STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to reschedule and hold a care plan meeting that was previously cancelled and invite the resident to participate in the care planning process for 1 of 1 sampled resident (Resident #43). Findings included: Resident #43 was admitted to the facility on [DATE]. Review of a Care Conference Record dated 12/02/24 revealed a quarterly care plan meeting was held with Resident #43 in attendance. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had intact cognition. Review of a Social Worker (SW) progress note dated 03/11/25 revealed Resident #43 was currently in the hospital and his care plan meeting would be rescheduled upon his return to the facility. Review of a physician progress note dated 03/17/25 revealed Resident #43 was seen for a post-hospitalization visit following his hospital stay on 03/08/25 through 03/14/25. Review of Resident #43's electronic medical record revealed no documentation that a care plan meeting was held or Resident #43 was invited to attend a care plan meeting following his return from the hospital on [DATE]. During an interview on 04/28/25 at 9:50 AM, Resident #43 stated he had attended care plan meetings in the past but could not recall attending one this year (2025). Resident #43 stated he was usually notified of upcoming care plan meetings and expressed that he wanted to participate in the care plan meetings so he could communicate and provide input about his care. During an interview on 04/30/25 at 12:15 PM, the SW revealed she was the one responsible for keeping track of the schedule for care plan meetings and invited alert and oriented residents to attend when a care plan meeting was due. The SW confirmed the care plan meeting scheduled for Resident #43 in March 2025 was cancelled due to him being in the hospital. The SW explained she had planned on rescheduling the care plan meeting once Resident #43 returned from the hospital but she dropped the ball and the meeting was never rescheduled. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/25 at 5:37 PM, the Administrator explained the SW was very good at keeping track of the care plan meeting schedule and Resident #43's care plan not getting rescheduled following his hospital stay was an oversight. The Administrator stated she would have expected for the SW to make a follow-up note to reschedule Resident #43's care plan meeting when he returned from the hospital and a care plan meeting held with Resident #43.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff and resident interviews, the facility failed to assess residents for the ability to self-administer medications for 1 of 1 resident reviewed for self-administering medications (Resident #59). The findings included: Resident #59 was admitted on [DATE] with diagnosis that included type 2 diabetes and gastroesophageal reflux disease. Resident #59 had a physician's order for calcium carbonate antacid 2 tablets every 6 hours as needed for gastroesophageal reflex disease ordered 10/9/24. Resident #59's quarterly minimum data set (MDS) assessment dated [DATE] coded her as cognitively intact. A review of Resident #59's care plan dated 3/7/25 revealed no care plan for self-administration of medication. A review of Resident #59's medical record found no assessment for self-administration of medication. An observation in Resident #59's room on 4/28/25 at 10:58 AM found a partially used bottle of liquid bismuth, a bottle of chewable antacids, and an unopened box of [topical treatment for the mouth and gums that may be used to relieve pain] on her bedside table. The resident stated she had the medications for a long time and would take them when her stomach was hurting. Resident #59 said she had the medications ordered and delivered to her. On 4/28/25 at 2:19 PM an observation with Nurse #2 in Resident #59's room found the medications remained at bedside. Resident #59 stated to Nurse #2 she had always had the medications and that she bought them from a store. Nurse #2 told the resident she was not allowed to keep the medications in her room or take them without a nurse giving them to her to take. On 4/28/25 at 2:19 PM Resident #59's assigned Nurse #2 was interviewed. Nurse #2 stated she had administered Resident #59's medication that morning and had not noticed any medications in Resident #59's room. Nurse #2 said Resident #59 was not assessed to take her own medications and should not have any medications stored in her room. Nurse #2 was observed removing the bottle of bismuth, antacid chewable, and the unopened box of [topical treatment for the mouth and gums] from the bedside table. The Nurse stated she was unaware the Resident had those medications at bedside and did not see them in the room when she administered Resident #59's morning medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 5/1/25 at 4:37 PM. She stated that Resident #59 would often order items that included medications to be delivered to her at the facility. The DON said Resident #59 would not let the facility search her items or her room for any medications she may have ordered. Additionally, the DON stated Resident #59 needed to have a self-administration of medication assessment completed by a nurse and needed a physician's order for her to self-administer medication. The DON said medications should not be stored in the resident's room and needed to be stored on the nurse's medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to label and store personal items in 2 of 6 shared bathrooms (room [ROOM NUMBER] and room [ROOM NUMBER]) and maintain packaged terminal air conditioners (PTACs) in good repair in 6 of 15 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]). These failures occurred on 1 of 4 halls (400 hall) reviewed for home-like environment. Findings included: 1. (a). An observation of the shared bathroom of room [ROOM NUMBER] on 04/27/25 at 10:52 AM revealed a plastic basket containing an unlabeled toothbrush sitting on the side of the sink. Additional observations of the shared bathroom of room [ROOM NUMBER] on 04/28/25 at 3:20 PM, on 04/29/25 at 11:05 AM, on 04/30/24 at 2:14 PM, and on 05/01/25 at 11:24 AM revealed a plastic basket containing an unlabeled toothbrush sitting on the side of the sink. (b). An observation of the shared bathroom of room [ROOM NUMBER] on 04/27/25 at 2:56 PM revealed an unlabeled and uncovered bedpan placed between a towel rack and the wall and an unlabeled closed denture cup sitting on a rail behind the toilet. Additional observations of the shared bathroom of room [ROOM NUMBER] on 04/30/25 at 3:27 PM and 05/01/25 at 11:20 AM revealed an unlabeled and uncovered bedpan placed between a towel rack and the wall and an unlabeled closed denture cup sitting on a rail behind the toilet. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed all resident care items in shared bathrooms should be labeled and covered appropriately by nursing staff. She stated ensuring personal items were labeled and covered should be monitored as nursing staff came and went from shared bathrooms. 2. (a). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 10:26 AM revealed multiple broken slats to the top of the unit. Additional observations of the PTAC unit in room [ROOM NUMBER] on 04/28/25 at 8:53 AM and 05/01/25 at 11:21 AM revealed multiple broken slats to the top of the unit. (b). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 10:43 AM revealed multiple broken slats to the top of the unit and the control cover of the unit was hanging off the front. Additional observations of the PTAC unit in room [ROOM NUMBER] on 04/28/25 at 9:06 AM, on 04/30/25 at 2:17 PM, and 05/01/25 at 11:04 AM revealed multiple broken slats to the top of the unit and the control cover of the unit was hanging off the front. (c). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:02 AM revealed multiple broken slats to the top and front of the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Additional observations of the PTAC unit in room [ROOM NUMBER] on 04/30/25 at 3:20 PM and 05/01/25 at 11:20 AM revealed multiple broken slats to the top and front of the unit. (d). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:05 AM revealed multiple broken slats to the top of the unit. Additional observations of the PTAC unit in room [ROOM NUMBER] on 04/28/25 at 9:06 AM, 04/20/25 at 2:18 PM, and 05/01/25 at 11:05 AM revealed multiple broken slats to the top of the unit. (e). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:19 AM revealed multiple broken slats to the top of the unit. (f). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:20 AM revealed multiple broken slats to the top of the unit. Additional observations of the PTAC unit in room [ROOM NUMBER] on 04/28/25 at 9:07 AM and on 05/01/25 at 11:18 AM revealed multiple broken slats to the top of the unit. An interview with the Maintenance Director on 05/01/25 at 2:35 PM revealed she had been in her position approximately 2 months and was trying to order 2 PTAC units a month but had not gotten around to replacing the PTAC units on 400 hall. She stated she expected the PTAC units to be in good repair. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she was not aware of any concerns with the slats on the PTAC units. She stated management should have noticed the slats during their daily room rounds and notified her so she could see if replacement parts could be ordered or if the entire units would need to be replaced. The Administrator stated she expected the PTAC units to be in good repair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the Law Enforcement Detective and staff, the facility failed to protect the residents' rights to be free from misappropriation of controlled medication for 4 of 4 residents reviewed for misappropriation of resident property (Residents #173, #174, #175, and #176). The findings included: The facility's Abuse, Neglect, Exploitation and Misappropriation policy, last revised on 11/16/22, revealed in part the facility would ensure all residents were free from misappropriation of property. a. Resident #173 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder and anxiety disorder. The physician's order dated 01/16/25 revealed Resident #173 had an order to receive one tablet of clonazepam 0.5 milligrams (mg) by mouth every morning (6:00 AM) and at bedtime (9:00 PM) for anxiety/panic attacks. The pharmacy proof of delivery shipment summary sheet revealed 60 tablets of clonazepam 0.5 mg were shipped on 02/18/25 for Resident #173 and was received by the facility on 02/19/25 at 3:13 AM. The February 2025 Medication Administration Record (MAR) revealed starting on 02/19/25 Resident #173 received a total of 5 tablets of clonazepam 0.5 mg. The clonazepam was documented as administered per physician order on 02/19/25 at 6:00 AM and 9:00 PM, 2/20/25 at 6:00 AM and 9:00 PM, and 02/21/25 at 6:00 AM. No further doses were documented as administered for the remainder of the month and there should have been 55 tablets left remaining. The shift change controlled substance inventory count sheet revealed the former Director of Nursing (DON) initialed that she removed one card of clonazepam 0.5 mg tablets for Resident #173 from the medication cart on 02/21/25 and noted the medication was being returned to the pharmacy. The initial allegation report dated 03/01/25 revealed the facility became aware of an incident on 02/28/25 at 7:54 PM when the Administrator was notified by Medication Aide (MA) #3 that Resident #173's clonazepam (medication used to treat panic disorders and seizures) and declining count sheets were missing, and Law Enforcement was notified. A telephone attempt on 05/01/25 at 2:43 PM for interview with MA #3 was unsuccessful. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigative report dated 03/08/25 revealed the facility completed a review of pharmacy and facility documentation which revealed on 02/21/25 the former DON removed Resident #173's clonazepam from the medication cart and noted on the controlled substance shift change report that the medications were sent back to the pharmacy and the declining count sheet could not be located. The pharmacy sent 60 tablets of clonazepam on 02/18/25 and review of Resident #173's medication administration record (MAR) revealed 55 of the 60 tablets were unaccounted for. It was noted that Resident #173 did not suffer any harm or mental anguish, and the medication was replaced at the facility's expense. The former DON's last day worked was on 02/25/25 and she did not return back to the facility after that date. Resident #173 passed away at the facility on 04/01/25. b. Resident #174 was admitted to the facility on [DATE] with diagnoses that included chronic pain. The physician's order dated 01/30/25 revealed Resident #174 had an order to receive one tablet of oxycodone 5 mg by mouth every 6 hours as needed for pain. The pharmacy proof of delivery shipment summary sheet revealed 30 tablets of oxycodone 5 mg were shipped on 01/30/25 for Resident #174 and was received by the facility on 01/31/25 at 2:08 AM. The January 2025 MAR for Resident #174 revealed he received a total of 2 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on 01/31/25 at 3:47 PM and 10:09 PM. After the last dose was administered on 01/31/25, there should have been 28 tablets remaining. The February 2025 MAR for Resident #174 revealed he received a total of 5 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on 02/01/25 at 9:14 PM, 02/02/25 at 11:00 AM, 02/03/25 at 9:46 PM, 02/06/25 at 2:35 PM, and 02/07/25 at 9:56 AM. After the last dose was administered on 02/07/25, there should have been 23 tablets of Oxycodone left remaining. Resident #17 discharged to the hospital on [DATE] and had not returned to the facility at the time of this investigation. The shift change controlled substance inventory count sheet revealed the former DON initialed that she removed one card of oxycodone 5 mg tablets for Resident #174 from the medication cart on 02/21/25. The initial allegation report dated 03/04/25 revealed the facility became aware on 03/04/25 at 4:40 PM during a narcotic audit that 20 tablets of Resident #174's oxycodone (opioid pain medication) was unaccounted for, and Law Enforcement was notified. The investigative report dated 03/08/25 revealed during a narcotic audit, it was discovered that the former DON removed Resident #174's oxycodone from the medication cart and the medication was missing along with the declining count sheet. c. Resident #175 was admitted to the facility on [DATE] with diagnoses that included chronic pain. The physician's order dated 02/10/25 revealed Resident #175 had an order to receive one tablet of oxycodone 5 mg by mouth every 6 hours as needed for pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The pharmacy proof of delivery shipment summary sheet revealed 28 tablets of oxycodone 5 mg were shipped on 02/10/25 for Resident #175 and was received by the facility on 02/10/25 at 6:15 PM. The February 2025 MAR for Resident #175 revealed she received at total of 10 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on 02/10/25 at 10:12 PM, 02/11/25 at 10:38 AM, 02/12/25 at 9:22 AM and 3:35 PM, 02/13/25 at 9:40 AM, 02/14/25 at 8:47 AM, 02/15/25 at 2:54 PM and 10:20 PM, and 02/16/25 at 10:04 AM and 10:16 PM. After the last dose was administered on 02/16/25, there should have been 18 tablets remaining. The shift change controlled substance inventory count sheet revealed the former DON initialed that she removed one card of oxycodone 5 mg tablets for Resident #175 on 02/21/25 and noted the medication was being returned to the pharmacy. Resident #175 discharged to the hospital on [DATE] and had not returned to the facility at the time of this investigation. The initial allegation report dated 03/04/25 revealed the facility became aware on 03/04/25 at 4:40 PM during a narcotic audit that 18 pills of Resident #175's oxycodone was unaccounted for and Law Enforcement was notified. The investigative report dated 03/08/25 revealed during a narcotic audit, it was discovered that on 02/21/25 the former DON removed Resident #175's oxycodone from the medication cart and the medication was missing along with the declining count sheet. d. Resident #176 was admitted to the facility on [DATE] with diagnoses that included fracture of the lower end of the left radius (one of the two long bones in the forearm located on the thumb side). The physician's order dated 01/13/25 revealed Resident #176 had an order to receive one tablet of oxycodone 5 mg by mouth every 6 hours as needed for pain. The physician's order dated 01/15/25 revealed Resident #176 had an order to receive one tablet of oxycodone-acetaminophen 5-325 mg by mouth every 6 hours as needed for pain for one day and to discontinue when the oxycodone 5 mg arrived. The pharmacy proof of delivery shipment summary sheets for Resident #176 revealed the following: - 30 tablets of oxycodone 5 mg were shipped on 01/14/25 and was received by the facility on 01/15/25 at 3:57 AM. - 30 tablets of oxycodone 5 mg were shipped on 01/24/25 and was received by the facility on 01/25/25 at 3:08 AM. - 30 tablets of oxycodone 5 mg were shipped on 02/04/25 and was received by the facility on 02/04/25 at 6:11 PM. - 30 tablets of oxycodone 5 mg were shipped on 02/14/25 and was received by the facility on 02/15/25 at 2:34 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2025 MAR for Resident #176 revealed she received one tablet of oxycodone-acetaminophen 5-325 mg on 01/15/15 at 1:24 PM. The January 2025 MAR for Resident #176 further revealed she received a total of 48 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on: -01/13/25 at 4:00 PM -01/14/25 at 12:16 AM -01/15/25 at 2:36 AM and 9:54 PM -01/16/25 at 5:31 AM, 11:55 AM and 5:57 PM -01/17/25 at 12:21 AM, 10:28 AM and 5:52 PM -01/18/25 at 12:33 AM, 6:34 AM, 1:04 PM, and 9:35 PM -01/19/25 at 5:42 AM and 10:07 PM -01/20/25 at 9:09 AM, 4:57 PM and 11:44 PM -01/21/25 at 5:48 AM, 12:56 PM and 7:12 PM -01/22/25 at 2:45 AM, 9:09 AM and 3:30 PM -01/23/25 at 2:05 AM, 9:00 AM, 3:23 PM, and 11:58 PM -01/24/25 at 11:11 AM and 5:26 PM -01/25/25 at 8:13 PM -01/26/25 at 7:02 PM -01/27/25 at 2:35 AM, 10:15 AM and 5:12 PM -01/28/25 at 5:10 AM, 12:39 PM and 7:19 PM -01/29/25 at 6:21 AM and 4:54 PM -01/30/25 at 12:16 AM, 6:20 AM, 1:34 PM, and 8:27 PM -01/31/25 at 3:03 AM, 9:57 AM and 7:06 PM. The February 2025 MAR for Resident #176 revealed she received a total of 51 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on: -02/01/25 at 4:06 AM, 10:27 AM, 5:12 PM, and 11:45 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-02/02/25 at 5:47 AM, 1:10 PM and 8:26 PM -02/03/25 at 6:00 AM, 12:56 PM and 7:37 PM -02/04/25 at 5:01 AM and 11:01 AM -02/05/25 at 9:11 AM, 3:28 PM and 9:30 PM -02/06/25 at 5:41 AM, 12:50 PM and 8:49 PM -02/07/25 at 5:56 AM, 12:55 PM and 7:50 PM -02/08/25 at 4:28 AM, 10:59 AM, 5:38 PM, and 11:47 PM -02/09/25 at 12:28 PM and 8:15 PM -02/10/25 at 5:02 AM, 11:16 AM, 5:35 PM, and 11:45 PM -02/11/25 at 6:45 PM -02/12/25 at 1:20 AM, 11:45 AM and 5:58 PM -02/13/25 at 5:02 AM and 8:51 PM -02/14/25 at 4:27 AM, 11:19 AM and 6:35 PM -02/15/25 at 2:51 AM and 8:53 PM -02/16/25 at 5:59 AM and 7:13 PM -02/17/25 at 9:43 AM and 5:49 PM -02/18/25 at 6:49 AM, 1:08 PM and 8:23 PM -02/19/25 at 4:06 AM and 10:24 AM. Resident #176 discharged home on [DATE]. The shift change controlled substance inventory count sheet was signed by MA #2 on 02/21/25 indicating one card of oxycodone 5 mg tablets for Resident #176 was removed from the medication cart. There was no other signature verifying the narcotics were removed. Included in the facility's investigation documentation was a typed statement dated 03/01/25 written by the current DON that revealed in part, on 02/21/25 MA #2 and the former DON were observed at the 400 Hall medication cart. The former DON was observed removing several narcotic cards and declining count sheets from the medication cart and then walked back up the hallway away from the medication cart with the narcotics and count sheets in hand. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The initial allegation report dated 03/04/25 revealed the facility became aware on 03/04/25 at 4:40 PM that 18 pills of Resident #176's oxycodone was unaccounted for and Law Enforcement was notified. The investigative report dated 03/08/25 revealed during a narcotic audit, it was determined that between 01/14/25 to 02/14/25 the pharmacy sent 120 tablets of oxycodone for Resident #176 of which she received 100 doses. There were 20 tablets of oxycodone unaccounted for and the medication was missing along with the declining count sheet. During phone interviews on 04/29/25 at 12:36 PM and 04/30/25 at 4:42 PM, the former DON stated her last day working at the facility was on 02/25/25 and she left without notice because she no longer felt safe working at the facility. The former DON could not recall the date but stated an Officer came to speak with her to get a statement and hinted that she was being accused of narcotic diversion, but he did not go into the specifics of what she was being accused of. She stated she never and would never take any medication from a facility or resident. The former DON stated during her employment at the facility, narcotic medication that needed to be returned to the pharmacy was kept locked in the medication cart. She explained that was not a process she was comfortable with and felt that the narcotic medication should be locked up in the DON's office until the pharmacy picked them up. She could not recall the exact date but stated it was a day or two before the last day she worked (02/25/25) when the Assistant Director of Nursing at the time, who was now the facility's current DON, asked if she would clear the carts, which she explained meant removing narcotic medication that needed to be returned to the pharmacy, and help her finish up the pharmacy returns. The former DON stated she removed some narcotic medication with the associated declining count sheets from the 300 Hall medication cart, but she did not recall the name of the resident the medication belonged to or the name of the medication she removed. She scanned the cards to create a pharmacy return, faxed the log to the pharmacy and placed the narcotic medication into a sealed bag for the pharmacy to pick up. She then handed the bagged medication to Nurse #6 to place back on the medication cart until the pharmacy picked it up. The former DON stated she felt that someone was forging her initials on the narcotic count sheets and just before she left, she had voiced her concerns to the Administrator and ADON that she felt there was some drug diversion going on and there needed to be an audit, but they did not seem to take her concerns seriously. The former DON stated she felt this entire accusation was retaliatory on the facility's part because she quit without notice. She restated she never took any narcotic medication and someone at the facility forged her initials. During a phone interview on 05/01/25 at 9:25 AM, Nurse #6 revealed she no longer worked at the facility. Nurse #6 could not recall the date but stated the former DON had given her some medications that were sealed in a bag for the pharmacy to pick up and she placed the bag in the 100 Hall medication cart because pharmacy usually didn't pick up medications at night which was when she worked. During a phone interview on 04/29/25 at 4:11 PM, the Law Enforcement Detective stated he and the Drug Enforcement Administration (DEA) Officer spoke with the former DON together and she denied taking any medications from the facility. The Law Enforcement Officer stated when he reviewed the facility's records, the documentation was not as clean cut as he would have liked. He explained there were gaps from the date the former DON initialed the sheets as having removed the medications and when the medications were noticed missing which meant others had access to the medications during the time frame. The Law Enforcement Detective stated he was closing his investigation, and no charges were filed as he could not determine what actually happened to the medications but felt there was definitely a breakdown in the facility's process that allowed the diversion to occur. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint interview was conducted with the current DON, Administrator and Regional [NAME] President of Operations on 04/30/25 at 1:26 PM. The Administrator stated on 02/28/25, MA #3 came to let her know that she (MA #3) had tried to get Resident #173's clonazepam refilled but the pharmacy stated it was too soon to refill the medication. The Administrator stated she immediately reviewed the pharmacy sheets for deliveries and then she along with the current DON started looking everywhere to see if Resident #173's clonazepam had been placed in another location by mistake which included checking all medication carts, offices, filing cabinets, desk, and the non-narcotic pharmacy return box. She stated when Resident #173's clonazepam couldn't be located, she called the Regional [NAME] President of Operations to inform him of the situation, and he instructed them to start an investigation and conduct a narcotic audit going back 30 days. She stated the Pharmacy Account Manager came to the facility to help with the investigation and completed a reconciliation of all resident narcotic medications. The Administrator stated during the narcotic audit they discovered that there were a total of 11 narcotic cards with the declining count sheets that had been removed from the medication carts and 4 of the 11 narcotic cards could not be accounted for, there were no narcotic card, declining count sheets or record of return to the pharmacy. She stated there was one common denominator, the former DON had signed off as having removed all 11 narcotic cards/sheets from the medication carts and they were all removed on the same day. She explained she started comparing the narcotic sheets they were able to locate that the former DON had signed as removing the medication from the medication cart with the pharmacy delivery sheets and report of pharmacy returns. Through that process, she was able to determine what medications were unaccounted for and verify there was no pharmacy order for the unaccounted medications to be returned. She then compared the unaccounted medications with the pharmacy delivery sheets and confirmed there was no order from the pharmacy for a return. She stated they determined the medications that were unaccounted for belonged to Resident #173, #174, #175 and #176. She explained Resident #173 was the only resident still at the facility when the incident occurred and her clonazepam was replaced at the facility's expense. Resident #174 and Resident #175 both had discharged to the hospital and Resident #176 had discharged home. The Administrator stated when the current DON talked to Resident #176, she confirmed no medication was provided to her upon her discharge, but she did get a prescription to have filled. The Administrator stated they could not prove that the former DON took the medications, but it was the only thing they could determine likely happened based on their investigation and the former DON was not returning their calls. The Administrator stated the last day the former DON actually worked at the facility was on 02/25/25 and then she sent a text message on 02/28/25 to the current DON (who was the ADON at the time) stating that she was quitting. She stated the Law Enforcement Detective and DEA Officer came to the facility, talked to each of them individually and then came back to the facility to talk to them again after speaking with the former DON. She stated the Law Enforcement Detective and DEA Officer stated that the former DON denied taking the medications and was basically putting the blame for the missing medications on the current DON. The interview continued with the current DON, Administrator and Regional [NAME] President of Operations all stating the former DON never voiced any concerns of diversion to them and as the DON of record at the time, she could have initiated an investigation if she did have concerns but didn't. They all explained the process at the time was for the DON to pull narcotic medications from the medication cart, scan the bar code to initiate a return to the pharmacy, seal the medication in a bag with the bag number for the return, place the bag on the locked medication cart until pharmacy arrived to pick it up and when pharmacy arrived to pick up the medication, they provided a receipt of return. The Administrator and Regional [NAME] President of Operations both stated they realized the protocol was not being consistently followed and a corrective action plan was discussed at QAPI and implemented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided the following corrective action plan with a completion date of 03/06/25: How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On Friday, February 28, 2025, the Executive Director was notified by a Medication Aide that Resident #173 Clonazepam 0.5mg tablets and declining count sheet was missing. The current Director of Nursing phoned the pharmacy. The pharmacy checked on the missing Clonazepam 0.5 mg tablets and explained to the DON that the Clonazepam was never returned to the pharmacy. The pharmacy replaced the Clonazepam 0.5 mg rapid tablets on the same day as phoned and the charge for those was billed to the facility. A search of the facility was completed by the Executive Director and the Director of Nursing. This included all offices to included desks, filing cabinets, drawers, bookshelves, boxes, shred boxes, removing locks on any locked drawers, filing cabinets, desks, etc. When the search was completed and the missing medication and declining count sheets could not be located, the Regional [NAME] President of Operations, the Regional Clinical Director of Nursing were notified via telephone conference. It was decided that an audit needed to be started and that an ADHOC QAPI needed to be held to discuss and formulate an action plan. On 2/28/25, the Executive Director and the Director of Nursing conducted a Root Cause Analysis regarding the missing controlled medication for Resident #173. It was determined through the root cause analysis, the system for removing narcotics from the medication cart was not always followed with 2 signatures. It was also identified that shift change controlled substance inventory count sheet was not thorough for accurately tracing of narcotics removed from the cart. Through the review of the Shift Change Controlled Substance Count Sheets, it was identified that the previous Director of Nursing had signed the narcotics off of the cart on 2/21/25. The pharmacy return record of controlled substances was reviewed for the date that the narcotics were signed as removed from the medication cart, lock box and the missing narcotics did not appear on the pharmacy return record of controlled substances. The Medical Director, The Regional [NAME] President of Operations, and the Regional Director of Clinical Services was made aware of this root cause analysis. On 2/28/25, an ADHOC QAPI was held with the following quality assurance performance improvement team members: Executive Director, Director of Nursing, Business Office Manager, Social Worker, Medical Records, Maintenance Director, Rehab Manager, Housekeeping Supervisor, and the Medical Director attended by phone. The proposed plan of correction was reviewed, discussed, and agreed upon regarding the corrections needed to attain and sustain compliance. On 3/1/2025, local law enforcement, the regulatory agency and the Board of Nursing were notified of the missing narcotics. The Board of Nursing was notified of the former Director of Nursing potential involvement in regard to the missing narcotics. How will the facility identify other residents having the potential to be affected by the same deficient practice? The Executive Director and the Director of Nursing completed a quality review of prescribed controlled medications that were received from or returned to the pharmacy over the prior 30 days. This review was conducted from 2/28/25 through 3/4/25 to identify other residents having the potential to be affected by the same deficient practice. Included in the 30-day review were the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Shift Change Controlled Substance Count Sheets- which indicates how many narcotic cards/containers are active on the cart and also reveals when controlled substances are added and or removed from the cart. -Pharmacy Delivery Sheets -Destruction History -Current Residents with an order for controlled substances -Discharge Residents that had an order for controlled substances -Controlled Substance Declining Count Sheets, Controlled Substances in Medication Carts -Medication administration records related to controlled substances At the conclusion of this process on 3/4/25, 3 other residents were affected by this deficient practice. Included here are the results of the audit: Resident #176 was admitted to the Oaks at Sweeten Creek on 01/13/2025 and discharged home 02/19/2025. Resident #176 had a physician's order for Oxycodone 5mg tablet every 6 hours as needed for pain. The pharmacy delivery report indicated the following was delivered to the facility: 02/14/2025 Oxycodone 5mg tablet- 30 pills-7 day supply. The last dose being administered on 02/19/2025. The shipment that was received on 02/14/2025 including 30 pills had 18 pills remaining that were unaccounted for, and the declining count sheet was also missing. The DON contacted Resident #176 to ask if she was discharged with the narcotic card of medication. Resident #176 indicated she was not discharged with the medication; but that she received a prescription for the medication. The previous DON removed the controlled substance and the declining count sheet from the cart on 02/21/2025. On 03/04/2025, The Executive Director and Pharmacy representative reviewed medications returned to the pharmacy and there was no indication this controlled substance medication was returned, and the declining controlled substance count sheet could not be located. Resident #174 was admitted to the Oaks at Sweeten Creek in 01/27/2025 and discharged to the hospital on [DATE]. On 01/30/2025, Resident #174 received a physician's order for Oxycodone 5mg tablet every 6 hours as needed for pain. The pharmacy delivery report indicated the following was delivered to the facility: 01/30/2025 Oxycodone 5mg tablet- 30 pills- 7-day supply. A review of the Medication Administration Record indicated that Resident #174 had 7 pills administered to him during his stay, with the last dose being administered on 02/07/2025. The 23 remaining pills were unaccounted for. It is noted that the previous DON removed the controlled substances and the declining count sheet from the medication cart on 02/25/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/2025, The Executive Director and Pharmacy representative reviewed medications returned to the pharmacy and there was no indication this controlled substance medication was returned to the pharmacy, and the declining controlled substances count sheet could not be located. Resident #175 was admitted to the Oaks at Sweeten Creek on 02/08/2025 and discharged to the hospital on [DATE]. On 02/10/2025, Resident #175 received a physician's order for Oxycodone 5mg tablet every 6 hours as needed for pain. The pharmacy delivery report indicated the following was delivered to the facility: 02/10/2025 Oxycodone 5mg tablet- 28 pills- 7-day supply. A review of the Medication Administration Record indicated that Resident #175 received 10 pills with the last dose being administered on 02/16/2025. The controlled substance medication was discontinued on 02/17/2025. There were18 pills remaining that were unaccounted for. It is noted that the previous DON removed the controlled substance from the medication cart on 02/21/2025. On 03/04/2025, The Executive Director and Pharmacy representative reviewed medications returned to the pharmacy and there was no indication this controlled substance medication was returned to the pharmacy, and the declining controlled substances count sheet could not be located. On 3/4/25, the Pharmacy Account Manager came to the facility to assist with the quality review and concurred with the findings. A licensed nurse completed pain assessments on all current residents on the dates of 3/3/25 through 3/5/25 and there were no residents identified as having pain. On 3/3/2025, the Social Worker conducted interviews with residents with a BIMS of 8 or greater to determine if any of them were in pain, if they received pain medication when they are experiencing pain, and if they have had any issues with receiving pain medications and there were no issues identified. On 3/2/2025, the Executive Director reviewed the grievances for the months of January and February for any issues related to the medication without any concerns noted. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? On 3/1/2025, the VP of Clinical Services educated the Executive Director and Director of Nursing via telephone to ensure narcotic control sheets were being utilized per policy, removing controlled substances from the medication carts that are ZEROs (with no pills remaining), removing controlled substances with pills remaining and utilizing the company's policy regarding the returning/ destruction process. On 3/1/2025, The Director of Nursing and Executive Director began education for licensed nurses and medication aides on the policy to ensure proper documentation on controlled substances/ narcotic count sheet and ZERO TOLERANCE- Diversion of Drugs, this education was completed by 3/4/2025 and is included in orientation for newly hired nurses and medication aides. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/2025, the Pharmacy Account Manager educated the Executive Director and Director of Nursing on delivery and receipt of controlled substances on 3/4/25. Storage and inventory of medications, controlled substances, and products, returns and disposal of medications and controlled substances, maintenance and the file system of controlled substance declining count sheets, delivery and returns to include 2 nurse or 1 nurse and 1 medication aide verification for receiving controlled substances, how to waste/destroy medications, and the Director of Nursing only is to remove narcotics from medication cart along with 1 nurse or 1 medication aide for verification. Per policy, controlled substances are to be removed by the Director of Nursing, any wasted controlled substance is to be performed by two licensed nurses or a licensed nurse and a medication aide. On 03/04/2025, the Executive Director and Director of Nursing educated licensed nurses and medication aides on the new Shift Change Controlled Substances Inventory Count Sheet and delivery and receipt of controlled substances, Storage and Inventory of medications, controlled substances, and products, returns and disposal of medications and controlled substances, maintenance and file system of controlled substance declining count sheets, delivery and returns to include 2 nurse or 1 nurse and 1 medication aide verification for receiving controlled substances, waste/destroy, with the Director of Nursing only to remove narcotics from medication cart with 1 nurse or 1 medication aide for verification. Medication Aides cannot add, remove, destroy/waste of controlled substances without the presence of 1 nurse or the Director of Nursing. Nurses cannot add, remove, destroy/waste of controlled substances without the presence of 1 med aide, another nurse or the Director of Nursing. Newly hired staff will be educated upon hire. The shift change form has been replaced with the Shift Change Controlled Substances Inventory Count Sheet that now includes the following: number of cards, number of count sheets in medication cart, controlled substances added and remove include residents name, medication, strength, number of cards, number of declining count sheets, verified by 2 nurses or 1 nurse and 1 medication aide. Count to be completed with the change of keys from nurse/med aide to nurse/med aide, or when DON is removing controlled substance cards/sheets with doses remaining. It includes the date, time, controlled substance medications at start of the count, declining narcotic count sheets at the start of the count, with 2 signature verification. Also included is the date, time, controlled substance medications at start of the count, declining narcotic count sheets at the start of the count, with 2 signature verification. The directions included on each Shift Change Controlled Substance Inventory Count Sheet are as follows: -Oncoming Nurse/Med Aide must verify count of all controlled substances anytime the keys are changed. If the keys are changed out several times in one day because working partial shifts, then a new row is to be used stating the date and time the controlled substances are inventory count was completed. Only full legible signatures are to be used, NOT INITIALS. -Nurse/Med Aide must count the actual total # of Cards/Containers AND actual total # of count sheets for all supplies in the drawer. -When cards are added, 2 nurses or 1 nurse/1 Med Aide are to add the number of cards/sheets added to include: resident name, drug [NAME][TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, Family Member and staff interviews, the facility failed to have a discharge planning process in place that included documentation of referrals submitted to other skilled nursing facilities (SNF) and documenting the responses to the referrals submitted for a resident who wished to discharge to another SNF closer to family for 1 of 1 sampled resident (Resident #41). Findings included: Resident #41 was admitted to the facility on [DATE] with diagnoses that included quadriplegia (form of paralysis that affects all four limbs and torso, pressure ulcer of the sacral region, osteomyelitis (bone infection), bipolar disorder, and anxiety disorder. Resident #41's comprehensive care plans included a discharge care plan, initiated on 06/13/23 and last revised on 02/02/24, that revealed Resident #41 wished to return to a facility closer to her family and would remain at the current facility for long-term care until a transfer could be made. Review of the Social Services progress notes for Resident #41 for January 2024 to April 2025 revealed the following: - An entry dated 06/14/24 written by the former SW revealed a referral was emailed to a SNF located close to Resident #41's Family Member at the Family Member's request. There was no entry after 06/14/24 noting the SNF's response to the referral sent on 06/14/24. Other than the referral submitted to a SNF on 06/14/24, there were no further entries indicating additional referrals were made to other SNF closer to Resident #41's Family Member during the period January 2024 to April 2025. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 had intact cognition and there was no active discharge plan in place. During a phone interview on 04/28/25 at 1:19 PM, Resident #41's Family Member expressed she wanted Resident #41 to move to a SNF closer to her so that she could be more involved in her care. The Family Member revealed she had asked the SW multiple times to send referrals to a SNF near where she lived but when she (Family Member) called the SNF, they had not received any referrals from the SW. The Family Member stated when she tried to call the SW to follow-up on the referrals, the SW didn't call her back. During an interview on 04/28/25 at 3:04 PM, Resident #41 expressed she wanted to transfer to a SNF closer to her home but only if it was an hour or less from her Family Member, otherwise she would just stay at this facility. The former SW was unable to be interviewed during this investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/28/25 at 3:42 PM, the SW revealed she had only been back at the facility since January 2025. The SW stated she had sent several referrals to SNF closer to Resident #41's Family Member but she would have to look through her files to see where and when the referrals were sent. The SW stated she did not follow-up with the SNF after she sent the referral. She explained if the SNF was willing to accept Resident #41, they would contact her but so far she had not received any responses. She stated the Administrator recently printed off a list of SNF close to Resident #41's Family Member and they were currently working on sending additional referrals. During a follow-up interview on 04/30/25 at 12:15 PM, the SW stated she faxed referrals to SNF located close to Resident #41's Family Member on 02/07/25, 02/25/25, 03/03/25, 03/24/25, 04/01/25, and 04/11/25. The SW explained she did not write down the names or contact information of the SNF she faxed the referrals to, only the city where the SNF was located. During an interview on 05/01/25 at 3:02 PM, the Administrator revealed she recently printed off a list of SNF and highlighted each one within a 50 mile radius of Resident #41's Family Member for referrals to be sent. She stated that she knew the SW had previously sent referrals to SNF for Resident #41 but she was not sure if it was feasible for the SW to follow-up on each referral as the other SNF didn't always respond if they were not wanting to make a bed offer. The Administrator stated there should be documentation in the resident's medical record noting where and when referrals were sent when requested by the resident or Responsible Party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #19 was admitted on [DATE] and re-admitted on [DATE]. Resident #19's diagnoses included paranoid schizophrenia that was present on admission [DATE]). Resident #19 was care planned for receiving antipsychotic therapy (haloperidol) for diagnosis of paranoid schizophrenia dated 10/28/24. Resident #19's annual Minimum Data Set (MDS) assessment dated [DATE] included an active diagnosis of schizophrenia. A review of Resident #19's physician orders revealed an order for haloperidol 0.5 milligrams 2 times daily for diagnosis of paranoid schizophrenia dated 3/14/25. Resident #19's quarterly Minimal Data Set (MDS) assessment dated [DATE] did not include an active diagnoses of schizophrenia. On 5/01/25 at 11:57 AM the MDS Nurse stated Resident #19 was readmitted to the facility on [DATE] with a diagnosis of paranoid schizophrenia. The MDS Nurse stated she was directed to not code a diagnosis of schizophrenia on the MDS by direction of the facilities corporate office after Resident #19's annual MDS assessment had been completed and submitted. She stated Resident #19 did not have enough supporting documentation available when admitted to the facility and the MDS assessment dated [DATE] should not have included the diagnosis of schizophrenia and that was a coding error. The Administrator was interviewed on 5/01/25 at 5:24 PM and stated MDS assessments should be coded accurately. Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the area of active diagnosis for 2 of 23 residents reviewed for MDS accuracy (Resident #16 and Resident #19). Findings included: 1. Resident #16 was admitted to the facility 03/28/25 with a diagnosis including depression. Resident #16's admission Minimum Data Set (MDS) assessment dated [DATE] indicated she had a diagnosis of post-traumatic stress disorder (PTSD). Review of a Psychiatry evaluation note for Resident #16 dated 04/04/25 read in part as, She did not [have] a history of PTSD. In an interview with the MDS Coordinator on 05/01/25 at 11:57 AM she confirmed she completed Resident #16's admission MDS dated [DATE]. She stated the MDS should not have been coded to reflect Resident #16 had a diagnosis of PTSD and this was a coding error. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed she expected MDS assessments to be coded accurately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected MDS assessments to be coded correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a baseline care plan that addressed the resident's immediate needs within 48 hours of admission for 4 of 13 sampled residents (Residents #73, #16, #72, and #323). The findings included: 1. Resident #73 was admitted to the facility on [DATE] with diagnoses that included diabetes, chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and chronic obstructive pulmonary disease (difficulty breathing). The nursing admission data collection assessment initiated on 04/28/25 and completed on 04/29/25 revealed Resident #73 received insulin injections, antidepressant and diuretic medications. Review of Resident 73's electronic medical record on 04/29/25 revealed no evidence a baseline care plan that addressed her immediate needs was initiated or completed within 48 hours of her admission to the facility on [DATE]. During an interview on 04/30/25 at 9:13 AM, the Director of Nursing (DON) explained when residents admitted after-hours (after normal business hours) or over the weekend, nursing staff called her and she assisted them with entering physician orders and starting a baseline care plan for the resident. The DON could not explain why a baseline care plan was not initiated for Resident #73 and stated either she or the nurse should have completed a baseline care plan within 48-hours of Resident #73's admission to the facility on [DATE]. During an interview on 05/01/25 at 5:37 PM, the Administrator stated baseline care plans should be completed within 48 hours of a resident's admission. She stated the baseline care plan should contain pertinent information that addressed a resident's immediate care needs for staff until the comprehensive care plans were developed. 2. Resident #72 was admitted to the facility on [DATE] with a diagnosis including muscle weakness. Resident #72 discharged home on [DATE]. Review of Resident #72's medical record revealed there was no baseline care plan included in the medical record. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed the interdisciplinary team initiated the baseline care plan upon admission and it was sent to the MDS Coordinator to assist with developing the comprehensive care plan. She stated once the comprehensive care plan was initiated, the baseline care plan was sent to medical records to be scanned into the electronic medical record. The DON confirmed Resident #72 should have had a baseline care plan and it was overlooked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 05/01/25 at 5:39 PM revealed she was unaware a baseline care plan was not completed for Resident #72. The Administrator stated she expected all residents to have a baseline care plan completed within 48 hours of the resident's admission. 3. Resident #16 was admitted to the facility 03/28/25 with a diagnosis including colostomy status (having a colostomy in place). Review of Resident #16's baseline care plan dated 03/28/25 did not reflect she had a colostomy (a surgically created opening that connects one end of the large intestine to the abdomen). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had a colostomy. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed the interdisciplinary team initiated the baseline care plan upon admission and it was sent to the MDS Coordinator to assist with developing the comprehensive care plan. She stated once the comprehensive care plan was initiated, the baseline care plan was sent to medical records to be scanned into the electronic medical record. The DON stated Resident #16's baseline care plan should have reflected that she had a colostomy, and it was an oversight. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected baseline care plans to be accurate. 4. Resident #323 was admitted to the facility on [DATE] with diagnoses that included lack of coordination and dementia. Review of Resident #323's medical record revealed there was no baseline care plan completed within 48 hours of Resident #323's admission. An interview with the Director of Nursing (DON) on 5/01/25 at 5:15 PM revealed that she had medical records look for Resident #323's baseline care plan. She stated that a baseline care plan could not be found. She stated that the interdisciplinary team (IDT) was responsible for completing the baseline care plan. An interview with the Administrator on 5/01/25 at 5:44 PM revealed that her expectation was that a baseline care plan be completed within 48 hours of a resident's admission to provide comprehensive care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to perform activities of daily living (ADL) care for a resident (Resident #30). This was for 1 of 11 residents reviewed for (ADL) care. Findings included: Resident #30 was admitted on [DATE] with diagnoses that included Parkinson's disease. A review of Resident #30's care plan dated 5/2/24 found he had a care plan for activities of daily living (ADL) self-care performance deficit related to generalized muscle weakness and impaired mobility. Interventions included improved level of function in ADL performance through next review date, clean, check nail length and trim on bath days. An additional intervention included revealed Resident #30 required set-up or clean-up assistance with personal hygiene. A review of Resident #30's quarterly Minimum Data Set (MDS) assessmnet dated 1/28/25 coded him as cognitively intact. Resident #30 had impairment to both sides for upper and lower extremities, needed maximum assistance with bathing, and set-up or clean-up assistance with personal care. A review of the facility's shower schedule found Resident #30's assigned bath days were Tuesday and Friday. On 4/27/25 at 1:17 PM Resident #30 was observed in his room lying on his bed with approximately ½ inch long whiskers and beard hair on his face. The resident stated he preferred to have his face shaved and that he had not had a bath in a week. A review of Resident #30's Nurse Aide (NA) task summary for showers and bathing from 4/1/25 through 4/30/25 found no record of showers or bathing completed for Resident #30. A review of Resident #30's shower sheet records for April 2025 found a shower sheet dated 4/22/25 and 4/29/25 completed for the resident. The 4/29/25 shower sheet was signed completed by NA #2. An in-room observation and interview with Resident #30 on 4/29/25 at 1:35 PM found the resident's beard and whisker hair to remain unchanged. Resident #30 stated he had received a bed bath on 4/29/25 and he had requested the bed bath over a shower. Resident #30 said he asked NA #2 to shave him, and NA #2 had said she would not shave him because she was too nervous. The resident said NA #2 did not come back to tell him who would shave him or when he would be shaved. Resident #30 stated he was not able to shave himself and that he thought he had only been shaved one time in April. NA #2 was interviewed on 4/30/25 at 1:29 PM. She stated she provided the bed bath to the resident Resident #30 on 4/29/25. NA #2 said Resident #30 declined a shower and asked for a bed bath. She said Resident #30 had asked her to shave his face during the bed bath and she told the resident she did not feel comfortable shaving him because of her arm tremors. NA #2 said she told Resident #30 someone else would come back and shave him. The NA stated she was not able to recall who she asked to shave the resident after completing the bed bath on 4/29/25. NA #2 said she does forget to fill out the shower sheets for residents after completing a shower or bath, but she had always given her assigned residents a shower or bath when scheduled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview with NA #2 was conducted on 4/30/25 at 2:41 PM. NA #2 stated she was unaware if Resident #30 was able to shave himself with a razor. She added that the resident would probably be able to use an electric razor to shave himself. NA #2 said shaving a resident was completed when providing a bath or shower for a resident that liked to be shaved. The Director of Nursing (DON) was interviewed 5/1/25 at 4:37 PM. The DON stated shower sheets were supposed to be completed by NAs after every shower or bath. The DON stated if Resident #30 had requested to be shaved then he should have been shaved by NA#2 or the NA who agreed to shave Resident #30.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to post cautionary and safety signs that indicated the use of oxygen and ensure the physician order included the oxygen flow rate (amount of oxygen administered in liters per minute) and delivery method (nasal cannula) for 1 of 1 resident reviewed for respiratory care (Resident #73). Findings included: Resident #73 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and chronic obstructive pulmonary disease (difficulty breathing). A physician's order dated 04/25/25 for Resident #73 read, respiratory: oxygen-continuous. The physician order did not indicate the oxygen flow rate to be administered or directions or how the oxygen was to be delivered, such as nasal cannula. The Brief Interview for Mental Status (BIMS) assessment (tool used to gauge an individual's cognition) dated 04/25/25 revealed Resident #73 had intact cognition. During an observation and interview on 04/27/25 at 12:22 PM, Resident #73 was lying in bed receiving supplemental oxygen via nasal cannula with the flow rate on the oxygen concentrator set at 3 liters per minute (LPM). Resident #73 stated she used supplemental oxygen to help with her breathing but was not sure how many LPM she was supposed to receive. There was no cautionary signage posted on the door, doorframe or in Resident #73's room to indicate oxygen was in use. During subsequent observations conducted on 04/28/25 at 8:00 AM, 04/29/25 at 4:50 PM and 04/30/25 at 8:31 AM, Resident #73 was lying in bed receiving supplemental oxygen via nasal cannula with the oxygen concentrator set at 3 LPM. There was no cautionary signage posted on the door, doorframe or in Resident #73's room to indicate oxygen was in use. During an interview on 04/30/25 at 9:13 AM and follow-up interview on 04/30/25 at 12:31 PM, the Director of Nursing (DON) confirmed there was no cautionary signage placed on the door, doorframe or in Resident #73's room to indicate oxygen was in use and explained there should have been as that was the facility's process. The DON stated the placement of the signage was likely overlooked because Resident #73 admitted to the facility after-hours (after normal business hours). The DON was unaware Resident #73's oxygen order did not indicate the oxygen flow rate and explained it was an oversight that she did not include the LPM when she entered Resident #73's oxygen order in her electronic medical record. During an interview on 05/01/25 at 5:37 PM, the Administrator stated physician orders for oxygen use should include the amount of oxygen to be administered and cautionary signage should be posted on the doors of residents' rooms who were receiving supplemental oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews the facility failed to assess a resident for risk of entrapment prior to installing and/or using bed rails for 1 of 4 sampled residents reviewed for accidents (Resident #18). Findings Included: Resident #18 was admitted to the facility on [DATE]. Her cumulative diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebrovascular disease (conditions that affect blood flow to the brain) affecting the left dominant side, left knee contracture and chronic pain. The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had intact cognition. She had impairment on one side of the lower extremity, was dependent on staff for assistance with bed mobility and did not use bed rails during the MDS assessment look-back period. During an observation and interview on 04/27/25 at 11:20 AM, quarter bed rails were observed in the upright position on each side of Resident #18's bed. Resident #18 explained she used the bed rails to reposition herself when lying in bed. Review of Resident #18's electronic medical record on 04/28/25 revealed no evidence Resident #18 was assessed for risk of entrapment prior to installing and/or using bed rails. An additional observation conducted on 04/29/25 at 4:40 PM revealed Resident #18 lying in bed watching TV with quarter bed rails in the upright position on each side of the bed. During an interview on 04/30/25 at 9:13 AM, the Director of Nursing (DON) explained when therapy agreed bed rails would aid a resident with independent bed mobility, an initial bed rail assessment was completed and then bed rails were installed for the resident to use. The DON also stated residents were reassessed quarterly to determine the continued need for bed rail use. The DON stated she did not realize a bed rail assessment needed to be completed for Resident #18 because the use of bed rails were ordered by Hospice. During an interview on 05/01/25 at 8:32 AM, Nurse Aide #1 revealed Resident #18 used the quarter bed rails for independent bed mobility and repositioning. During an interview on 05/01/25 at 5:27 PM, the Administrator stated she would expect bed rail assessments to be completed per the facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and staff interviews, the facility failed to have a system in place to ensure Nurse Aides (NA) were able to demonstrate the competency and skills necessary for providing care to meet the individual care needs of residents' that included hand hygiene during incontinence care for 3 of 5 employee files reviewed (NA #2, NA #3 and NA #4). On 04/30/25, NA #3 did not remove soiled gloves and perform hand hygiene before applying a clean brief and touching other items in the resident's environment after providing incontinent care to a dependent resident. Findings included: This tag is crossed referenced to: F 880: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies when Nurse Aide (NA) #3 did not don (put on) a gown while providing urinary catheter (a tube that drains urine out of the body) care to Resident #65 who required enhanced barrier precautions (EBP) due to the presence of a urinary catheter and failed to follow their Hand Hygiene policy when NA #3 did not remove soiled gloves and perform hand hygiene before applying a clean brief and touching other items in the resident's environment while providing incontinence care to Resident #65. This deficient practice occurred for 1 of 4 staff members observed for infection control practices (NA #3). a. Review of NA #2's employee file revealed she had been employed at the facility since 12/01/22. The employee file did not contain any evidence that NA #2's skills or competencies were checked upon hire or thereafter. b. Review of NA #3's employee file revealed she had been employed at the facility since 03/17/25. The employee file did not contain any evidence that NA #3's skills or competencies were checked upon hire or thereafter. During an interview on 04/30/25 at 2:49 PM, NA #3 stated she had not received any training from the facility regarding her removing gloves, performing hand hygiene and applying clean gloves after removing stool during incontinent care and before touching other items in the room. c. Review of NA #4's employee file revealed she had been employed at the facility since 08/24/23. The employee file did not contain any evidence that NA #4's skills or competencies were checked upon hire or thereafter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record review, and staff interviews the facility failed to record opened dates on multi-dose oral inhalers and label and date opened multi-dose bottles of eye drops on 3 of 4 medication carts (400 Hall, 200 Hall, and 300 Hall) reviewed for medication storage. Findings included: 1. An observation was made of the 400 Hall medication cart on 05/01/25 at 2:35 PM in the presence of Medication Aide (MA) #1. The observation revealed the following: (a). An opened and undated 7.5 milliliter (ml) multi-dose bottle of Neomycin and Polymyxin (antibiotics) eye drops were stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. (b). An opened and undated multi-dose bottle of Prednisolone Acetate (steroid) 1% eye drops was stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding them on or before the expiration date. (c). An opened, undated, and unlabeled 15 ml multi-dose bottle of Polyethylene Glycol 400 4% and Propylene Glycol 0.3% (eye lubricants) was stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. (d). An opened and undated multi-dose oral inhaler containing Fluticasone Propionate (a steroid) 250 micrograms (mcg) and Salmeterol Xinafoate (medication to keep airways open) 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. (e). An opened, undated, and unlabeled multi-dose oral inhaler containing Fluticasone Propionate 250 mcg and Salmeterol Xinafoate 50 mcg was stored on the medication cart. The medication did not include the name of the resident it had been dispensed for. The manufacturer recommended discarding one month after opening the foil pack. An interview with MA #1 on 05/01/25 at 2:35 PM revealed she was not sure why the eye drops and inhalers did not have an opened date or why the Fluticasone Propionate and Salmeterol Xinafoate inhaler did not have a resident name on it. 2. An observation of the 200 Hall medication cart was conducted in the presence of Nurse #5 on 05/01/25 at 2:56 PM. The observation revealed the following: (a). An opened and undated multi-dose oral inhaler containing Fluticasone Propionate 100 mcg and Salmeterol 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. An interview with Nurse #5 on 05/01/25 at 2:56 PM revealed all multi-dose oral inhalers should be dated when opened and she did not notice the inhaler did not have a date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An observation of the 300 Hall medication cart was conducted in the presence of Medicatio Aide (MA) #2 on 05/01/25 at 3:11 PM. The Assistant Director of Nursing (ADON) was also present for part of the observation. The observation revealed the following: (a). Two opened and undated 2.5 ml bottles of Latanoprost 125 micrograms (mcg) were stored on the medication cart. The manufacturer recommended dating the medication when opening and discarding within 6 weeks after opening. (b). An opened and undated 5 ml bottle of Levobunolol 0.5% drops (drops that lower pressure inside the eye) was stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. (c). An opened and undated multi-dose oral inhaler containing Umeclidinium 62.5 mcg and Vilanterol 25 mcg (medications used to relax airways) was stored on the medication cart. The manufacturer recommended dating the inhaler when removing from the foil pack and discarding the medication 6 weeks after opening. (d). An opened and undated multi-dose oral inhaler containing Fluticasone Propionate 250 mcg and Salmeterol Xinafoate 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. (e). An opened and undated multi-dose oral inhaler containing Olodaterol (medication used to relax airways) 2.5 mcg was stored on the medication cart. The manufacturer recommended discarding within 3 months of first use. An interview with MA #2 on 05/01/25 at 3:11 PM revealed all opened medication should have an opened date and he was not sure why the eye drops and inhalers were undated. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed all opened medications should be labeled with the resident's name and date they were opened by the staff member who opened the medication. The DON stated third shift was responsible for checking medication carts nightly to ensure all medications were labeled and dated and the staff member assigned to the medication cart was also responsible for ensuring medications were labeled and dated. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected all medications to be labeled and dated at the time they were opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, observations and interviews with staff, the facility failed to follow the meal spreadsheet and posted menu when they ran out of a food item while plating meals. This deficient practice impacted 7-9 residents who did not receive regular consistency carrots for their lunch meal. Findings included: The facility's menu spreadsheet for the lunch meal dated 4/29/25 was reviewed. The spreadsheet read Swedish meatballs with gray, buttered noodles, and sliced carrots. On 4/29/25 at 11:40 AM an observation of the lunch meal tray line found the posted lunch meal was Swedish Meatballs with gravy, buttered noodles, and carrots. An observation of the tray line on 4/29/25 at 12:12 PM found the [NAME] plating the last available serving of regular consistency carrots from the trayline. On 4/29/25 at 12:14 PM the [NAME] stated there were not enough regular consistency carrots to finish serving the 300 hall residents (7-9) for the meal. The [NAME] said she had used all the carrots available in the kitchen for the meal. She also said the District Dietary Manager was cooking capri vegetables (mixed vegetables) as a substitute for carrots. On 4/29/25 at 12:16 PM the District Dietary Manager was observed cooking the capri vegetables. On 4/29/25 at 12:17 PM the [NAME] stated she normally needed 6 bags of carrots to prepare a meal for all the residents, and she only had 5 bags to use for the lunch meal. An observation on 4/29/25 at 12:22 PM found the substituted capri vegetable were placed on the tray and the [NAME] resumed plating the lunch meal with the capri vegetables. On 4/29/25 at 12:35 PM the [NAME] stated she did not notify the Dietary Manager that she might not have enough carrots for the meal until the lunch meal tray line had started. The Dietary Manager stated on 5/01/25 at 1:43 PM the cook should have notified the Dietary Manager when she was preparing the meal. The Dietary Manager stated the facility would have purchased more carrots from a store to make sure there were enough for the meal. The Administrator was interviewed on 5/01/25 at 5:24 PM. She stated the posted menu should be followed and accurate. The Administrator stated the cook should have communicated to the DM there were not enough carrots when she first knew the amount on hand was not going to be enough.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews the facility failed to remove food stored past the use by date from the dry goods storage area. Additionally, the facility failed to clean a circulatory fan cover and prevent water from dripping onto stored food in 1 of 2 kitchen refrigerators (the walk-in refrigerator). This practice had the potential affect food served to residents. The findings included: a. On 4/27/25 at 10:20 AM an observation of the dry goods storage area's bread rack with a fill in Dietary Manager (DM #2) from a sister facility found stored bread past the use by date. DM #2 stated the facility's Dietary Manager (DM #1) was not available on 4/27/25, and he was filling in for the day. The bread rack contained 8 loaves of sliced bread with a use by date of 4/25/25 and 3 packages of hamburger buns with a use by date of 4/23/25. The DM #2 stated during the observation the procedure was to remove the bread from the [NAME] rack and place it into the freezer before the use by date. The DM #2 stated the DM #1 was responsible for ensuring the bread was removed before the use by date. b. On 4/27/25 at 10:27 AM an observation of the walk-in refrigerator with the fill in DM #2 found the refrigeration unit leaking water. The water was a steady drip coming from a pipe connected to the back of the refrigeration unit to the wall. The water was dripping onto a lid of a container labeled pickles, and water was observed on the floor of the walk-in refrigerator. The circulatory fan cover was also observed to contain a thick buildup of crumbly black and gray substance on the cover. The DM #2 stated he did not know how long the refrigerator unit had been dripping water and would notify maintenance about the water and the fan cover. The DM #1 was interviewed on 5/1/25 at 1:43 PM. He stated he had not seen the refrigerator unit dripping water before and the circulatory fan cover would be included on a regular cleaning schedule. The DM #1 said the bread was ultimately his responsibility to ensure it was frozen by the use by date. The Maintenance Supervisor was interviewed on 5/1/25 at 2:00 PM. She stated a refrigerator repair company was called and came to the facility on 4/28/25 to fix the water leak and she had not been aware of the leaking water prior to 4/28/25. The Maintenance Supervisor stated a pipe was not fully insulated and was causing condensation to drip and was fixed. The Maintenance Supervisor stated the fan cover was not on a routine cleaning schedule, and she would include it. The Administrator was interviewed on 5/1/25 at 5:24 PM. She stated the bread should have been removed or frozen by the use by date and the walk-in refrigerator fan cover should be cleaned routinely. She also stated the water dripping from the refrigeration unit should be repaired to prevent any potential contamination of food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain complete and accurate medical records by not documenting when residents admitted to the facility, discharged from the facility or expired at the facility for 3 of 23 sampled residents (Residents #73, #71, and #72). Findings included: 1. The profile page in Resident #73's electronic medical record revealed she was admitted to the facility on [DATE]. Review of the staff progress notes for Resident #73 revealed no entry on [DATE] regarding her admission to the facility, such as the time of her arrival, condition or care needs. An unsuccessful telephone attempt was made [DATE] at 2:43 PM to interview Nurse #2 who had provided Resident #73's care on [DATE]. During an interview on [DATE] at 9:14 AM, the Director of Nursing (DON) stated she would have expected for the nurse to have written a progress note when Resident #73 admitted to the facility that included details such as the time she arrived to the facility and her condition upon arrival. The DON stated it was likely that the nurse just forgot since Resident #73 admitted to the facility after-hours (after normal business hours). 2. The profile page in Resident #71's electronic medical record revealed he was admitted to the facility on [DATE]. Review of Resident #71's Minimum Data Set (MDS) assessment history revealed a death in the facility tracking record dated [DATE]. Review of the staff progress notes for Resident #71 revealed the last documented staff progress note was an entry dated [DATE] at 9:47 AM. There was no entry on [DATE] detailing the events of Resident #71's death. During a phone interview on [DATE] at 12:35 PM, Nurse #1 recalled being notified by staff on [DATE] that Resident #71 had passed which she confirmed upon her assessment. Nurse #1 stated she should have written a progress note detailing the events of his death and was not sure why she had not. During an interview on [DATE] at 9:14 AM, the Director of Nursing (DON) stated she would have expected for the nurse to have written a staff progress note when Resident #71 passed away that included details such as how he was found, the time of death and that the funeral home, Responsible Party and provider were all notified. 3. The profile page in Resident #72's electronic medical record revealed he was admitted to the facility [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The discharge return not anticipated Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 discharged home. Review of staff progress notes for Resident #72 on [DATE] revealed no documentation of his discharge home. Further review of Resident #72's medical record revealed all applicable discharge notices were issued as required. Review of the schedule revealed a medication aide (MA) was assigned to care for Resident #72 on [DATE] and Nurse #3 and Nurse #4 were assigned to oversee the MA. A telephone interview with Nurse #3 revealed she did not specifically remember working on [DATE] but if a MA was assigned to care for a resident and was discharged home, she or another nurse was responsible for writing a discharge note. She was unable to state why there was no discharge note for Resident #72 on [DATE]. Nurse #4 was unavailable for interview during the investigation. An interview with the Director of Nursing (DON) on [DATE] at 9:17 AM revealed any time a resident was discharged home there should be a nurse's note including what time the resident left, who they left with, any complaints or concerns they may have had, and their condition at the time they left the facility. A follow-up interview with the DON on [DATE] at 4:38 PM revealed if a MA was working and a resident discharged home, it was the responsibility of nurse who was overseeing the MA to write a discharge note and she was not sure why there was not a discharge note for Resident #72 on [DATE]. An interview with the Administrator on [DATE] at 5:39 PM revealed she expected a nurse's note to be included in a resident's medical record including their status at discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and staff interviews, the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) related to Registered Nurse (RN) hours and licensed nursing coverage 24-hours per day. This was for 1 of 3 quarters reviewed for sufficient nurse staffing (Quarter 1: October 1-December 31, 2024). Findings included: The PBJ report for the Fiscal Year Quarter 1 2025 (October 1 through December 31, 2024) revealed there were no Registered Nurse (RN) hours for 10/12/24, 10/13/24, 11/17/24, 12/14/24, 12/15/24, and 12/22/24. The PBJ report also noted the facility failed to have licensed nursing coverage 24 hours a day for 10/12/24, 10/13/24, 11/09/24, 11/10/24, 11/17/24, and 12/14/24. The daily staff schedules for 10/12/24, 10/13/24, 12/14/24, 12/15/24, and 12/22/24 revealed there was a RN onsite for at least 8 hours a day. Further review revealed on 11/17/24 there was no RN onsite for at least 8 hours a day. The nursing staff time detail reports for 10/12/24, 10/13/24, 11/17/24, 12/14/24, 12/15/24, and 12/22/24 revealed there was no RN onsite for at least 8 hours a day. The daily staff schedules revealed there was no licensed nursing coverage at the facility 24 hours a day on 10/12/24 and 10/13/24. Further review revealed there was licensed nursing coverage at the facility 24 hours a day on 11/09/24, 11/10/24, 11/17/24, and 12/14/24. The nursing staff time detail reports revealed there was no licensed nursing coverage at the facility 24 hours a day on 10/12/24, 10/13/24, 11/09/24, 11/10/24, 11/17/24, and 12/14/24. During an interview on 04/28/25 at 10:26 AM, the Regional [NAME] President of Operations revealed for the dates of 10/12/24, 10/13/24, 11/09/24, 11/10/24, 11/17/24, 12/14/24, 12/15/24, and 12/22/24, the facility did have an RN 8 hours a day and licensed nursing coverage for 24 hours a day. He explained the facility did not use agency staffing and on the above dates, the Administrator at the time, who was an RN, and Director of Nursing both worked shifts as nurses on various days but since they were both salaried they did not clock in or out and their hours would not show on the time detail reports. He stated the corporate office had to manually adjust and input any hours salaried nursing staff worked covering shifts. He explained when nurses from sister facilities worked shifts at this facility, their hours would not show up on the time detail reports because they were only able to clock in and out at their home facility. He stated the corporate office had to manually adjust their hours from the home facility and input the hours at the facility where they had worked. The Regional [NAME] President of Operations revealed the corporate office was not always consistent with the process of manually adjusting and inputting nursing staff hours for payroll data to accurately reflect nursing staff coverage on the PBJ reports submitted to CMS which was why no RN coverage and no licensed nursing staff coverage triggered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews the facility failed to implement their infection control policies when Nurse Aide (NA) #3 did not don (put on) a gown while providing urinary catheter (a tube that drains urine out of the body) care to Resident #65 who required enhanced barrier precautions (EBP) and failed to follow their Hand Hygiene policy when NA #3 did not remove soiled gloves and perform hand hygiene before applying a clean brief and touching other items in the resident's environment while providing incontinence care to Resident #65. This deficient practice occurred for 1 of 4 staff members observed for infection control practices (NA #3). Findings included: Review of the facility's Hand Hygiene policy last revised 02/05/21 read in part as follows: The CDC [Centers for Disease Control] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). Hand Hygiene should be performed before initiating a clean procedure, after contact with body fluids or excretions, when hands are moved from a contaminated-body site to a clean body site during patient care, and after glove removal. Review of the facility's Enhanced Barrier Precautions (EBP) policy last updated in August 2022 read in part as follows: EBPs are utilized to prevent the spread of multi-drug-resistant organisms (MDROs). EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (urinary catheter and feeding tube). An observation of Resident #65's door on 04/30/25 at 2:39 PM revealed a sign hanging on the door indicating he was on EBP and a shelf containing gowns and gloves was hanging on the door. A continuous observation of NA #3 on 04/30/25 from 2:40 PM until 2:49 PM revealed she performed hand hygiene with alcohol-based hand rub, entered Resident #65's room, applied gloves, pulled back his bed cover, un-fastened his brief, cleaned his penis and urinary catheter with a resident care wipe, discarded the wipe in a trash bag, assisted Resident #65 onto his right side, removed stool with a resident care wipe, rolled the soiled wipe up into the used brief, rolled a clean brief under Resident #65's right side, assisted Resident #65 onto his back, pulled the brief into place and fastened it, placed a pillow under his head and under his right side, pulled his bed cover into place, picked up the bed control and used it to raise the head of his bed, clipped the bed control to his blanket, picked up the soiled brief, placed it in a trash bag, removed her gloves and placed them in the bag, gathered the trash bag containing the soiled brief, performed hand hygiene with alcohol-based hand rub, and exited resident #65's room. NA #3 did not don a gown before performing urinary catheter care and did not remove gloves and perform hand hygiene after removing stool and before touching other items and surfaces. An interview with NA #3 on 04/30/25 at 2:50 PM revealed she was not aware that Resident #65 was on EBP, and use of a gown was required when performing catheter care. She also stated she did not usually change her gloves after during incontinence care unless they were visibly soiled with stool, and she did not see any stool on her gloves when she was performing incontinence care for Resident #65. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Assistant Director of Nursing (ADON) on 04/30/25 at 3:03 PM revealed staff should wear a gown when providing urinary catheter care according to EBP guidelines. She stated gloves should be removed and hand hygiene should be performed any time there was contact with stool. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed she expected staff to wear a gown when providing catheter care and gloves should be removed and hand hygiene should be performed after cleaning stool and before touching other items. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected staff to follow EBP signage and the policy for hand hygiene when providing incontinence care.