STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Hills	2101 Homestead Hills Drive Winston-Salem, NC 27103

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff, Nurse Practitioner (NP), Pharmacist, and Medical Director interviews, the facility failed to have effective systems in place to prevent a significant medication error. Resident #4 was severely cognitively impaired and had a diagnosis of sinus bradycardia (slow heart rate). On 3/11/2026 the Medication Aide (MA) administered morning medications to Resident #4 which included extended-release propranolol (a betablocker used to treat hypertension which slows the heart rate, reduces the force of heart contractions, and lowers blood pressure), quetiapine (antipsychotic medication that can cause sudden drops in blood pressure) and donepezil. Donepezil can slow the heart rate and affect the sinoatrial (SA) node and atrioventricular (AV) nodes, potentially leading to bradycardia or heart block which is a disruption in the electrical signals that regulate heartbeat. (The SA node set the heart's rate and rhythm, and the AV node regulates the timing of ventricular contractions). The Medication Aide returned to the medication cart and prepared Resident #47's medications and proceeded to administer these to Resident #4. The medications included metoprolol succinate extended release (a betablocker used to treat hypertension that slows the heart rate and lowers blood pressure), tamsulosin (an alpha-blocker used to treat symptoms of enlarged prostate which can cause low blood pressure), and amlodipine (a calcium channel blocker used to treat hypertension and chest pain that lowers blood pressure by causing blood vessels to relax and widen throughout the body), and donepezil. Approximately 30 minutes later the Medication Aide realized he had administered medications prescribed for Resident #47 to Resident #4 and reported this to the nurse immediately. Resident #4 was assessed by the nurse and NP, was lethargic, and his heart rate was in the 40's range and dropped into the high 30's with a blood pressure (BP) reading of 90/60. (The normal range for heart rate is 60 to 100 beats per minute (bpm)). Emergency Medical Services (EMS) was contacted and transported Resident #4 to the hospital for evaluation and treatment. The physician documented the principal problem was severe symptomatic bradycardia and hypotension (low blood pressure) secondary to an unintentional medication overdose with betablockers and amlodipine. The resident received epinephrine drip (a continuous intravenous infusion used to support blood pressure, heart function and bronchodilation in critical situations) and atropine (anticholinergic medication used to treat bradycardia) for his low heart rate. Blood pressures improved and his heart rate was in the mid 40's. The plan was to continue the epinephrine drip and transfer the resident to the Critical Care Unit (CCU) for monitoring. Initial management included epinephrine infusion and atropine with limited response which suggested a high degree heart block (a high-degree heart block is a serious form of AV block where the electrical signals from the atria to the ventricles are significantly impaired). Resident #4's hospital electrocardiogram (ECG) results (An ECG checks the heartbeat and electrical signals in the heart and can help diagnose heart attacks and irregular heartbeats, called arrhythmias) showed progression from sinus bradycardia with a second-degree AV block (second-degree heart block, also known as second-degree AV block, is characterized by the intermittent failure of atrial impulses to conduct to the ventricles) to a complete heart block (complete heart block is a serious condition where electrical signals from the atria fail to reach the ventricles, often requiring urgent medical intervention). On 3/13/26 Resident #4 was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Hills	2101 Homestead Hills Drive Winston-Salem, NC 27103

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	implanted with dual-chamber pacemaker (A dual chamber pacemaker regulates both the atrium and ventricle to maintain synchronized heartbeats and optimize cardiac efficiency). The resident's clinical status improved, and he was discharged back to the facility on 3/16/26. Resident #4 had a serious adverse outcome as a result of the medication error. The deficient practice occurred for 1 of 5 residents reviewed for significant medication errors (Resident #4).Finding included:Resident #4 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, Type II diabetes mellitus (DM), depression, hypertension, sinus bradycardia (2/28/25), and psychotic disorder with hallucinations due to known physiological condition. On 01/28/2026, Resident #4 was transitioned to Hospice services. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was severely cognitively impaired, independent with eating and required maximum assistance for activities of daily living (ADL) and used a wheelchair for mobility. Resident #4 had functional limitation of range of motion on both sides of his upper extremities and one side of his lower extremities.A review of Resident #4's active physician orders for the month of March 2026 revealed the following medication orders:Quetiapine (Seroquel) 25mg (milligrams), give one tablet orally every 12 hours for Alzheimer's disease.Donepezil (Aricept)10 mg once daily at 8:00 AM for Alzheimer's disease.Metformin ER (extended release) 500mg, give once daily at 8:00 AM for DM.Propranolol ER 60mg, give once daily at 8:00 AM for hypertension.Citalopram 10 mg, give 0.5 (one-half tablet) 5mg once daily at 8:00 AM for depressive disorder.Review of Resident #4's Medication Administration Record (MAR) for March revealed on 3/11/26 Resident #4's morning medications were documented as administered at 8:27 AM by Medication Aide #1.Resident #47 was admitted to the facility on [DATE].A review of Resident #47's active physician orders for the month of March 2026 included the following medication orders: Donepezil 5 mg, give one orally one time a day at 8:00 AM related to Alzheimer's disease.Metoprolol Succinate ER 25mg, give one tablet orally one time a day for atrial fibrillation.Amlodipine 5mg daily for essential hypertension.Tamsulosin 0.4 mg for benign prostatic hyperplasia.MA #1 was interviewed on 06/25/2026 at 7:54 AM and revealed he recalled working with Resident #4 on 03/11/2026 and giving Resident #4 his scheduled morning medications on 03/11/2026 at approximately 8:30 AM in the common area. MA #1 indicated he returned to the medication cart and prepared Resident #47's medication and returned to the common area and without realizing it, administered Resident #47's medications to Resident #4. Approximately 30 minutes later, MA #1 stated he realized he had given Resident #4 medications that should have been administered to Resident #47. He stated he immediately informed Nurse #1 about the medication error. MA #1 stated Resident #4 appeared to be sleepy prior to EMS arrival.Review of nurse progress note dated 03/11/2026 at 2:26 PM written by Nurse #1 revealed Resident #4 received his scheduled medications on the morning of 03/11/2026 and his roommate's (Resident #47) scheduled medications. Resident #4 received metoprolol 25mg ER, tamsulosin 0.4mg, norvasc (amlodipine) 5mg, and aricept (donezepil) 5mg. Review of vital signs documented by the facility on 3/11/2026 at 10:32 AM revealed heartrate of 36 and BP of 90/60.An interview was conducted with Nurse #1 on 06/25/2026 at 8:39 AM and revealed the MA on duty (MA #1) came to her on 3/11/26 between 8:30 AM and 9:00 AM and reported he had accidentally given Resident #4 Resident #47's medication in error. Nurse #1 indicated when she first assessed Resident #4, she recalled obtaining and writing down his vital signs and remembered Resident #4's heartrate was in the 60's and his blood pressure (BP) was within normal limits. Nurse #1 could not recall Resident #4's blood pressure. Nurse #1 stated she knew the NP was in the facility and went to get her. Nurse #1 recalled when she and the NP arrived to assess Resident #4 his heartrate had begun dropping into the 40's bpm. The NP gave orders to send Resident #4 out to be evaluated at the hospital and EMS was called and arrived on-site 5 to 10 minutes later.Review of Resident 4's NP provider's note dated 03/11/2026 revealed Resident #4 was being seen per nursing request. The NP progress note revealed Resident #4 was given his medication, and in addition, Resident #47's medication on the morning of 03/11/2026. The provider's note also indicated upon assessment, Resident #4's heart rate was in the 40's range and dropped into the high 30's. Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Hills	2101 Homestead Hills Drive Winston-Salem, NC 27103

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#4 was hypotensive with a blood pressure reading of 90/60. The decision was made to call 911 and Resident #4 was sent to the hospital for further management. NP interview 06/25/2026 at 10:28 AM revealed Resident #4 had a medication error on 03/11/2026. The NP indicated on 03/11/2026 Nurse #1 notified her of a medication error occurred when Resident #4 received all his scheduled morning medications and Resident #47's scheduled morning medications. Upon assessing Resident #4 at approximately 10:00 AM, he was symptomatic to include his heartrate being 30 to 40 bpm and he was lethargic but arousable. NP stated Resident #4 could have experienced a drop in heart rate because of the betablockers he was prescribed. When the NP was asked, were his symptoms of his heart rate dropping into the 30 to 40 bpm range a direct result of receiving another resident's medications (Resident #47) that were not prescribed to him, her answer was, Most likely, yes.Review of the EMS records dated 03/11/2026 indicated EMS was contacted at 10:34 AM regarding a possible medication error. The EMS record indicated they arrived at the facility at 10:52 AM and were at the bedside at 10:54 AM. Resident #4's vital signs were taken and revealed a heartrate of 43 bpm and blood pressure of 144/69. Per EMS report nursing staff (not named) stated Resident #4 had received an extra blood pressure pill but wasn't sure which one. A second staff member (not named) arrived and stated Resident #4 had received all his morning medications and another resident's morning medications which included propranolol 60mg and metoprolol succinate ER 25mg. Resident #4 was alert and transported via EMS and arrived at the hospital at 11:06 AM. An attempt to start an IV was unsuccessful due to Resident #4's movement.Review of the hospital emergency department (ED) provider note and History and Physical (H&P) dated 03/11/2026 noted Resident #4 was hypotensive and severely bradycardic with pulse rate in the 20's. The physician documented the principal problem was severe symptomatic bradycardia and hypotension secondary to an unintentional medication overdose with betablockers and amlodipine. ED triage vital signs included BP 123/68 and pulse 40 bpm. The resident received epinephrine drip and atropine for his low heart rate. Blood pressures improved and his heart rate was in the mid 40's. The plan was to continue the epinephrine drip and transfer the resident to the Critical Care Unit (CCU) for monitoring. The physician noted they would hold Resident #4's donepezil, propranolol and quetiapine given concerns for bradycardia and would monitor with telemetry. Donepezil, propranolol and quetiapine are all AV [NAME] blockers which slow electrical conduction through the atrioventricular (AV) node of the heart. The hospital Discharge summary dated [DATE] indicated Resident #4 was admitted to the hospital on [DATE]. The physician noted Resident #4 was a [AGE] year-old male with a history of sinus bradycardia, hypertension associated with type II DM, noninsulin-dependent DM, moderate Alzheimer's dementia, and failure to thrive who was admitted for symptomatic sinus bradycardia. He was admitted after he received his prescribed propranolol and metoprolol, amlodipine and tamsulosin resulting in severe bradycardia and hypotension. Active hospital problems included symptomatic bradycardia, complete heart block and sinus bradycardia (first noted 2/28/25). Initial management included epinephrine infusion and atropine with limited response which suggested a high degree heart block. Resident #4's hospital electrocardiogram ECG results showed progression from sinus bradycardia with a second-degree AV block to a complete heart block. On 3/13/26 Resident #4 was implanted with dual-chamber pacemaker. The resident's clinical status improved, and he was discharged back to the facility on 3/16/26.Pharmacist interview on 06/25/2026 at 4:46 PM revealed metoprolol 25mg ER would release slower throughout the day, but due to Resident#4 receiving his scheduled betablockers, and then getting his roommates (Resident #47) betablocker and alpha betablocker, this would be the cause of Resident #4's drop in heartrate and BP. She further stated the combination including other medications which can lower BP, including tamsulosin, would have been the cause of Resident #4's change in condition.Interview with the Medical Director 06/25/2026 at 11:35 AM revealed she recalled being informed by the NP about Resident #4 receiving another resident's medications in addition to his scheduled medications. The Medical Director indicated metoprolol succinate 25mg was an extended-release meaning and it entered the resident's body system slowly and not acutely (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Hills	2101 Homestead Hills Drive Winston-Salem, NC 27103

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(immediate releasing). The Medical Director indicated the medication error could have caused Resident #4's heartrate to decrease into the 30's to 40's and stated any blood pressure pill can cause a decreased heart rate and BP. She stated due to Resident #4's age and comorbidities, his symptoms of low BP and low heartrate could have happened at any time and did not feel this medication error contributed to Resident #4's symptoms of low blood pressure and low heartrate. Interview with the Administrator on 6/25/2026 at 4:30 PM, revealed she became aware of the medication error involving Resident #4 after the Medication Aide #1 informed Nurse #1. The root cause of this incident was a medication administration error related to Medication Aide #1's failure to properly verify Resident #4 identity according to established protocols. The Administrator was notified of the Immediate Jeopardy (IJ) on 06/25/2026 at 5:45pm. The facility completed a Plan of Correction (POC) to include reeducation of medication administration, identifying the correct resident, facility medication policies, observation individual med pass of all staff who pass medications to ensure proper protocol was followed when identifying a resident. The Administrator provided the following corrective action plan with a compliance date of 3/19/2026. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On March 11, 2026, at approximately 8:20 AM, during a routine medication pass, Medication Aide #1 administered Resident #4 his prescribed medications which included Quetiapine 25 mg, Donepezil 10 mg, Metformin ER 500 mg, Propranolol ER 60 mg, Citalopram 10 mg. Medication Aide #1 returned to the medication cart and prepared Resident #47's medications which included Donepezil 5 mg, Tamsulosin 0.4 mg, Eliquis 5 mg, Memantine HCL 5 mg, Metoprolol Succinate ER 25 mg, and Amlodipine 5 mg and administered them to Resident #4 in error. Medication Aide #1 realized the error and reported this to the nurse approximately 15 to 30 minutes upon discovery of the error and the Director of Nursing (DON) and the Nurse Practitioner were notified. Resident #4 was promptly assessed by the DON and a nurse, which included vital signs revealing Resident #4's pulse to be 36 (bradycardic) and O2 saturation 94%. Resident #4 was found to be lethargic and in no acute distress, sitting up in his wheelchair. Which prompted floor staff to notify the Nurse Practitioner to provide a more comprehensive assessment immediately. The Nurse Practitioner (NP) assessed the resident and found him to be bradycardic and hypotensive. The NP determined the resident needed to be sent to the hospital ED for an evaluation. Resident #4 was transported to the hospital at 10:00 AM on March 11, 2026. Hospital diagnoses included severe bradycardia, sinus bradycardia, and hypotension. Hospital ECGs demonstrated progression from sinus bradycardia with second-degree AV (Mobitz 1) block to marked sinus with first-degree AV block, and ultimately to complete heart block. Review of the hospital records indicated Resident #4 had a pacemaker placed during the hospitalization on March 13, 2026, and did not receive any new medication orders. Resident #4 returned to facility on March 16, 2026, where he resumed and continued hospice services at prior baseline. The root cause of this incident was a medication administration error related to failure to properly verify resident identity according to established protocols. On March 11th, 2026 immediately after identifying medication error occurred Medication Aide #1 was removed from medication administration duties pending investigation and retraining. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practices. There were no medication discrepancies identified for trend review, and no medication errors had been noted within the last six months. Because a medication administration error has the potential to affect all residents, the facility conducted a review focused on the performance of the nursing staff and Medication Aide through medication pass evaluations where staff demonstrate the 7 rights of medication administration. Between March 13, 2026 and March 18, 2026 the Assistant Director of Nursing and designee completed medication administration evaluations on all licensed nurses and medication aides ensuring that all licensed nurses and medication aides demonstrated competency in applying the 7 Rights during medication administration. All Licensed Nurses and Medication Aides who were responsible for medication administration including Medication Aide #1 were evaluated by using the facility's Medication Pass Evaluation Form, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Hills	2101 Homestead Hills Drive Winston-Salem, NC 27103

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	which includes four required areas of competency. The four competency areas included: (1) proper medication preparation and resident identification according to the Rights of Medication Administration prior to medication administration; (2) adherence to the Rights of Medication Administration, including the right resident, medication, dose, route, and time; (3) compliance with medication-specific instructions and documentation requirements, including medication parameters, administration instructions, medication crushing procedures when applicable, documentation immediately following medication administration, and controlled substance documentation; and (4) appropriate communication and timely reporting of any medication errors or concerns to the supervisor were included in medication pass evaluation observation competency to ensure medication errors were recognized and reported timely. These competencies of resources listed above are available in the agency education binder which is required to review before any worked shifts. The medication pass evaluations included direct observation of an actual medication pass to ensure medications were administered safely and in accordance with physician orders and facility policy. During this evaluation process, no concerns were identified with staff adherence to resident identification procedures, medicationˆspecific parameters, or crushing requirements. Staff demonstrated appropriate knowledge of reporting expectations. All licensed nurses and medication aides hired after March 18, 2026 received this same education and competency evaluation during orientation, provided by the Director of Nursing or designee, to ensure consistent understanding of medication administration expectations from the beginning of employment and ongoing compliance. Overall responsibility for ensuring completion of education, competency validation, and ongoing compliance remains with the Director of Nursing and the Assistant Director of Nursing. On March 11, 2026 and March 12, 2026 the Director of Nursing (DON) completed Medication Administration Record (MAR) audits for all current residents to ensure all resident admission, discharges, and medication order changes via provider orders were accurate. The MAR audits included review of the census sheet for March 11, 2026 and March 12, 2026, verification of any missed medications or medications not administered, and a full audit comparing all medications on the MAR to the physician order summary to ensure accuracy and consistency of orders and documentation. The DON determined there were no medication administration issues identified. On March 11, 2026, after the facility became aware of the incident all current residents were placed under observation for any changes in health status by Director of Nursing or Designee, to identify any deviations from baseline condition including neurologically via resident interviews or if any unintended harm was done from an adverse event relating to a medication error. Residents were observed for any adverse signs or symptoms related to medication administration, and no concerns were identified. No residents required further medical intervention as a result of these observations. 3. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur. To ensure that this deficient practice does not recur, the facility has implemented several systemic changes focused on strengthening staff competency, reinforcing adherence to the 7 Rights of Medication Administration, and establishing ongoing quality monitoring audits. By March 18, 2026, all licensed nurses and medication aides were educated by the DON in person and via the phone on resident rights related to medication administration, with specific emphasis on the 7 Rights of Medication Administration, including the right resident, right medication, right dose, right route, right time, and right documentation. The staff members educated via phone were reeducated in person by the Assistant DON during the medication pass evaluation observation. This education reinforced the importance of accurate resident identification prior to medication administration. Staff were educated to utilize the resident photograph displayed in the electronic Medication Administration Record (eMAR) to properly identify the correct resident before administering medications. Education also reinforced that resident identification must be verified prior to each medication administration and that staff were expected to follow facility policy regarding resident identification at all times. Education was provided in person to all licensed nurses and medication aides by the Director of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Hills	2101 Homestead Hills Drive Winston-Salem, NC 27103

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing starting on March 11, 2026 and concluding on March 18th, 2026. The 7 rights of medication administration were added to the new hire orientation training via in person education and demonstrated during medication pass evaluation observation. Since the incident, the facility has had one new hire, who received the required education during orientation and was observed completing medication administration competency prior to working independently on the floor. The 7 rights of medication administration was added to the agency staff onboarding binder. Agency nurses are required to review the onboarding binder upon entering the facility for each shift, which includes facility policies and procedures, prior to providing resident care. 4. How will the facility monitor its corrective action to ensure the deficient practice will not recur? A Quality Monitoring Audit was initiated on March 11, 2026 to evaluate compliance with the facility's medication administration policy, including adherence to the 7 rights and resident identification procedure by Director of Nursing and/or designee. The Director of Nursing or Assistant Director of Nursing conducted random audits of medication administration passes with 2 Licensed Nurses or Medication Aides weekly for 12 weeks, to ensure adherence of the 7 rights of medication administration, which included right medication, right resident, right dose, right time, right route, right reason, and right documentation. Quality Monitoring Auditing was conducted on both 1st shift (7:00 a.m. to 7:00 p.m.) and 2nd shift (7:00 p.m. to 7:00 a.m.) to ensure ongoing compliance with medication administration practices and identified concerns were addressed through immediate feedback and reeducation as indicated. The results of the quality monitoring were reported by the Director of Nursing or Designee to the Quality Assurance Performance Improvement Committee meeting for 3 months, no negative findings noted. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Care Service Administrator, Director of Nursing, Assistance Director of Nursing, Social Worker, Activities Director, Health Care Liaison, Medical Director, Maintenance Director, Minimum Data Assessments Nurse, and at least one direct care staff member. Alleged date of immediate jeopardy removal and compliance date: 3/19/26.The validation of the corrective action plan was completed on 07/01/2026.The facility completed a sixˆmonth review of medication records to identify any trends or patterns; no discrepancies, trends, or patterns were identified. Between March 13-16, 2026, the Assistant Director of Nursing conducted comprehensive medication pass evaluations on all staff nurses and Medication Aides. Agency staff received Medication Administration education before each shift and signed verification of training completion. This was confirmed by a review of in-service sign in sheets. Staff interviews further confirmed that nurses, medication aides, and agency staff had completed the required education and were able to verbalize the 7 rights of medication administration, utilizing the resident photograph displayed in the electronic Medication Administration Record (eMAR) to properly identify the correct resident, and the importance of reporting any medication error. This was further confirmed by a review of in-service sign in sheets. The facility also provided documentation demonstrating that newly hired staff and agency personnel assigned to Medication Administration duties had received current training.A Medication Administration Observation was completed during the validation with no medication errors noted.The facility submitted documentation confirming completion of weekly directˆobservation medication pass audits for two staff members per week over a 12ˆweek period, in accordance with corrective action plan. The facility also provided documentation and interviews related to the Quality Assurance and Performance Improvement (QAPI) Committee meetings.The immediate jeopardy removal and compliance date of 3/19/26 was validated.