

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Tower Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 Bond Street Raleigh, NC 27604	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, Resident Representative (RR) and staff interviews, the facility failed to provide written information about advance directives and/or an opportunity to formulate advance directives, and to obtain advance directives and maintain the advance directives in the medical record for 11 of 30 residents reviewed for advance directives (Residents #1, #2, #4, #18, #41, #50, #54, #55, #81, #83 and #100).a. Resident #83 was admitted to the facility on [DATE] with diagnosis that included diabetes, kidney disease and hypertension.Resident #83 had a Full Code physician order dated 5/22/26.An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was cognitively intact.An interview completed with Resident #83 on 7/15/26 at 12:28 PM. Resident #83 stated that he does not recall receiving written education regarding Advance Directives.There was no documentation in the record for education regarding formulation of Advance directives and/or an opportunity to formulate Advance directives was offered.b. Resident #81 was admitted to the facility on [DATE] with diagnosis that included rhabdomyolysis and dysphagia.Resident #81 had a Full Code Physician order dated 6/20/26.An admission MDS assessment dated [DATE] revealed Resident #81 was cognitively intact.During an interview completed with Resident #81 on 7/15/26 at 1:23 PM. He stated that he does not recall receiving written education regarding advance directives.There was no documentation in the record for education regarding formulation of Advance directives and/or an opportunity to formulate Advance directives was offered.c. Resident #1 was admitted to the facility on [DATE] with diagnoses that included a history of a stroke and diabetes. Resident #1 had a Do Not Resuscitate physician order dated 6/5/23. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was severely cognitively impaired. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. Attempts to contact the Resident Representative (RR) were unsuccessful. d. Resident #2 was admitted to the facility on [DATE] with diagnoses that included high blood pressure and diabetes. Resident #2 had a Full Code physician order dated 1/9/26.A quarterly MDS dated [DATE] revealed Resident #2 was severely cognitively impaired. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. Attempts to contact the Resident Representative (RR) were unsuccessful. e. Resident #4 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, heart disease, and congestive heart failure. Resident #4 had a Full Code physician order dated 12/31/24. A quarterly MDS assessment dated [DATE] revealed Resident #4 was moderately cognitively impaired. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive (continued on next page)		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was offered. An interview completed with the RR on 7/16/26 at 3:35 PM revealed they were unaware if advanced directive education had been provided by the facility.f. Resident #18 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease and atrial fibrillation. Resident #18 had a Do Not Resuscitate Physician order dated 5/8/26. A quarterly MDS assessment dated [DATE] revealed Resident #18 was cognitively intact. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. An interview completed on 7/16/26 at 10:20 AM with Resident #18 revealed Resident #18 did not recall receiving written education regarding the formulation of an advance directive.g. Resident #41 was admitted to the facility on [DATE] with diagnoses that included heart disease and high blood pressure. Resident #41 had a Full Code physician order dated 5/15/25. A quarterly MDS assessment dated [DATE] revealed Resident #41 was cognitively intact. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. An interview completed on 7/15/26 at 9:35 AM with Resident #41 revealed Resident #41 did not recall receiving written education regarding the formulation of an advance directive.h. Resident #50 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, chronic respiratory failure, and heart disease. A quarterly MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. Resident #50 had a Full Code physician order dated 6/16/26. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. An interview completed on 7/17/26 at 11:00 AM with Resident #50 revealed Resident #50 did not recall receiving written education regarding the formulation of an advance directive.i. Resident #54 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and diabetes. Resident #54 had a Full Code physician order dated 2/25/25. A quarterly MDS assessment dated [DATE] revealed Resident #54 was cognitively intact. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. An interview completed on 7/16/26 at 2:34 PM with Resident #54 revealed Resident #54 did not recall receiving written education regarding the formulation of an advance directive.j. Resident #55 was admitted to the facility on [DATE] with diagnoses that included a history of a stroke and high blood pressure. Resident #55 had a Full Code physician order dated 5/20/25. An annual MDS assessment dated [DATE] revealed Resident #55 was severely cognitively impaired. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. Attempts to contact the RR were unsuccessful.k. Resident #100 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease and heart disease. An admission MDS dated [DATE] revealed Resident #100 was cognitively intact. Resident #100 had a Full Code Physician order dated 7/3/26. An interview completed with Resident #100 on 7/16/26 at 2:00 PM did not recall receiving written education regarding advance directive. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. An interview was completed on 7/15/26 at 10:55 AM with the Director of Nursing (DON). The DON revealed the facility only discussed the resident's code status with the resident and/or their responsible party.An interview was completed on 7/15/26 at 12:52 PM with the Regional [NAME] President of Operations. He revealed the facility recently had turnover in the Social Worker role that resulted the failure to ensure there was education provided to residents or their representatives regarding advance directive education.Attempts to contact the facility's previous Social Worker were unsuccessful.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, Resident Representative (RR), and staff interviews, the facility failed to ensure a written grievance decision included all required components and to provide a written grievance summary for 7 of 7 resident reviewed for grievances (Resident #11, Resident #2, Resident #41, Resident #43, Resident #50, Resident #28 and Resident #85). The findings included: Review of the facility policy dated 07/01/2018 titled Resident Grievance Policy indicated the Administrator was responsible for overseeing, directing and investigating grievances in a prompt manner; reviewing the results of the grievance investigations for conclusion; initiating corrective measure or actions; and ensuring the resident or resident representative is notified timely of the results of the investigation, of corrective measures taken, and this notification will be documented. 1. Resident # 11 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident #11's Significant Change Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. A grievance dated 07/02/25 filed by the Endocrinology Nurse Practitioner included a note from the Endocrinology appointment that indicated Resident #11 reported she didn't get her medications in time. The form did not include the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the concerns, any corrective action taken by the facility as a result of the grievance, or a date the written grievance decision was issued. There was no documentation on the grievance form that a written response was issued to the resident or resident representative and there was no signature of the facility's grievance officer. A grievance dated 8/30/25 filed by Resident #11 indicated an issue with resident's room being cold at night. The form did not include the date the written grievance decision was issued and there was no documentation that indicated a written response was provided to the resident. The document was signed by the previous Administrator, Administrator #1, who was the grievance officer on 8/30/25. A grievance dated 9/5/25 filed by Resident #11 indicated an issue with the staff that transferred Resident #11 to the toilet. The form did not include who filed the grievance, the date the written grievance decision was issued and there was no documentation that indicated a written response was provided to the resident. The document was signed by Administrator #1 who was the grievance officer on 9/8/25. A grievance dated 9/15/25 filed by Resident #11 indicated an issue with the resident's room being cold and the resident's maneuvering of their wheelchair to the toilet. The form did not include the date the written grievance decision was issued and there was no documentation that indicated a written response was provided to the resident. The document was signed by Administrator #1 who was the (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2e. Resident 85 was admitted to the facility on [DATE]. She was discharged to the community on 7/9/26. Resident #85's Minimum Data Set (MDS) dated [DATE] indicated she had moderate cognitive impairment. A grievance dated 6/18/26 filed by Resident #85's Responsible Party noted concerns related to Resident #85 not changed into nightclothes for bed, medications and assistance with meals. The form did not include the date the written grievance decision was issued and there was no documentation on the grievance form that a written response was issued to Resident #85 or her Responsible Party. The grievance form was signed by Administrator #2. A grievance dated 6/22/26 filed by Resident #85's responsible party stated there were concerns about Resident #85 being put to bed in the same clothes she had worn all day. The form did not include the date the written grievance decision was issued and there was no documentation on the grievance form that a written response was issued to Resident #85 or her responsible party. The grievance form was signed by Administrator #2. A telephone interview was conducted 7/17/26 at 9:30 AM with Resident #85's Responsible Party who stated she was not asked whether she wanted a written grievance summary and had not received a written grievance summary. She stated the Director of Nursing spoke with her about the grievances and stated the facility would ensure that Resident #85 changed her clothing prior to going to bed, answered her medication questions, and that Resident #85 received assistance with meals. The Responsible Party reported that Resident #85 was discharged shortly after the 6/22/26 grievance was filed (7/9/26). 2f. Resident #28 was admitted to the facility on [DATE]. A grievance dated 4/30/25 indicated concerns regarding a medication pass issue and a missed appointment. The form did not indicate who made the grievance, the employee receiving grievance, or the date the written grievance decision was issued. There was no documentation on the grievance form that written response was issued to Resident #28. The grievance was signed by Administrator #3. Resident #28's Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. An interview was conducted with Resident #28 who stated she had not been asked whether she wanted a written grievance summary and had not received a written grievance summary. Resident #28 stated she remembered filing the grievance but could not recall if anyone spoke with her about grievance resolution. She indicated the grievance was resolved. A phone interview was conducted with a former Administrator, Administrator #3, on 7/17/26 at 10:28 AM who stated he worked at the facility from March 2025 until July 2025. He reported he did not recall the circumstances of the grievance filed on behalf of Resident #28. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the current Social Worker, Social Worker #1, on 7/16/26 at 1:50 PM. Social Worker #1 stated he was responsible for logging the grievances in the grievance logbook and distributing the grievance to the department head responsible for grievance concerns. Social Worker #1 stated the person receiving the grievance was responsible for filling in the resident's name, date received, who the concern/grievance was made by, the name of the employee receiving concern/grievance, and the nature of the concern/grievance. Social Worker #1 stated the grievance was then given to him, he assigned the grievance to the department head, added the date the grievance was assigned to the form and logged the grievance in the grievance logbook. Social Worker #1 stated he then notified the Administrator that the grievance had been filed and logged. An interview was conducted with the previous Social Worker, Social Worker #2, on 7/20/26 at 9:21 AM. Social Worker #2 stated she had worked at the facility from January 2026 to March 2026. She reported that it was her responsibility to log the grievances in the grievance logbook when she received them. Social Worker #2 stated that once the grievance was assigned to the department head and distributed, it was the department head's responsibility to fill in the steps taken, findings, and actions taken/to be taken section of the grievance form. Social Worker #2 stated the department head would bring the grievance back to her once the issue had been addressed. Social Worker #2 stated she then took the grievance form to the Administrator for them the follow up on the concern/grievance resolution. An interview was conducted with Administrator #2 on 7/20/26 at 9:29 AM. Administrator #2 confirmed she was the grievance officer and responsible for overseeing the grievance process. Administrator #2 stated she was not fully aware that complainants and those filing a grievance on the residents' behalf must receive a written summary of the grievance findings. She confirmed that she had only given the written summary of grievance findings to the complainant if the person requested the documentation. She stated the grievance resolutions had been communicated through phone calls or in person conversations by the staff responsible for the grievance. Administrator #2 confirmed that all grievances had been resolved but no written documentation had been provided. An interview was conducted with the [NAME] President of Operations on 7/17/26 at 3:00 PM. The [NAME] President (VP) of Operations stated staff were expected to follow the facility's grievance policy ensuring the complainant was informed of the grievance summary and conclusion.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when Nurse Aide (NA) #1 placed linen on the floor. The deficient practice occurred for 1 of 3 staff observed for infection control practices. (Nurse Aide #1).The findings included: The facility's Infection Prevention and Control Program (IPCP) policy last updated 4/2023 indicated that the facility was responsible for establishing and maintaining an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections.The facility's Linen Handling Policy which is part of the Infection Prevention and Control Program (IPCP) policy read in part The risk of actual disease transmission from soiled linen with pathogenic microorganisms is insignificant if it is handled, transported, and laundered in a way that avoids transfer of microorganisms. Soiled linen should be bagged or placed in containers at the location where used. Wet and or soiled lines should be placed and transported in leak proof bags.During a continuous observation on 07/15/2026 at 9:34 AM, Nurse Aide (NA) #1 was observed to place the linen that consisted of sheets, a pillowcase, a shirt and a pair of pants on the floor prior to exiting a resident's room. NA#1 exited room [ROOM NUMBER] and proceeded up the hallway to retrieve a couple of trash can liners from a chair that was sitting outside of room [ROOM NUMBER] in the hallway. NA #1 returned to the resident's room and picked up the dirty laundry and placed it into the liner. NA #1 tied the liner, removed her gloves and performed hand hygiene before taking the liner to the soiled linen bin. During an interview with NA #1 on 07/15/2026 at 9:40 AM, she stated she had assisted the resident with changing his clothing and stripped his bed. NA #1 stated that she had placed the linen on the floor by the door because she did not have a clear trash can liner to place the linen in. NA #1 stated she had been trained to not put linen on the floor. NA #1 stated she was trying to get the soiled linen and dirty clothing out of the resident's room. An interview was conducted with the Director of Nursing on 7/17/26 at 2:48 PM. The DON stated it was her expectation that NA#1 follow the Infection Control Policies and Procedures. The DON verified that NA #1 had received the infection prevention education and that nursing staff receive the education during orientation, yearly, and as needed. The DON stated that NA #1 should not have placed the linen on the floor. An interview with the [NAME] President of Operations on 7/17/26 at 3:01 PM revealed he expected NA #1 would have not placed the linen on the floor.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to notify the resident and resident's representative (RR) in writing of the reason for the transfer/discharge to the hospital and send a copy of the notice to the Ombudsman. The facility also failed to notify the resident and/or Resident's Representative of the facility policy for bed hold for 4 of 7 residents reviewed for hospitalization (Resident #11, Resident #43, Resident #54, and Resident #55). The findings included:1. Resident #11 was admitted to the facility on [DATE].a. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 6/20/25 revealed Resident #11 was sent out to the hospital at 4:33 PM with elevated blood glucose and generalized weakness. The nursing progress note dated 6/22/25 revealed Resident #11 was readmitted to the facility at 5:45 PM in stable condition.The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #11's hospital transfer dated 6/20/25.b. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 6/26/25 revealed Resident #11 was sent out to the hospital at 6:55 PM with elevated blood glucose.The nursing progress note dated 7/1/25 revealed Resident #11 was readmitted to the facility at 2:26 PM in stable condition.The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #11's hospital transfer dated 6/26/25.c. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 8/25/25 revealed Resident #11 was sent out to the hospital at 12:35 AM with altered mental status and generalized weakness.The nursing progress note dated 8/27/25 revealed Resident #11 was readmitted to the facility at 3:22 PM in stable condition.The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #11's hospital transfer dated 8/25/25.d. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 12/22/25 revealed Resident #11 was sent out to the hospital at 12:31 PM for loss of consciousness and unresponsiveness.The nursing progress note dated 12/24/25 revealed Resident #11 was readmitted to the facility at 1:00 PM in stable condition.The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #11's hospital transfer dated 12/22/25.e. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 1/4/26 revealed Resident #11 was sent out to the hospital at 10:48 AM for decreased blood pressure and decreased oxygen saturation.The nursing progress note dated 1/7/26 revealed Resident #11 was readmitted to the facility at 5:25 PM in stable condition.The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #11's hospital transfer dated 1/7/26.f. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 2/5/26 revealed Resident #11 was sent out to the hospital at 2:26 PM for unresponsiveness.The nursing progress note dated 2/7/26 revealed Resident #11 was readmitted to the facility at 3:13 PM in stable condition. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Tower Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 Bond Street Raleigh, NC 27604	
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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #11's hospital transfer dated 2/5/26.g. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 2/18/26 revealed Resident #11 was sent out to the hospital at 1:22 PM for elevated blood glucose and lethargy.The nursing progress note dated 2/20/26 revealed Resident #11 was readmitted to the facility at 6:50 PM in stable condition. The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #11's hospital transfer dated 2/18/26.Multiple attempts to contact Resident #11's RR were unsuccessful.During an interview with the current Social Worker on 5/19/26 at 10:18 AM, he stated he had started working at the facility in March of 2026. The Social Worker stated he began sending out written notification of discharge/ transfer to hospital to the Resident Representative (RR) and Ombudsman when he began working in March. He further stated the bed hold policy was sent to the RR when residents were transferred to the hospital. The Social Worker stated he was unable to locate written discharge/ transfer to hospital notification and reported that information to his director. An interview was conducted with the [NAME] President of Operations on 7/16/2026 at 3:06 PM. The VP of Operations stated he had been made aware that the written notification of transfer/discharge to hospital to resident and resident representative, Ombudsman notification and bed hold policy notification had not been sent out by the previous social worker. The VP of Operations stated the Social Worker was responsible for these tasks and he was unable to locate any documentation from the previous Social Worker. The VP of Operations stated the previous Social Worker was responsible for the notices being cited.2. Resident #43 was admitted to the facility on [DATE].The nursing progress note dated 1/21/26 revealed Resident #43 was sent out to the hospital at 4:35 PM due to a change in mental status and elevated blood pressure. The nursing progress note dated 1/28/26 revealed Resident #11 was readmitted to the facility at 6:22 PM in stable condition. The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #43's hospital transfer dated 1/21/26.Attempts to contact Resident #43's RR were unsuccessful.During an interview with the current Social Worker on 5/19/26 at 10:18 AM, he stated he had started working at the facility in March of 2026. The Social Worker stated he began sending out written notification of discharge/ transfer to hospital to the Resident Representative (RR) and Ombudsman when he began working in March. He further stated the bed hold policy was sent to the RR when residents were transferred to the hospital. The Social Worker stated he was unable to locate written discharge/ transfer to hospital notification and reported that information to his director. An interview was conducted with the [NAME] President of Operations on 7/16/2026 at 3:06 PM. The VP of Operations stated he had been made aware that the written notification of transfer/discharge to hospital to resident and resident representative, Ombudsman notification and bed hold policy notification had not been sent out by the previous social worker. The VP of Operations stated the Social Worker was responsible for these tasks and he was unable to locate any documentation from the previous Social Worker. The VP of Operations stated the previous Social Worker was responsible for the notices being cited.3. Resident #54 was admitted to the facility on [DATE].The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 1/3/26 revealed Resident #54 was sent out to the hospital at 6:19 AM due to scrotal cellulitis that was warm and tender to touch with pain at rest.The nursing progress note dated 1/6/26 revealed Resident #54 was readmitted to the facility on (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Tower Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 Bond Street Raleigh, NC 27604	
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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	[DATE] at 6:43 PM in stable condition. The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #54's hospital transfer dated 1/3/26. During an interview with the current Social Worker on 5/19/26 at 10:18 AM, he stated he had started working at the facility in March of 2026. The Social Worker stated he began sending out written notification of discharge/ transfer to hospital to the Resident Representative (RR) and Ombudsman when he began working in March. He further stated the bed hold policy was sent to the RR when residents were transferred to the hospital. The Social Worker stated he was unable to locate written discharge/ transfer to hospital notification and reported that information to his director. An interview was conducted with the [NAME] President of Operations on 7/16/2026 at 3:06 PM. The VP of Operations stated he had been made aware that the written notification of transfer/discharge to hospital to resident and resident representative, Ombudsman notification and bed hold policy notification had not been sent out by the previous social worker. The VP of Operations stated the Social Worker was responsible for these tasks and he was unable to locate any documentation from the previous Social Worker. The VP of Operations stated the previous Social Worker was responsible for the notices being cited. 4. Resident #55 was admitted to the facility on [DATE]. a. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 5/14/25 revealed Resident #55 was sent out to the hospital for further evaluation. The nursing progress note dated 5/19/25 revealed Resident #55 was readmitted to the facility on [DATE] at 5:48 PM in stable condition. The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #55's hospital transfer dated 5/14/25. b. The Situation, Background, Assessment and Recommendation (SBAR) Summary for Provider dated 8/29/25 revealed Resident #55 was sent out to the hospital for further evaluation. The nursing progress note dated 9/1/25 revealed Resident #55 was readmitted to the facility on [DATE] at 6:43 PM in stable condition. The facility was unable to provide documentation of written notification of hospital transfer to the Resident Representative or the Ombudsman, and the facility was unable to provide documentation of notification of the bed hold policy for Resident #55's hospital transfer dated 8/29/25. Multiple attempts to contact Resident #55's RR by phone were unsuccessful. During an interview with the current Social Worker on 5/19/26 at 10:18 AM, he stated he had started working at the facility in March of 2026. The Social Worker stated he began sending out written notification of discharge/ transfer to hospital to the Resident Representative (RR) and Ombudsman when he began working in March. He further stated the bed hold policy was sent to the RR when residents were transferred to the hospital. The Social Worker stated he was unable to locate written discharge/ transfer to hospital notification and reported that information to his director. An interview was conducted with the [NAME] President of Operations on 7/16/2026 at 3:06 PM. The VP of Operations stated he had been made aware that the written notification of transfer/discharge to hospital to resident and resident representative, Ombudsman notification and bed hold policy notification had not been sent out by the previous social worker. The VP of Operations stated the Social Worker was responsible for these tasks and he was unable to locate any documentation from the previous Social Worker. The VP of Operations stated the previous Social Worker was responsible for the notices being cited. The facility submitted a plan of correction dated 3/9/26 that was not accepted due to not having the required components for the identified deficient practice. The missing components included identification of findings that led to the deficient practice, did not address all areas identified in the deficient practice, no identification of other residents having the potential to be affected by (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	deficient practice, no designee for providing education, no information regarding audits being reported to Quality Assurance and Performance Improvement Committee (QAPI), and no date of compliance.		