

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Sanford Health & Rehabilitation CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 Farrell Road Sanford, NC 27330	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to honor a resident's choice and provide showers as scheduled (Resident #86) for 1 of 3 residents reviewed for choices. The findings included: Resident #86 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, pain, osteoarthritis and muscle weakness. An admission Minimum Data Set assessment dated [DATE] indicated Resident #86 was cognitively intact and required maximum assistance from staff for bathing. A review of Resident #86's active care plan included a problem area that was initiated on 7/14/26 for requiring assistance from staff with Activity of Daily Living (ADL) care secondary to weakness and overall deconditioning. One of the interventions included assisting with ADLs. A review of the Nurse Aide (NA) Care Guide indicated Resident #86 was to receive a shower every Monday and Thursday on the 3:00 PM to 11:00 PM shift. A review of Resident #86's personal care flow records indicated she received one shower from 6/26/26 to 7/22/26. She received a shower on 7/9/26 on the 3:00 PM to 11:00 PM shift as scheduled. The nursing progress notes were reviewed from 6/26/26 to 7/22/26 and did not reveal any refusals of showers. An interview occurred with Resident #86 on 7/20/26 at 12:09 PM and stated that she had received one shower since her admission to the facility and would like them more regularly. She stated she was aware showers were provided twice a week, but she had only been offered a shower once by an NA that provided one for her. Resident #86 continued to say that she received a bed bath every morning before getting out of bed but would like to receive her showers as well. On 7/22/26 at 2:52 PM, an interview occurred with NA #5, who cared for Resident #86 during the 7:00 AM to 3:00 PM shift. She explained that Resident #86 was to receive her scheduled showers on the 3:00 PM to 11:00 PM shift on Monday and Thursdays. NA #5 stated that she provided Resident #86 with a bed bath in the morning and had not known Resident #86 to refuse a bed bath. An interview was completed with NA #3 on 7/22/26 at 3:21 PM. She had been assigned to Resident #86 on her scheduled shower days of 7/6/26, 7/13/26, 7/16/26 and 7/20/26 on the 3:00 PM to 11:00 PM shift. NA #3 was unable to state why she didn't provide Resident #86 with showers as scheduled. The Director of Nursing was interviewed on 7/23/26 at 1:17 PM and stated she expected all residents to receive showers as requested and scheduled. If a resident refused, the NA should alert the nurse so a progress note could be written, and an alternate means of a bath provided.		

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews with the Nurse Practitioner and staff, the facility failed to assess the use of an abdominal binder (a wide compression belt worn around the abdomen) as a restraint and failed to obtain Responsible Party (RP) written consent for the use of a restraint. This deficient practice affected 1 of 1 resident reviewed for restraints (Resident #12).The findings included:Resident #12 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder, and metabolic encephalopathy.A review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had severe cognitive impairment, no documented behavior, and he was dependent on staff for feeding. The assessment further revealed Resident #12 had no impairment of range of motion (ROM) of the upper extremities and did not have a feeding tube.A review of a nursing progress note dated 6/26/26 by Unit Manager #2 indicated Resident #12 was discharged to the hospital on 6/26/26.A review of the hospital Discharge summary dated [DATE] revealed that during the hospitalization Resident #12 had a Percutaneous Endoscopic Gastrostomy (PEG) tube (a medical device used for long-term nutritional support in patients who cannot safely swallow or consume adequate nutrition by mouth) placed in his abdomen on 7/2/26. Resident #12 was readmitted to the facility on [DATE]. There were no orders included in the hospital discharge summary for use of an abdominal binder.A nursing progress note dated 7/8/26 by Nurse #3 revealed Resident #12 readmitted to the facility from an acute care hospital. During Resident #12's assessment it was observed that he had a PEG tube present in the upper abdominal quadrant. The presence of an abdominal binder was not included in the progress note.During an interview with Nurse #3 on 7/22/26 at 12:58 PM she revealed she completed an admission assessment on Resident #12 when he returned from the hospital on 7/8/26 and the abdominal binder was in place over the PEG tube at that time. She stated the abdominal binder was used to help prevent Resident #12 from pulling out the PEG tube. Nurse #3 stated there was no physician order for the abdominal binder when Resident #12 returned from the hospital on 7/8/26 and she was not aware one was needed. She also stated that she had never observed Resident #12 pulling on the PEG tube or abdominal binder. Nurse #3 added that she was not aware the binder could be considered a restraint.A nursing progress note dated 7/9/26 at 11:29 AM indicated the Wound Nurse completed a skin check on Resident #12 following readmission. The Wound Nurse indicated there was a PEG tube in the upper abdomen with an abdominal binder present.During an interview with the Wound Nurse on 7/22/26 at 11:30 AM, he indicated Resident #12 returned to the facility from the hospital on 7/8/26. He stated the next morning on 7/9/26 he completed a skin check on Resident #12. The Wound Nurse stated that he observed the abdominal binder in place securing the PEG tube during his assessment. The Wound Nurse stated he had not observed Resident #12 pulling on the PEG tube or abdominal binder. The Wound Nurse added that he had never observed Resident #12 remove the binder and was unsure if he could.A nursing progress note dated 7/11/26 at 5:37 AM by Nurse #4 revealed that while making rounds she observed that Resident #12's feeding tube was out, while the abdominal binder remained in place. Resident #12 was sent to the hospital for replacement of the PEG tube on 7/11/26. Attempts to reach Nurse #4 during the survey were unsuccessful.A review of the hospital medical record dated 7/13/26 revealed that Resident #12's PEG tube was replaced on 7/13/26. The note further detailed the PEG tube had been replaced previously on 7/6/26 and 7/7/26. A review of the hospital Discharge summary dated [DATE] revealed that on 7/11/26, Resident #12 pulled out his PEG tube and was sent (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with the Nurse Practitioner, Medical Director and staff, the facility failed to have an adequate clinical indication for the use of antipsychotic medications (Residents #4 and #88). This was for 2 of 6 residents whose medications were reviewed. The findings included: 1. A review of Resident #4's medical record revealed a hospital Discharge summary dated [DATE] that included an order for Olanzapine (an antipsychotic medication) 2.5 milligrams (mg) take one tablet by mouth at bedtime. The hospital discharge summary included Resident #4 had a history of depression and anxiety and was to continue the antidepressant medication and Olanzapine. Resident #4 was admitted to the facility on [DATE] with diagnoses that included recent history of a stroke, major depressive disorder, anxiety disorder, and dementia without behavioral/psychotic/mood disturbances. A review of Resident #4's active physician orders included an order dated 6/10/26 for Olanzapine 2.5 mg one tablet by mouth daily at 8:00 PM for dementia without behavioral disturbance. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 had moderately impaired cognition and received an antipsychotic medication during the seven-day assessment period. A review of the June 2026 and July 2026 Medication Administration Records (MARs) indicated Resident #4 received Olanzapine at 8:00 PM, as ordered. Nurse Practitioner #1 was interviewed on 7/22/26 at 9:57 AM and reviewed Resident #4's active physician orders. She confirmed the diagnosis for Olanzapine use was dementia without behavioral disturbance and stated that it was not an appropriate clinical indication. She stated it was an oversight to not have changed the clinical indication to a more appropriate diagnosis. On 7/22/26 at 10:09 AM, an interview occurred with Nurse #1, who entered the Olanzapine medication order on 6/10/26. She explained that the dementia without behavioral disturbance was used based on the hospital discharge summary. Nurse #1 stated she was unaware that a diagnosis of dementia without behavioral disturbance was not an appropriate clinical indication for the use of Olanzapine. On 7/22/26 at 12:53 PM, an interview was conducted with Unit Manager #1 who had reviewed Resident #4's admission medications on 6/11/26 and obtained consent for psychotropic medication use from the Responsible Party (RP). Unit Manager #1 stated it was an oversight to not have identified the clinical indication for the use of Olanzapine as dementia without behavioral disturbance as inappropriate. Unit Manager #1 acknowledged she was aware dementia without behaviors was not an appropriate clinical indication for the use of an antipsychotic medication and should have reached (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	out to a provider for a more appropriate diagnosis. A phone interview was held with the Medical Director on 7/23/26 at 10:09 AM. She was able to review Resident #4's medical record and indicated when she was admitted to the facility on [DATE], the diagnosis of dementia without behavioral disturbance was chosen inadvertently. She stated she was aware that a diagnosis of dementia without behavioral disturbance was not an appropriate clinical indication for the use of Olanzapine and stated the order should have been clarified at the time of admission. An interview occurred with the Director of Nursing (DON) on 7/23/26 at 1:17 PM. She reviewed Resident #4's active physician orders and confirmed the diagnosis for Olanzapine use was dementia without behavioral disturbance, which was not an appropriate clinical indication. 2. Resident #88 was admitted to the facility on [DATE] with diagnoses that included dementia, unspecified severity, without behavioral disturbance, psychotic. A review of Resident #88's active physician orders included an order dated 06/25/26 for Invega (paliperidone) (an antipsychotic medication) 3mg (milligrams) ER (extended release) tablet once a day for dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Another order was dated 06/25/26 for quetiapine (an antipsychotic medication) 50 mg; once a day at 09:00 PM for dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #88's cognition was moderately impaired and received an antipsychotic medication during the seven-day assessment period. A review of the June 2026 and July 2026 Medication Administration Records (MARs) indicated Resident #88 received Invega and quetiapine as ordered. Nurse Practitioner #1 was interviewed on 7/22/26 at 9:43 AM and reviewed Resident #88's active physician orders. She confirmed the diagnosis for Invega, and quetiapine use was dementia without behavioral disturbance and stated that it was not an appropriate clinical indication. She stated it was an oversight not to have changed the clinical indication to a more appropriate diagnosis. An interview was conducted on 07/22/26 at 3:02 PM with Unit Manager #1. She stated the psychiatry provider entered Resident #88's antipsychotic medication orders dated 06/25/26 however she did recall reviewing the orders. Unit Manager #1 explained it was an oversight to not have identified the clinical indication for the use of Invega and quetiapine as dementia without behavioral disturbance as inappropriate. She could not recall if she reviewed the actual clinical indication for use in this situation. Unit Manager #1 acknowledged she was aware dementia without behaviors was not an appropriate clinical indication for the use of antipsychotic medication. A phone interview was held with the Medical Director on 7/23/26 at 10:17 AM. The Medical Director verified that the current diagnosis attached to Resident #88's antipsychotic medications (Invega and (continued on next page)		

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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** Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of weights (Residents #32 and #124) and skin treatments (Resident #5) for 3 of 26 residents reviewed for MDS accuracy. The findings included: 1. Resident#32 was admitted to the facility on [DATE]. A review of Resident #32's weight history from January 2026 to July 2026 included one weight of 218 pounds on 1/1/26. A review of Resident #32's nursing progress notes revealed she had refused monthly weights from February 2026 to July 2026. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 was cognitively intact and was coded with rejection of care one to three days during the seven-day look back period. Her weight was recorded as 218 pounds. On 7/23/26 at 12:38 PM, an interview was conducted with the MDS Nurse who stated the Registered Dietitian coded the nutritional section of the MDS assessment. She reviewed Resident #32's weight data and annual MDS assessment dated [DATE]. The MDS nurse confirmed the weight from 1/1/26 was used on the assessment in error. She further stated the section should have been marked with dashes since there was no weight within 30 days of 4/28/26 for Resident #32. The MDS Nurse acknowledged that Resident #32 refused weights from time to time. Attempts to contact the Registered Dietitian were unsuccessful during the survey. During an interview on 7/23/26 at 1:17 PM, the Director of Nursing indicated it was her expectation for the MDS to be coded correctly. 2. Resident #124 was admitted to the facility on [DATE] with diagnoses that included a stroke with dysphagia (difficulty swallowing), dementia, and adult failure to thrive. Resident #124's weight data revealed the following weights during the Minimum Data Set (MDS) assessment look back period of 11/13/25 to 12/12/25, which showed a weight loss of 5% in a month: 12/12/25 150.2 pounds (lbs.)11/13/25 158.3 lbs. (-8.1 lbs.) A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #124 had severely impaired cognition and required setup assistance for eating. Her weight was entered as 150 lbs. and was not marked for weight loss or weight gain in the past month. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #124's weight data revealed the following weights during the MDS assessment look back period of 9/12/25 to 3/16/26, which showed a weight loss of 25% in the past six months: 3/16/26 130 lbs. 3/10/26 131 lbs. 2/16/26 134 lbs. 1/19/26 137.5 lbs. 12/19/25 149 lbs. 11/19/25 152.3 lbs. 10/17/25 159.3 lbs. 9/17/25 174.3 lbs. 9/12/25 174 lbs. A quarterly MDS assessment dated [DATE] indicated Resident #124 had severely impaired cognition and required maximum assistance from staff for eating. Her weight was documented as 131 lbs. and weight gain was coded. An interview occurred with the MDS Nurse on 7/23/26 at 12:38 PM. She reviewed Resident #124's weight data and MDS assessments completed on 12/17/25 and 3/17/26. She explained that the Registered Dietitian coded the nutrition section of the MDS assessment and then she will review to ensure all areas were coded. After reviewing the weight data and MDS assessments, the MDS Nurse confirmed that both MDS assessments should have been coded with weight loss and stated it was an oversight. Attempts to contact the Registered Dietitian were unsuccessful during the survey. During an interview on 7/23/26 at 1:17 PM, the Director of Nursing indicated it was her expectation for the MDS assessments to be coded correctly. 3. Resident #5 was originally admitted to the facility on [DATE] with diagnosis that included diabetes mellitus, non-pressure chronic ulcer of lower leg, and peripheral vascular disease. Review of Resident #5's April 2026 physician orders included an order dated 04/17/26 to apply skin prep to left and right lateral lower legs daily. This order was discontinued on 06/05/26. A review of the May 2026 Medication Administration Records (MARs) indicated Resident #5 received the skin prep as ordered. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5's cognition was severely impaired. The area for skin conditions for Resident #5 was not coded for receiving ointments/medications. An interview was conducted on 07/23/26 at 12:37 PM with the MDS Nurse. The MDS Nurse verified the MDS annual assessment dated [DATE] was not coded for Resident #5 receiving ointments/medications under skin conditions. The MDS Nurse stated she was unsure if she was supposed to code the skin protectant in this area. She explained she did not look up the information in the Resident Assessment Instrument (RAI) manual for clarification. An interview was conducted on 07/23/26 at 12:42 PM with the Administrator. He indicated the MDS assessment should be accurately coded in all care areas.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with the Medical Director, Pharmacy Consultant and staff, the Pharmacy Consultant failed to identify and address the use of antipsychotic medications without an adequate clinical indication for 2 of 6 residents whose medications were reviewed (Residents #4 and #88). The findings included: 1. Resident #4 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety disorder, and dementia without behavioral, psychotic, or mood disturbances. A review of Resident #4's active physician orders included an order dated 6/10/26 for Olanzapine (an antipsychotic medication) 2.5 mg (milligram) one tablet by mouth daily at 8:00 PM for dementia without behavioral disturbance. The Pharmacy Consultant's admission medication review, completed on 6/12/26, did not address the clinical indication for the use of Olanzapine to the physician or Director of Nursing (DON). An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 had moderately impaired cognition and received an antipsychotic medication during the seven-day assessment period. A review of the June 2026 and July 2026 Medication Administration Record (MAR) indicated Resident #4 received the Olanzapine at 8:00 PM, as ordered by the physician. The Pharmacy Consultant was interviewed via telephone on 7/23/26 at 10:31 AM. He was able to review Resident #4's medical record and reviewed the admission medication review that was completed on 6/12/26. The Pharmacy Consultant acknowledged Olanzapine was ordered for Resident #4 and he did not request the physician to provide an appropriate clinical indication for the use of Olanzapine at bedtime. He was unable to comment as to why this was not addressed at the time of the admission medication review. A phone interview was held with the Medical Director on 7/23/26 at 10:17 AM and verified the diagnosis of dementia without behaviors attached to Resident #4's antipsychotic medication, Olanzapine, was not an appropriate clinical indication for its use. She indicated the Pharmacy Consultant should have made a recommendation to address the clinical indication. An interview occurred with the Director of Nursing (DON) on 7/23/26 at 1:17 PM and stated she expected the Pharmacy Consultant to address the inadequate clinical indication for the use of Olanzapine with either herself or the physician. 2. Resident #88 was admitted to the facility on [DATE] with diagnoses that included dementia (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Sanford Health & Rehabilitation CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 Farrell Road Sanford, NC 27330	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	without behavioral disturbance, restlessness and agitation. A review of Resident #88's physician orders from May 2026 through June 2026 included the following antipsychotic medication orders: -An order dated 5/14/26 for quetiapine (an antipsychotic medication) 25 milligram (mg) at bedtime for restlessness and agitation. This order was discontinued on 05/21/26. -An order dated 5/21/26 for quetiapine 25 mg twice a day for dementia without behavioral disturbance. This order was discontinued on 06/04/26. -An order dated 6/04/26 for quetiapine 50 mg twice a day for restlessness and agitation. This order was discontinued on 06/25/26. - An order dated 6/25/26 for quetiapine 50 mg once a day for dementia without behavioral disturbance. Review of the consultant pharmacist's Medication Regimen Reviews (MRR) dated 05/18/26 and 06/09/2026, indicated that a monthly medication review was completed but did not address the clinical indication for the use of quetiapine to the physician or Director of Nursing (DON). An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #88's cognition was moderately impaired and received an antipsychotic medication during the seven-day assessment period. Verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others occurred 4 to 6 days, but less than daily during the look back period. A phone interview was conducted on 07/23/26 at 9:20 AM with the facility Pharmacy Consultant. He stated he was aware of the guidelines for needing a supporting diagnosis for prescribed antipsychotics. The Pharmacy Consultant indicated it was an oversight that he did not address and alert the physician or the DON that Resident #88's order for quetiapine did not include an appropriate clinical indication for its use. He did not realize he did not have a supporting diagnosis for the antipsychotic medication. The Pharmacy Consultant verified the last review he completed for Resident #88 was on 06/09/26 and he had a planned visit for 07/27/26. A phone interview was held with the Medical Director on 7/23/26 at 10:17 AM. The Medical Director verified that the diagnosis attached to Resident #88's antipsychotic medication, quetiapine, was not an appropriate clinical indication for its use. She indicated the pharmacy consultant should have made a recommendation as well An interview occurred with the DON on 7/23/26 at 3:27 PM, who explained that a resident should not be on antipsychotic medication without a supporting diagnosis. She indicated the Pharmacy Consultant should review the medications on admission and monthly to ensure there were no irregularities or concerns with the medications.		