STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dahlia Gardens Center for Nursing and Rehabilitati	915 Pee Dee Road Aberdeen, NC 28315

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and staff interviews, the facility failed to dispose of a stained urine collection hat stored underneath a sink on the floor in a resident's bathroom. This deficient practice affected 1 of 7 residents on the 400 hall memory care unit who were reviewed for a safe, clean, comfortable, homelike environment (Resident #74).The findings included:An initial observation completed on 12/1/25 at 1:03 PM, and a follow-up observation on 12/2/25 at 11:28 AM, revealed a yellow stained white urine collection hat (a device placed inside the commode to collect urine for sampling) with a tissue inside lying on the floor underneath the sink in Resident #74's bathroom. The device was not labeled with a resident's name or stored in a bag. Resident #74 resided in the memory care unit and was in his room during both observations, and he was unable to state if the device belonged to him.On 12/2/25 at 11:32 AM an interview was conducted with Nurse Aide (NA) #3 who stated she was unaware there was a urine collection hat on the floor of Resident #74's bathroom and stated she would take care of it. NA #1indicated the hat was one used on the unit to collect urine samples for testing, and it should have been cleaned after use and labeled with the resident's name and stored in a closed bag if it was meant for reuse. NA #3 further stated it was the responsibility of the NA to remove urine collection hats from resident's rooms after use.The Unit Manager was interviewed on 12/3/25 at 2:11 PM and stated if a urine collection hat was used for obtaining a urine sample, then it should be thrown away. However, if one was kept for a resident then it should be labeled with the resident's name and stored in a plastic bag once cleaned after use.On 12/3/25 at 3:08 PM the Director of Nursing (DON) was interviewed and stated the urine collection hat should have been thrown away after use. The Administrator was interviewed on 12/4/25 at 1:42 PM and stated urine collection hats were typically used to obtain a sample for urine testing. She indicated once staff obtained the sample, the device should have been thrown away. The Administrator stated the used hat should not have been stored in the resident's bathroom, and she would expect the staff to obtain a new urine collection hat if the resident required a follow up sample.

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Nurse Practitioner, Pharmacist, and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication (methadone) prescribed to treat pain. This affected 1 of 3 residents reviewed for misappropriation (Resident #17).The findings included: A review of the facility's policy entitled Abuse, Neglect, and Exploitation implemented 12/1/22 and revised 1/1/25 read in part . It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent. Resident #17 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II with diabetic polyneuropathy and chronic pain due to trauma. A review of the quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #17 to be cognitively intact without behaviors. The active medication orders for Resident #17 during the month of 2/2025 revealed an order for methadone 10 mg (milligrams) with an ordered date of 1/1/25 given by mouth three times a day for pain. A review of the medication administration record (MAR) for the month of 2/2025 revealed Resident #17 was administered methadone 10 mg three times daily by the facility staff except for the leave of absence (LOA) from 2/24/25 to 2/27/25. The facility sent ten tablets of methadone with the party responsible for the resident during her LOA. Resident #17's ordered methadone was signed as being received at the facility by Medication Tech #1 on 1/28/25. The medication count sheets were listed as having 30 tablets of methadone on each medication card. A review of the narcotic count sheets for Resident #17's methadone filled on 1/28/25 indicated the pharmacy sent one count sheet for each 30-tablet card. A review of the methadone count sheets for Resident #17 revealed count sheet #1 and count sheet #3 were present but count sheet #2 was missing. An initial allegation report was received by the State from the facility's Administrator on 2/25/25 at 7:05 PM. The report read that the facility initially became aware of the incident on 2/25/25 at 2:53 PM and alleged during reconciliation of Resident #17's medications post discharge, it was identified a methadone card was misplaced. Police were notified and the facility investigation was initiated. The incident was reported to local law enforcement on 2/25/25 at 6:46 PM. On 12/2/25 at 10:46 AM an interview was conducted with Resident #17 who stated she had become aware her methadone tablets were missing when the Director of Nursing (DON) and Administrator spoke with her about it. The resident stated as far as she knew, she received her methadone as she was supposed to and denied having uncontrolled pain during the month of 2/2025. Former Nurse Practitioner (NP) #1 was interviewed by phone on 12/3/25 at 1:18 PM. She stated on 2/22/25 she received a request from a nurse at the facility requesting a refill of methadone for Resident #17 (she was unsure of the nurse's name who called). NP #1 stated she submitted a refill request to pharmacy for the methadone, but later pharmacy notified her it was too soon to refill the medication. She stated she immediately notified the DON of a possible drug diversion. According to the NP, she had no previous cause for concern related to missing narcotic medications. Pharmacist #1 was interviewed by phone on 12/3/25 at 1:32 PM and stated he was notified of the missing methadone at the facility. He stated the pharmacy confirmed with the facility that no methadone had been returned for Resident #17, and he played a support role as the facility worked through their investigation regarding possible drug diversion. The Pharmacy Supervisor was interviewed by phone on 12/3/25 at 2:48 PM and stated the pharmacy filled a 90-tablet methadone prescription for Resident #17 on 1/28/25. She indicated the facility tried to submit a refill request around 2/22/25 for methadone 10 mg for Resident #17, but it was too soon to refill the medication. She stated the record showed the pharmacy did fill and deliver 10 tablets of methadone on 2/22/25 to the facility. The Pharmacy Supervisor stated their role was to support the facility as they investigated possible drug diversion. On 12/3/25 at 3:08 PM an interview was conducted with the Director of Nursing (DON) who stated she completed an investigation into possible drug diversion when the NP notified her on 2/25/25 of a refill request for Resident #17's methadone 10 mg being denied by pharmacy as being too soon to refill. The DON explained after researching the discrepancy it was found to have occurred when Nurse #1 last worked on 2/13/25. Nurse #1 had administered the last dose of methadone to Resident #17 from card #1. During the investigation she learned Resident #17's methadone card #2 was missing along with the methadone narcotic count sheet #2. She stated Nurse #1 had begun administering the methadone from card #3 and count sheet

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of rejection of care (Resident #35) for 1 of 19 MDS assessments reviewed.The findings included: Resident #35 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. A review of Resident #35's medical record revealed that she had refused medications a total of seven days prior to 10/27/25 for medication administration times of 6:30 AM, 8:00 AM and 8:00 PM. Review of the October 2025 Medication Administration Record (MAR) from 10/27/25 to 10/31/25, revealed that Resident #35 was marked as refused for the following: 10/27/25 at 8:00 PM for Ferrous Sulfate 220 milligrams (mg) per 5 milliliters (ml). Give 5 ml via feeding tube every morning and at bedtime for supplementation. 10/27/25 at 8:00 PM for Sennosides 8.6 mg. Give two tablets by mouth two times a day for constipation. 10/28/25 at 8:00 PM for inspection of surrounding skin to feeding tube area every morning and at bedtime. A MDS assessment dated [DATE] indicated Resident #35 had moderately impaired cognition and was not coded for rejection of care. Resident #35's active care plan, last reviewed 11/10/25, included a focus area for having a behavior problem related to attention seeking behaviors, noncompliance with tube feedings and ordered oral diet. The focus area was initiated on 12/15/23. Attempts to call Nurse #1 occurred during the survey but were unsuccessful. She was scheduled to care for Resident #35 on 10/27/25 and 10/28/25 when refusals were noted on the MAR. An interview with Nurse #2 occurred on 12/3/25 at 10:45 AM and stated that she frequently cared for Resident #35 during the day shift. Nurse #2 stated that Resident #35 would refuse care and medication. An interview with the MDS Nurse was conducted on 12/4/25 at 11:22 AM and stated that the Social Worker (SW) was responsible for completing the section of the MDS assessment that addressed rejection of care. On 12/4/25 at 11:29 AM, an interview occurred with the SW, who explained that she had been in the role for about two and half months and was responsible for completing the section addressing rejection of care on the MDS assessment. She explained that she looked at the nurses' notes only for this information and didn't review the MARs to see if a resident refused medications or treatments. The SW stated she wasn't sure where to look in the medical records for rejection of care. She reviewed Resident #35's MDS assessment dated [DATE] as well as the October 2025 MAR and verified that Resident #35 was marked as refusing medications and care on 10/27/25 and 10/28/25 which would have been during the MDS seven-day look back period and should have been coded on the 10/31/25 MDS assessment as rejection of care occurring one to three days. The Administrator was interviewed on 12/4/25 at 12:51 PM and stated she expected the MDS assessment to be coded accurately.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening Resident Review (PASRR) determination for a resident with a newly diagnosed serious mental illness for 1 of 2 residents reviewed for PASRR (Resident #4).The findings included:Resident #4 was admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder and unspecified depression. A level I PASRR was completed on 5/8/24 prior to admission.A review of a psychiatric assessment note dated 3/20/25 indicated Resident #4 was seen by the psychiatrist and diagnosed with bipolar disorder. A review of a psychiatry note dated 6/3/25 indicated a new medication order for Risperidone 0.25 milligrams (mg) by mouth once daily for behaviors related to psychosis based off the resident's self-reported mood swings, confusion, and crying. Resident #4's Representative provided informed verbal consent by phone on 6/3/25 for the psychiatric provider to begin the medication. A psychiatry note dated 6/9/25 indicated the staff reported Resident #4 continued to have mood swings, and the psychiatric provider included in his note an increase of Risperidone to 0.5 mg once daily.Review of the electronic medical record revealed there was no evidence that a level II PASRR screening was requested.A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #4 was severely cognitively impaired without behavioral concerns. Resident #4 was coded with bipolar disorder.On 12/4/25 at 12:01 PM the MDS Nurse was interviewed and stated she usually saw new mental health diagnoses and medication orders when she reviewed the providers' notes for gradual dose reductions of certain medications. She stated when she completed the quarterly MDS for Resident #4 she saw the new diagnosis of bipolar disorder for Resident #4 when she reviewed her orders and entered the diagnosis into the electronic medical record but clarified it did not dawn on me that she needed to notify the Administrator needed to submit a request for a Level II PASRR evaluation for Resident #4. She stated, I just missed it. Resident #4's annual Minimum Data Set, dated [DATE] assessed the resident was severely cognitively impaired and revealed she was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. The MDS coded Resident #4 with bipolar disorder.An interview was conducted with the Social Worker (SW) on 12/4/25 at 10:46 AM, and she stated she did not have access to North Carolina's MUST (Medicaid Uniform Screening System) system since being hired almost two months ago. The SW indicated the Administrator had been submitting PASRR requests to NCMUST during that timeframe.The Director of Nursing (DON) was interviewed on 12/4/25 at 11:40 AM and stated the facility's providers entered their own orders for medication changes and new diagnoses in the electronic medical record, and she confirmed the new orders once they were entered. The DON stated she tried to catch new orders and new diagnoses to inform the MDS Nurse. She further stated she kept a list of residents who needed a level II PASRR screening and thought Resident #4 already had a level II PASRR determination.On 12/4/25 at 11:07 AM, the Administrator was interviewed and affirmed she had been submitting requests for PASRR evaluations since the previous SW left. The Administrator stated the last PASRR for Resident #4 was completed prior to her admission on [DATE], and she had not submitted a request for a level II PASRR screening. She stated she was not aware Resident #4 needed a level II PASRR assessment, and the Administrator indicated she relied on the Director of Nursing and the Minimum Data Set (MDS) nurse to notify her of changes in a resident's condition so she could submit requests for PASRR screenings when needed.

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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 record review, observations, and resident and staff interview, the facility failed to ensure a resident who was dependent on staff assistance for nail care received assistance when needed for 1 of 5 residents reviewed for activities of daily living (ADL) (Resident #14).The findings included:Resident #14 was admitted to the facility on [DATE] with diagnoses that included a permanent neurological disorder affecting movement, posture, and coordination, contracture of left arm, and vascular dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #14's cognition was severely impaired. He exhibited behaviors that occurred for 1 to 3 days during the look-back period that included behavioral symptoms not directed towards others. He required moderate assistance with eating and was dependent on staff with personal hygiene, dressing, toilet hygiene, oral hygiene, shower/bath, bed mobility, and transfers. He was not coded for rejection of care. Resident #14 had range of motion impairment to both sides of his upper and lower extremities. Resident #14's active care plan, last revised on 10/10/25, included the focus area of an activity of daily living (ADL) self-care deficit and required assistance with ADL. Interventions included Resident required total assistance from staff for bathing and for staff to check nail length, trim, and clean on bath day and as necessary. Report any changes to the nurse.A review of Resident #14's nursing progress notes from 11/01/25 to 12/02/25 revealed no refusals of nail care documented.Record review revealed Resident #14's shower/bathing were scheduled for Wednesday and Saturday on night shift. Resident #14's shower schedule revealed no refusals from 11/01/25 through 12/02/25. Unsuccessful attempts were made to contact Resident #14's direct care NA for 11/29/25 (Resident #14's last scheduled shower day).An observation and interview were conducted on 12/01/25 at 11:10 AM with Resident #14. The observation revealed Resident #14's fingernails on his left and right hands extended approximately 1/4 to 1/2 of an inch beyond his fingertips and were jagged. A brown substance was observed under the pointer fingernail on the right hand. Resident #14 held his right hand up and stated, they need to be cut. When asked if he had asked anyone to cut his fingernails he did not respond.An observation of Resident #14 was conducted on 12/02/25 at 12:01 PM. He was observed sitting in his wheelchair watching television. The observation revealed Resident #14's fingernails were still long and jagged. A brown substance was observed under the pointer fingernail on the right hand.An observation of Resident #14 was conducted on 12/02/25 at 2:25 PM. Resident #14 was observed sitting in his wheelchair watching television. The observation revealed Resident #14's fingernails were still long and jagged. A brown substance was observed under the pointer fingernail on the right hand.An interview was conducted on 12/03/25 at 1:45 PM with Nursing Assistant (NA) #1. He verified he was the direct care NA for Resident #14 from 7:00 AM to 7:00 PM that day. He confirmed Resident #14's fingernails on his right and left hands were long, jagged, and the pointer fingernail had a brownish substance under it. He stated he did not realize Resident #14's nails needed to be cleaned and cut. An interview was conducted on 12/03/25 at 2:02 PM with the Director of Nursing (DON). She verified Resident #14's fingernails on his right and left hands were long, jagged, and the pointer fingernail had a brownish substance under it. She stated his showers are on 2nd shift however nailcare was everyone's responsibility. Staff normally performed nailcare on shower days, during morning care, and as needed. She indicated Resident #14's fingernails needed to be cut, filed, and cleaned. She indicated there was no reason his nails had not been tended to.An interview was conducted on 12/03/25 at 2:10 PM with Medication Aide (MA) #1. She verified she had been the direct care MA for Resident #14 since 12/01/25. She stated staff normally perform nailcare on shower days and as needed. She also stated she did not notice Resident #14's fingernails needed to be cut, filed, and cleaned. She indicated Resident #14 did not refuse nail care or showers.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to post accurate staffing information as compared to the daily staff schedule for 32 out of 32 days (11/01/25 through 12/02/25) reviewed. The findings included:a) A review of the facility's daily posting for nursing staff for the past 32 days (11/01/25 through 12/02/25) as compared to the daily staffing schedule revealed the total of actual hours worked for day shift, evening shift, and night shift, for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Aides were blank. b) A review of the facility's daily posting for nursing staff for the past 32 days as compared to the daily staffing schedule included an inaccurate total number of licensed staff working. These included the following:-The number of licensed staff on 1st shift was incorrect for the following dates: 11/03/25-11/07/25, 11/10/25-11/14/25, 11/17/25-11/22/25, and 11/24/25-12/02/25. -The number of licensed staff on 2nd shift was incorrect for the following dates: 11/23/25 and 12/02/25.-The number of licensed staff on 3rd shift was incorrect for the following dates: 11/01/25, 11/11/25, 11/19/25, 11/24,25, and 11/30/25.c) A review of the facility's daily posting for nursing staff for the past 32 days as compared to the daily staffing schedule included an inaccurate total number of unlicensed staff working. These included the following:-The number of unlicensed staff on 1st shift was incorrect for the following dates: 11/04/25-11/12/25, 11/14/25, 11/17/25, and 11/24/25-12/02/25.-The number of unlicensed staff on 2nd shift was incorrect for the following dates: 11/07/25-11/06/25, 11/12/25-11/10/25, 11/19/25, 11/24/25-11/26/25, and 11/28/25-11/30/25.-The number of unlicensed staff on 3rd shift was incorrect for the following dates: 11/01/25, 11/02/25, 11/07/25, and 11/25/25. An interview was conducted on 12/03/25 at 3:16 PM with the Receptionist. She stated she completed the daily nurse staffing summary sheets that were posted daily. She stated she did not complete the area of total hours for licensed or unlicensed staff because the facility got a new time clock system and she did not have access to the totals anymore. She explained that was how she added the hours up. It was an oversite that she forgot to add the census total on some of the sheets. She stated she was unaware she was to add the wound nurse and nurse supervisors to the licensed staff totals for each shift or the medication aide (MA) to the unlicensed staff totals. An interview was conducted on 12/04/25 at 11:22 AM with the DON. She reviewed and confirmed the daily Posted Nurse Staffing Information sheets were inaccurate and did not reflect the actual working hours or the correct number of staff. She stated the time totals should have been added to the total hours worked columns for each shift. She explained that the hours should have been calculated with 12 or 8 hours for each working employee, not the actual punch time totals. The census also should have been added and if a member of staff called out the sheet should have been adjusted to reflect the correct number of employees working. She explained she was unaware the posting sheets were not correct or completed accurately. An interview was conducted on 12/03/25 at 3:16 PM with the Administrator. She was unaware the staff sheets were not being filled out completely or correctly as the Director of Nursing (DON) oversees the task. A follow-up interview was conducted on 12/04/25 at 12:35 PM with the Administrator. She stated she was not involved in the staff posting sheets however she would expect them to display the correct information.