported Resident #44 only received a health shake once a day. She explained health shakes were given to residents by the nurse and were kept in the nourishment refrigerator or were sent from the kitchen.An interview was conducted with RD #2 on 4/29/26 at 9:27 AM. The RD stated Resident #1 had weight loss previously from December 2025 to January 2026. She reported her weights had remained stable from January until March and then her weight had started declining again in April. She explained she was the facility's routine RD and had been coming to the facility for 8 years. She reported she came to the facility every other week and then worked remotely every other week. RD #2 stated she did have other RDs who helped her review residents to keep up to date with assessments. RD #2 reported Resident #44 had been reviewed by RD #1 for weight loss on 4/14/26 and it was recommended to increase her health shakes to three times a day. RD #2 explained after residents were reviewed the RD recommendations were emailed to the Director of Nursing (DON) and the DON entered the new orders into the electronic computer system. RD #2 explained RD #1 had emailed his recommendations to her instead of emailing them to the facility after his review on 4/14/26. She stated RD #1's recommendations had probably gotten lost in her email, and she had missed sending them to the facility. RD #2 stated RD #1 had just started helping her and had not known he needed to email the recommendations to the facility. She reported RD #1 had been emailing his recommendations to her, but she had since corrected RD #1 and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told him he needed to email the recommendations to the facility.An interview was conducted with the DON on 4/29/26 at 10:20 AM. The DON stated monthly weights were typically completed by the 5th day of the month and then reviewed by the interdisciplinary team during the clinical morning meeting. She reported that after the monthly weights were reviewed the RD was notified if a resident had weight loss and needed to be seen. The DON indicated the RD also reviewed the weights. The DON said during the morning clinical meeting they discussed if there were any concerns about a resident losing weight, not eating, or showing decline and she notified the RD to see the resident. The DON reported she had not received the RD recommendation to increase Resident #44's health shake to three times a day. The DON said there was not a process in place for reviewing the RD notes. She explained she relied on the RD sending the recommendations to her by email and then she entered the orders for whatever was recommended. The DON stated she was not aware of another RD helping RD #2 and was not sure what had happened. The DON stated Resident #44 should have received the health shakes three times a day if it was recommended by the RD but she had not been aware. An interview was conducted with the Administrator on 4/30/26 at 5:34 PM. The Administrator stated the facility had a process for RD recommendations but that something happened in the process where they had not received the RD recommendations for Resident #44.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Medical Director interviews, the facility failed to ensure the physician visit included a plan to address an abnormal low thyroid laboratory test from the hospital discharge summary. This deficient practice occurred for 1 of 3 residents reviewed for physician visits (Resident # 1).Findings included:A hospital Discharge summary dated [DATE] indicated Resident #1 had been hospitalized for COVID-19 pneumonia. The discharge summary documented that her thyroid stimulating hormone (TSH) level was low with a result of 0.36 (typical normal range is 0.4-4.0). The discharge summary recommended follow up with primary care provider for repeat thyroid function tests.Resident #1 was readmitted to the facility on [DATE]. Her diagnoses included pneumonia due to COVID and dementia.Resident #23's medical record did not contain a diagnosis of thyroid disease or physician order for any thyroid medication.Resident #1's medical record did not contain any information indicating she had laboratory work completed by the facility to recheck her thyroid function.A physician visit note dated 3/16/26 by the Medical Director stated she was being seen for an initial assessment and history and physical after hospitalization. The note documented TSH was suppressed. Under the section diagnosis, assessment, and plan of the note, there was not a plan included which addressed rechecking her thyroid function or addressing the abnormal thyroid laboratory test. An admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had severe cognitive impairment.An interview was conducted with the Medical Director on 4/30/26 at 12:47 PM. The Medical Director stated he mentioned in his visit note on 3/16/26 that Resident #1's TSH was suppressed but said it had gotten by him to order it to be rechecked. He stated there should have been a plan to recheck her TSH. He reported Resident #1 did not have any mention in her medical history about thyroid issues and that was probably why he missed it. He explained he used the resident's medical history to populate and create the framework for his visit notes. The Medical Director stated checking a follow up TSH for Resident #1 was warranted. He reported the facility should also be monitoring and following up on labs too. The Medical Director stated he could not say there was no adverse effect until they assessed Resident #1's thyroid function thoroughly. He explained there were different medical conditions that could cause a low thyroid level such as a benign tumor (non-cancerous tumor) or mild version of grave's disease (thyroid disease) that would not be very problematic to treat. The Medical Director stated COVID could also cause inflammatory changes in organs, but that most likely Resident #1's low thyroid level was not a result of COVID and was most likely present before her COVID illness. An interview was conducted with the Administrator on 4/30/26 at 5:34 PM. The Administrator stated he expected staff to review the discharge summary and to follow and implement the orders from the discharge summary.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Consultant Pharmacist, and Consultant Pharmacist Supervisor, the Consultant Pharmacist failed to identify irregularities regarding laboratory monitoring for 1 of 1 resident with a diagnosis of diabetes reviewed for unnecessary medication (Resident #12).Findings included: Resident #12 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus. Review of Resident #12's electronic health record revealed an A1c of 7.9% dated 7/02/25. This was the last documented A1c in the medical record. (A1c is a blood test that measures your average blood sugar levels over the past 3 months). Nurse Practitioner progress note dated 10/30/25 read in part that the CBGs (capillary blood glucose) stable. The note recommended DC (discontinuation) of Accu-Cheks (finger sticks to check blood sugar) at that time and continue with routine A1c monitoring. Continue Metformin. Further review of Resident #12's electronic health record revealed there was no order for routine A1c monitoring. Review of Resident #12's medical records revealed the Consultant Pharmacist had conducted medication regimen reviews (MRRs) monthly on 11/12/25, 12/22/25, 1/15/26, 2/11/26, 3/13/26, and 4/12/26. There were no recommendations for any monitoring laboratory tests. During an interview on 4/30/26 at 3:54 PM the Consultant Pharmacist stated he had not recommended an A1c lab test for Resident #12's Metformin medication monitoring. He also stated he sometimes looked for laboratory results and sent recommendations to the Physician, but he did not catch everything. During an interview on 4/30/26 at 3:59 PM the Consultant Pharmacist Supervisor stated if a resident was taking diabetic medication such as Metformin, the Consultant Pharmacist should have reviewed laboratory test results for medication monitoring and made the necessary recommendations. She stated the Consultant Pharmacist should have recommended blood sugar level monitoring such as an A1c. An interview on 4/30/26 at 11:01 AM with the Director of Nursing (DON) revealed the Consultant Pharmacist did not make a recommendation for A1c laboratory tests for Resident #12. She stated the facility system for scheduled lab tests was after the Physician ordered the laboratory test, the nurse would write them in a calendar, and they would be drawn when they were due. The DON indicated although she reviewed the monthly medication regimen reviews, she had not identified that a recommendation for an A1c for Resident #12 was missing. An interview on 4/30/26 at 12:27 PM with the Administrator revealed he deferred to the Director of Nursing for questions about medical monitoring.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Physician, Consultant Pharmacist, and Consultant Pharmacist Supervisor interviews, the facility failed to ensure monitoring for medication management was completed as recommended by the medical provider for 1 of 6 resident with a diagnosis of diabetes reviewed for unnecessary medications (Resident #12).Findings included: Resident #12 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus. Resident #12's physician's orders included an order dated 8/07/25 for Metformin (oral medication primarily used to manage type 2 diabetes) 500 milligrams (mg) by mouth every day. A Nurse Practitioner progress note dated 10/30/25 read in part that the CBGs (capillary blood glucose) stable. The note recommended DC (discontinuation) of Accu-Chek (finger sticks to check blood sugar levels) at that time and continue with routine A1c (blood test that measures your average blood sugar levels over the past 3 months) monitoring. Continue Metformin. The Nurse Practitioner was not available for interview. Review of Resident #12's Physician's orders revealed the Nurse Practitioner discontinued the finger stick blood sugars on 10/30/25. Further review of Resident #12's physician's orders showed no diagnostic lab tests ordered for diabetes monitoring. During an interview on 4/30/26 at 12:45 PM the Physician stated that Resident #12 should have had an A1c test quarterly to monitor his blood sugar levels. He acknowledged it was his fault he had missed that the testing needed to be done and had not ordered it. During an interview on 4/30/26 at 3:59 PM the Consultant Pharmacist Supervisor stated if a resident was taking diabetic medication such as Metformin, the facility should have been monitoring the resident's blood sugar levels with an A1c laboratory test. An interview on 4/30/26 at 11:01 AM with the Director of Nursing (DON) revealed Resident #12 should have had an A1c test scheduled quarterly. She stated the Physician did not order any additional monitoring of Resident #12's blood sugar and the facility staff had not recognized that it should have been done. The DON stated Resident #12's progress notes were reviewed and discussed at morning meetings so the missing A1c order should have been identified during the review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observations and staff interviews, the facility failed to discard expired medication from the medication room for 1 of 1 medication room observed for medication storage and labeling. Additionally, the facility failed to keep unattended medications in a secured medication cart for 1 of 4 medication carts (300-hall medication cart) observed for medication storage. Findings included: 1. On 4/30/26 at 9:00 AM observations of the medication room were conducted with Unit Manager (UM) #1 and revealed the following: a. Three prefilled Pneumovax 23 (pneumonia vaccine) 0.5 milliliter (ml) single dose syringes were found in the refrigerator with a manufacturer's expiration date of 1/24/26. b. Two Acetaminophen 650 milligram (mg) suppositories with a manufacturer's expiration date of 3/2026. c. Four unopened 118 ml bottles of Dextromethorphan HBR Guaifenesin (cough medicine) with a manufacturer's expiration date of 2/2026. On 4/30/26 at 9:09 AM an interview was conducted with UM #1. She stated expired medications should be removed and discarded from the medication room. She was not sure who was responsible for checking the medication room for expired medications. An interview with the Pharmacist was conducted on 4/30/26 at 3:00 PM. The Pharmacist stated expired medications should be removed and discarded from the medication room. He said pharmacy performed a spot check of the medication room for expired medications but did not do an all-inclusive check of all the medications stored in the medication room. The Pharmacist reported the facility was responsible for checking the medication room for expired medication outside of the spot checks done monthly by the pharmacy. He said if he noticed a trend or issue with expired medications being found then he would let the facility know so they could do a more in-depth check. The pharmacist reported he had completed a spot check of the medication room last week on 4/16/26 and had not noticed a trend or issues with expired medications found. An interview was conducted with the Director of Nursing (DON) on 4/30/26 at 3:49 PM. The DON stated expired medication should be removed and discarded from the medication room. She reported the medication room was supposed to be checked weekly but said it was not assigned to a specific individual. She reported there was not a check list or anything staff completed or turned in when the medication room was checked. The DON further stated staff were supposed to check the expiration date anytime they took a medication out of the medication storage room. She stated it was an honor system that staff checked the medication room for expired medications. An interview was conducted with the Administrator on 4/30/26 at 5:34 PM. The Administrator stated he expected expired medications to be removed from the medication room. 2. On 4/28/26 at 10:24 AM an observation of the 300-hall medication cart revealed it was unattended (continued on next page)

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	345433	A. Building B. Wing	05/01/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the hallway and was unlocked (a red dot was visible on the lock mechanism which indicated an unlocked position). There was one resident in a wheelchair in the hallway during this time. Medication Aide #1 returned to the cart at 10:25 AM from behind a closed resident room door. During an interview on 4/28/26 at 10:25 AM Medication Aide #1 acknowledged she did not lock the medication cart and indicated she should have pushed in the lock before leaving the cart. Medication Aide #1 reported the medication cart should have been locked for resident safety. An interview on 4/29/2026 at 12:23 PM with the Director of Nursing (DON) revealed Medication Aide #1 should not have walked away and left the medication cart unlocked. She acknowledged the medication cart was supposed to be kept locked for resident safety. During an interview on 4/30/26 at 5:29 PM the Administrator revealed medication carts should be kept locked for safety when unattended.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews, the facility failed to implement their policy and procedures for glucometer disinfection, standard precautions, and hand hygiene when Medication Aide #1 failed to disinfect Resident #23's assigned glucometer after performing a capillary blood glucose (CBG) test. Additionally, Medication Aide #1 failed to wear gloves when she performed the CBG test and failed to perform hand hygiene before and after performing the CBG test. This deficient practice occurred for 1 of 3 glucometer infection control observations and 1 of 3 hand hygiene observations (Medication Aide #1).The findings included: a. The facility policy dated 6/1/25 and entitled Glucometer Disinfection read in part: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne disease to resident and employees.The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against Human Immunodeficiency Virus (HIV) (blood borne virus), Hepatitis C (blood borne virus), and Hepatitis B (blood borne virus).Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. The glucometer User Instruction Manual read in part: Put on gloves, inspect for blood, debris, dust or lint anywhere on the meter. Blood and bodily fluids must be thoroughly cleaned from the surface of the meter. To clean the meter, use a moist lint-free dampened cloth. To disinfect your meter, clean the meter surface with approved disinfecting wipe. Allow surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet. Avoid wetting the meter test strip port. Wipe meter dry or allow to air dry. A continuous observation was conducted on 4/29/26 from 11:25 AM to 11:35 AM of Medication Aide #1 performing a blood glucose test for Resident #23. Medication Aide #1 removed the glucometer from the top drawer of her medication cart. The glucometer was stored in a zippered storage bag and labeled with Resident #23's name. Medication Aide #1 gathered supplies (an alcohol pad, lancet, gauze pad, and test strips). Medication Aide #1 was accompanied as she carried the glucometer and supplies down to Resident #23's room. After entering the room, Medication Aide #1 put the glucometer and supplies down on the resident's bed. Medication Aide #1 wiped the resident's finger with an alcohol pad, used a lancet to perform a finger stick to obtain a drop of blood, and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Medication Aide #1 discarded the trash. She exited Resident #23's room with the lancet and glucometer. As she walked back up the hallway to the medication cart, Medication Aide #1 placed the glucometer back into the zippered storage bag labeled with Resident #23's name. When she returned to the medication cart, she placed the lancet into the sharps container and returned the glucometer to the top drawer of the medication cart. There were disinfectant wipes present in the bottom drawer of the medication cart. An interview was performed with Medication Aide #1 on 4/29/26 at 11:35 PM. Medication Aide #1 said resident glucometers were for individual use and not shared. Medication Aide #1 stated glucometers were supposed to be disinfected after each use. She explained she was planning on disinfecting all three of the glucometers on the medication cart after she was done doing all the CBG checks on her hall. Medication Aide #1 reported she was taught to disinfect the glucometer using a disinfectant wipe after each use, and before placing it back into the storage bag or putting the glucometer back into the medication cart. Medication Aide #1 then reported she had just forgotten to disinfect the glucometer. An interview was conducted with the Director of Nursing (DON) on 4/29/26 at 12:23 PM. The Director of Nursing reported glucometers were not shared and were for individual use. She stated that glucometers needed to be disinfected after each use to prevent the transmission of blood borne pathogens. An interview was conducted with the Administrator on 4/30/26 at 5:34 PM. The Administrator stated that glucometers should be disinfected after each use. He said staff should (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow the facility's policy for glucometer disinfection. b. A facility policy dated 6/1/25 and entitled Standard Precautions read in part: Staff must wear personal protective equipment (PPE) as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infections materials is likely. -Under Standard Precautions Infection Control Protocol section Personal Protective Equipment read in part, Gloves: for touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes, non-intact and intact resident skin. Hand Hygiene: After touching blood, body fluids, excretions, contaminated items; before and after removing PPE. A policy dated 6/1/25 entitled Hand Hygiene read in part All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in locations within the facility. -Hand hygiene is a general term for cleaning your hands by hand washing with soap and water or the use of antiseptic hand rub also known as alcohol-based hand rub.Staff will perform hand hygiene as indicated using proper technique consistent with accepted standards of practice. -Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. The hand hygiene table indicated hand hygiene should be performed after handling contaminated objects, before applying and after removing PPE, including gloves. Before performing resident care procedures and after handling items potentially contaminated with blood, body fluids, secretions or excretions. A continuous observation on 4/29/26 from 11:25 AM to 11:35 PM was conducted of Medication Aide #1 performing a CBG check for Resident #23. Medication Aide #1 removed the glucometer from the medication cart; she did not perform hand-hygiene while at the medication cart. She was accompanied as she walked to Resident #23's room. She entered the room and placed the glucometer down on the bed. After entering the room Medication Aide #1 did not perform hand hygiene or put on gloves. While not wearing gloves, Medication Aide #1 wiped the resident's finger with an alcohol pad, used the lancet to perform a finger stick, gently squeezed the tip of his finger until a drop of blood formed, wiped the first drop of blood from his finger using the gauze pad, then gently squeezed his finger again until a drop of blood formed, and applied the drop of blood to the test strip. After applying the drop of blood to the test strip she held the gauze pad on his finger to stop the bleeding. After performing the CBG test, she discarded the trash and exited the room. Medication Aide #1 did not perform hand hygiene prior to exiting the room. She was accompanied as she walked back to the medication cart. At the medication cart she discarded the lancet and opened the top drawer and placed the glucometer back into the cart. She then sanitized her hands using hand-sanitizer. An interview was conducted on 4/29/26 at 11.35 AM. Medication Aide #1 first said she did not wear gloves when performing CBG checks because she did not know she was supposed to. She stated she had not performed hand-hygiene before or after doing the CBG check because she was nervous and had forgotten but said she knew that she was supposed to. Medication Aide #1 then changed her response and stated she did typically wear gloves when performing CBG checks but had gotten nervous and forgotten. An interview was conducted with the Director of Nursing (DON) on 4/29/26 at 12:23 PM. The Director of Nursing stated Medication Aide #1 should have worn gloves when doing Resident #23's CBG check and should have performed hand-hygiene before and after. An interview was conducted with the Administrator on 4/30/26 at 5:34 PM. The Administrator said staff should follow the facility's policy for hand hygiene and Medication Aide #1 should have worn gloves.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to document a resident or Responsible Party (RP) were provided education regarding the benefits and potential side effects of the pneumococcal immunization or if the resident received the pneumococcal immunization or did not receive it due to a medical contradiction or refusal. In addition, there was no documentation the resident was offered the pneumococcal immunization. This occurred for 1 of 5 residents reviewed for immunizations (Resident #6). The findings included:A review of the facility's policy entitled Pneumococcal Vaccine' last revised 10/22/25 read in part that each resident will be assessed for pneumococcal immunization upon admission. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized in accordance with physician-approved standing orders.Resident #6 was admitted to the facility on [DATE] with diagnoses which included congestive heart failure and chronic obstructive pulmonary disease.Review of Resident #6's electronic medical record revealed no documentation education was provided about the risks and benefits of the pneumococcal immunization, if the immunization was offered, or if the immunization was received or refused.An interview on 4/30/26 at 10:30 AM with the Director of Nursing (DON) revealed the previous Infection Preventionist (IP) left the facility the first part of March 2026. She stated that currently she and the new Assistant DON were performing the IP functions. The DON was unable to provide any documentation about Resident #6 pertaining to pneumococcal immunization.An interview on 4/30/26 at 12:27 PM with the Administrator revealed the facility was attempting to hire an IP and he was aware that resident immunizations were not up to date.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to assess a resident for eligibility and ensure a resident was offered the COVID-19 vaccination for 1 of 5 residents reviewed for immunizations (Resident #6).Findings included:A review of the facility's policy entitled ?COVID-19 Vaccination' last revised 11/13/25 read in part that COVID-19 vaccinations will be offered to resident as per Centers for Disease Prevention and Control (CDC) guidelines unless it is medically contraindicated, the individual has already been immunized or refuses to receive the vaccine.Resident #6 was admitted to the facility on [DATE].Review of Resident #6's electronic medical record revealed no documentation the COVID-19 vaccine was offered to the resident. There was also no documentation the resident or responsible party were educated regarding the benefits and potential risks associated with the COVID-19 vaccine or if the resident consented to or refused the COVID-19 vaccine.An interview on 4/30/26 at 10:30 AM with the Director of Nursing (DON) revealed the previous Infection Preventionist (IP) left the facility the first part of March 2026. She stated that currently she and the new Assistant DON were performing the IP's functions. She stated she did not have a list of residents who had received the COVID-19 vaccine and was unable to provide information about Resident #6's COVID-19 vaccine status.An interview on 4/30/26 at 12:27 PM with the Administrator revealed the facility was attempting to hire an IP and he was aware that resident immunizations were not up to date.

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F 0712 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and physician interviews, the facility failed to ensure physician visits were performed at least once every sixty days for 3 of 3 sampled residents reviewed for physician visits (Residents #62, #44 and #9). 1. Resident #62 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, dementia and diabetes.Resident #62's annual Minimum Data Set (MDS) assessment dated [DATE] indicated she was severely cognitively impaired and was dependent on staff for most activities of daily living. A review of Resident #62's electronic health record revealed a Nurse Practitioner (NP) progress note dated 12/18/25 and a Physician's annual wellness visit dated 3/31/26. No further documentation was found to show the Physician or NP had visited or assessed the resident between 12/18/25 and 3/31/26. An interview with the Physician on 4/30/26 at 2:31 PM revealed he used scheduler software to track required resident visit dates. He explained he currently did not have an NP and was doing the best he could to stay in compliance with resident visits but acknowledged he let some visits slip by. An interview on 4/30/26 at 11:01 AM with the Director of Nursing (DON) revealed it was the Physician's responsibility to visit and assess residents as required by the regulation. She indicated the Physician was responsible for organizing and maintaining his visit schedule. During an interview with the Administrator on 4/30/2026 at 5:48 PM he revealed the Physician should have seen residents as required by regulation. 2. Resident #44 was admitted to the facility on [DATE]. Her diagnoses included dementia. A Nurse Practitioner (NP) note dated 1/29/26 indicated Resident #44 was seen for a 90 day follow up visit. A Physician visit note dated 4/20/26 indicated Resident #44 was seen for a federally mandated visit and acute visit. Resident #44's electronic medical record did not contain documentation where she was seen by the Physician or NP from 1/30/26 through 4/19/26 (80 days). An interview was conducted with the Director of Nursing (DON) on 4/30/27 at 2:00 PM. The DON was not sure how often residents were required to be seen by the Physician/ NP but said she would check. She explained the Medical Director kept up with his routine visits and when residents needed to be seen. An interview was conducted with the Medical Director on 4/30/26 at 12:47 PM. The Medical Director stated residents were supposed to be seen on admission, then 30 days after admission, 60 days after admission, 90 days after admission, and then every 60 days. He stated visits could be alternated with an NP. The Medical Director explained he currently did not have an NP to help him and said he was doing the best he could to stay in compliance with regulations. He reported he used an internal (continued on next page)

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F 0712 Level of Harm - Potential for minimal harm Residents Affected - Some	scheduler system to track and schedule resident visits but sometimes visits slipped through. He said he did not think anyone at the facility was following routine visits and when residents needed to be seen. The Medical Director stated Resident #44 should have been seen around 3/29/26 or early April and he missed it. An interview was conducted with the Administrator on 4/30/26 at 5:34 PM. The Administrator stated residents should be seen by the Physician/ NP timely and as required. The Administrator stated there had been transition in the NP role and thought it may have played a part in the missed visits. 3. Resident #9 was admitted to the facility on [DATE] with diagnoses which included coronary artery disease and hypertension. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #9 had moderately impaired cognition and required moderate staff assistance for most activities of daily living. Review of Resident #9's electronic health record revealed a Nurse Practitioner (NP) progress note dated 12/11/25 and a Physician's federal mandated visit dated 2/10/26. No further documentation was found to indicate the Physician or NP had visited or assessed the resident after 2/10/26. An interview on 4/30/26 at 2:31 PM with the Physician revealed he used scheduler software to track required resident visit dates. He explained he currently did not have an NP and was doing the best he could to stay in compliance with resident visits but acknowledged that some visits 'slip by.' He confirmed that Resident #9's last visit occurred on 2/10/26 and she should have been seen on 4/16/26 but was not. He stated he was not at the facility on 4/16/26, so that visit had been missed. An interview on 4/30/26 at 11:01 AM with the Director of Nursing (DON) revealed it was the Physician's responsibility to visit and assess residents as required by regulation. An interview on 4/30/26 at 12:27 PM with the Administrator revealed the Physician was responsible for seeing residents as required by regulation.