STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Fuquay-Varina	410 S Judd Parkway SE Fuquay Varina, NC 27526

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure a resident was treated respectfully when a Nurse Aide was using her personal cell phone rather than responding to a resident's verbal yell for help and the activation of his call bell. This was for 1 of 15 sampled residents (Resident # 15).The findings included:Resident # 15 resided at the facility from 11/13/25 to 11/20/25. The resident was [AGE] years of age. Review of Resident # 15's 11/13/25 hospital discharge summary revealed the following information. Resident # 15 had undergone left hip surgery in February 2025 for a broken hip. He was admitted to the hospital again on 11/10/25 where he was identified to have a left acetabular fracture (a fracture in the socket in the left pelvis that forms the hip joint with the femur (leg bone) and also a sacral ala fracture (a fracture in the portion of the sacrum at the base of the spine and which can cause buttock and low back pain). Resident # 15 underwent conservative treatment and no surgery. Review of Resident # 15's 11/16/25 admission Minimum Data Set Assessment, dated 11/16/25, revealed the resident was moderately cognitively impaired. He required substantial to maximum assistance to turn in bed. He received pain medication. Review of Resident # 15's November 2025 Medication Administration record revealed Resident # 15 received a prescribed dose of Oxycodone on 11/16/26 at 9:30 AM by Medication Aide # 2 for a reported pain level of 6 on a pain scale of 1 to 10. Resident # 15's family member was interviewed on 12/4/25 at 10:05 AM and reported the following information. He had arrived on 11/16/25 and could hear Resident # 13 yelling for help 200 to 300 feet before he reached the room. He could hear Resident # 13 yelling before he even passed the nursing desk. When he passed the nursing desk there was a staff member sitting at the desk who was in some other world. She had her head down and was looking at her phone and ignoring Resident # 15's yelling. The staff member was so engrossed in her phone that she did not even see him (the family member) pass by. After arriving to Resident # 15's room, he (the family member) found that the resident needed to be made comfortable and use the bathroom. He thought if the staff member ignored the verbal yelling, then the staff member would respond to the call light. He (the family member) turned on the call light. The call light stayed on for about 13 to 14 minutes. He tried to calm Resident # 15 down. No one came to assist Resident # 15. He approached the nursing desk and the same staff member, who he had passed at the nursing desk, was still seated at the nursing desk on her personal phone. He called her out for not doing her job. Two other staff members arrived and one of them went to take care of Resident # 15's needs. One of the staff members whispered to him that, She does this all the time referring to the staff member who had been on her phone while Resident # 15 needed help. Nurse Aide # 2 (NA # 2) was interviewed on 12/4/25 at 9:05 AM and reported the following information. She had been working on another unit on 11/16/25 but she was passing by Resident # 15's Nursing Station when she saw the call light was on in Resident # 15's room. The resident was yelling, help me, help me, get me up. She saw a family member come out of the room and approach the nursing desk. At the time that the call light was on and Resident # 15 was yelling for help, NA # 4 had been at the nursing desk and using her personal phone. She had not attempted to go check on the resident. The family member started talking to NA # 4 and NA # 4 still did not go check on the resident. Instead NA # 4 cursed at the family member. Therefore, she (NA # 2) went to check on Resident # 15. She knew he had a fracture and seemed to be in pain and uncomfortable in the bed. She helped reposition him and meet his needs and then the resident stopped yelling. He was okay after care was rendered. Medication Aide # 2 was interviewed on 12/4/25 at 9:30 AM and reported the following information. She did not care for Resident # 15 a lot but she knew the resident would yell. She thought this was because of pain. On 11/15/25 she heard loud voices and was on the adjacent hall from Resident # 15's hall. She went to the desk and saw that Resident # 15's light was on. NA # 4 was at the desk and on her phone. The phone was a personal device and NA # 4 was not charting. Resident # 15's family member was there and reported that the call light had been on for awhile. Nurse Aide # (NA) # 4 was interviewed on 12/5/25 at 11:19 AM and reported the following information. Resident # 15 was experiencing pain on 11/16/25 before she got him dressed. She had told the Medication Aide. She did not recall the specific Medication Aide. She assisted Resident # 15 up to the chair that morning and he yelled his butt was hurting. She therefore put him back in bed. She went to lunch. She came back from lunch and was entering the nursing station when Resident # 15's family arrived at the nursing desk and wanted to know who she was and to which hall she was assigned. She was putting her personal phone down when she came into the nursing station. Resident # 15's family member reported

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and staff interviews, the facility failed to protect a resident's right to be free from misappropriation. This was for 1 of 1 sampled resident who was reported to have possible diversion of her pain medication (Resident #2). The findings included:Record review revealed Resident # 2 resided at the facility from 9/11/25 until 9/23/25. According to Resident # 2's hospital discharge summary Resident # 2 had undergone surgical repair of a fractured femur on 9/4/25 and was transferred to the facility for rehabilitation. The resident also had a diagnosis of dementia according to the discharge summary.Facility admission orders included Oxycodone 5 mg (milligrams) every six hours as needed for pain. Additionally, Resident # 2 was ordered to receive Acetaminophen 500 mg (milligrams) on a scheduled basis every eight hours for 10 days. Review of pharmacy delivery records revealed on 9/12/25 at 4:20 AM 28 tablets of Oxycodone 5 mg were delivered and received by the facility.Review of Resident # 2's September 2025 MAR (Medication Administration Record) revealed Nurse # 13 signed she administered Oxycodone 5 mg to Resident # 2 on 9/11/25 at 9:44 PM and again on 9/12/25 at 3:46 AM.Resident # 2's controlled drug receipt record was reviewed. (A controlled drug receipt record contains documentation of all controlled medication pills that are removed from storage. Nurses are required to sign the date and time when controlled medications are removed from storage, the amount of controlled pills removed, and sign their name on the controlled drug receipt sheet. The number of pills on the drug receipt record is then reconciled at the end of each shift when another nurse becomes accountable for the controlled medications by counting and reviewing the sheets with the actual number of pills in locked storage). A review of Resident # 2's Oxycodone controlled drug receipt record revealed the number of tablets that were labeled by the pharmacy had been marked through. Nurse # 13 had signed at the top of the controlled drug receipt record that the initial count of pills was 26 rather than the 28 that had been delivered from the pharmacy. On 9/11/25 Nurse # 13 signed that she removed 2 tablets at 9:30 PM from Resident # 2's Oxycodone supply which then left 24 tablets. On 9/12/25 at 3:50 AM, Nurse # 13 signed that she removed two tablets from Resident # 2's supply which then left 22 tablets. Therefore, the accounting sheet showed that during Nurse # 13's shift six tablets from Resident # 2's 28 dose supply had been removed while Nurse # 13 worked with Resident # 2 and four of these tablets which were removed were at a documented time on the accounting sheet prior to the Oxycodone being delivered to the facility (which was at 4:20 AM).Nurse # 10 was interviewed on 12/4/25 at 9:50 AM and reported the following information. She had relieved Nurse # 13 on 9/12/25 at 7:00 AM. Nurse # 13 was counting fast as they reconciled controlled medications. The count was correct. (The number of pills on the controlled drug receipt record matched the number in the resident's supply.) Resident # 2's Oxycodone was in a bubble pack card, and each dose was individually in its own bubble storage. Later in the day she noticed that the punches on the card seemed odd and that Nurse # 13 had signed out for two each time when the order was for only one. The resident also tended to ask for only acetaminophen. She also noticed that the number of pills which the pharmacy had put on a label when they filled the medication had been crossed out. Therefore, she reported the issue to the supervisor.The MDS (Minimum Data Set) assessment Nurse was interviewed on 12/4/25 at 5:00 PM and reported the following. She was acting DON (Director of Nursing) on 9/12/25 when Nurse # 10 reported a problem with the accounting of Resident # 2's Oxycodone. She had taken a picture of the card. The number of tablets that Nurse # 13 noted at the top of the drug receipt record by her signature was 26. The number on the label was marked through. She verified with the pharmacy that they had sent 28. The MDS Nurse also saw there had been four doses documented as removed from the supply at a time when the Oxycodone had not even been delivered to the facility. She also saw on the times that the medication was removed that Nurse # 13 had removed two tablets rather than one as ordered. She talked to Nurse # 13 and Nurse # 13 reported she had gotten the Oxycodone tablets from the facility's back up medication supply. There was no record of any Oxycodone being removed from the back up supply for Resident # 2. Nurse # 13 was questioned why she would have documented the removal of the Oxycodone in an amount more than prescribed and documented a time on the removal when the Oxycodone had not been available to administer. According to the MDS Nurse, Nurse # 13 did not have an explanation which would reconcile and account for the missing Oxycodone. She was suspended and then terminated and the Department of Drug Enforcement, North Carolina Division of Health and Human Services, and the North Carolina Board of Nursing (NCBON) were notified.At attempt was made to Interview Nurse # 13 on 12/5/25 at 10:45 AM and Nurse # 13 could not be reached for interview.Interview with the facility's Pharmacy Director

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews with staff and staff members at the North Carolina Board of Nursing, the facility failed to ensure it did not employ a nurse who currently had disciplinary action in effect against her professional license secondary to a history of drug diversion. This was for 1 of 2 staff members whose personnel information was reviewed (Nurse # 13). The findings included:Record review revealed Resident # 2 resided at the facility from 9/11/25 until 9/23/25. On 9/12/25 the facility reported an incident of suspected controlled pain medication diversion by Nurse # 13 to the state agency when multiple Oxycodone tablets could not be accounted for while Resident # 2 was under the care of Nurse # 13.The facility's MDS (Minimum Data Set) assessment Nurse was interviewed on 12/4/25 at 5:00 PM and reported the following. She was acting DON (Director of Nursing) on 9/12/25 and had completed the investigation while the Administrator was on a leave of absence. There had been problems with the following: 1) the number of tablets, which were filled and delivered by the pharmacy, was marked through on a pharmacy label located on the Oxycodone drug receipt record 2) Nurse # 13 had signed on the drug receipt record she had received 26 tablets which was less than the 28 tablets the pharmacy had records of sending 3) Nurse # 13 could not account for the extra tablets the pharmacy showed as sending 4) Nurse # 13 signed out more tablets at a time than Resident # 2 was ordered to receive 5) Nurse # 13 had no explanation which could reconcile the issues that had been found.Interview with the facility's Human Resources Director on 12/5/25 at 4:00 PM revealed the following information. Nurse # 13 had been hired on 8/12/25 and had restrictions on her license per the North Carolina Board of Nursing (NCBON). The facility had screened Nurse # 13 prior to hiring her and found that she had worked at two other skilled nursing facilities earlier in 2025 and was eligible for rehire at both of the facilities where she worked in 2025. They had obtained the restrictions from the NCBON for her employment at their facility (Facility # 1) when they hired her on 8/12/25.The facility provided Nurse # 13's license restrictions which had been given to them (the facility) when Nurse # 13 was hired. A review of the information which the facility (Facility #1) was given by the North Carolina Board of Nursing (NCBON) on 8/12/25 revealed Nurse # 13 had been disciplined for diverting Oxycodone while employed at a facility (Facility # 2) in 2021. Facility # 2 and Facility #1 were under the same corporation. A review of the information and orders from the NC Board of Nursing, dated 1/11/22, revealed the following information. The NCBON found that Nurse # 13's conduct constituted grounds for discipline based on their investigation into the case of diversion of Oxycodone in 2021 at Facility # 2. The NC Board of Nursing interviewed Nurse # 13 on 12/21/21. At that time Nurse # 13 admitted to the NC Board of Nursing that she had diverted 90 Oxycodone 10 mg pills from Skilled Nursing Facility # 2 and that she had begun diverting Oxycodone in the summer of 2021. Nurse # 13 also admitted she had a substance abuse disorder. The NCBON document included the following statements: 1. This matter is properly before the Board and the Board has jurisdiction overLicensee and the subject matter of this case.2. Licensee's conduct, as set out in the findings of fact above, constitutes groundsfor discipline pursuant to N.C. Gen. Stat. S90-171.37 as follows:(6) Engages in conduct that deceives, defrauds, or harms the public in thecourse of professional activities or services;(7) Has violated any provision of this Article or any provision of the rulesadopted by the Board under this Article; and 21 N.C. Admin. Code 36 .0217(a)(3) illegally obtaining, possessing, or distributing drugs or alcohol forpersonal or other use, or other violations of the North Carolina ControlledSubstances Act, G.S. S90-86 et seq.3. Grounds exist pursuant to N.C. Gen. Stat. S90-171.37 for the Board to revoke orsuspend a license to practice nursing and invoke other such disciplinary measures, such as censure or probative terms, against a Licensee as it deems fit and proper. One of the orders by the NC Board of Nursing was that Nurse # 13 enter the Alternative Program for Chemical Dependency. The order also noted Nurse # 13's license would have restrictions. The restrictions were categorized based on the number of years Nurse # 13 was employed in an approved nursing position.On 12/5/25 at 2:50 PM a member of the NC Board of Nursing, who was serving as the compliance case analyst and overseeing Nurse # 13's participation in the Alternative Program, was interviewed and reported the following. There were different encumbrances (restrictions) on a nurse's license based on the number of years within the program. Stricter encumbrances were during the first year of being in the program. This meant that a nurse had to complete a full year of employment while under the one year's restrictions set forth by the NCBON. Nurse # 13 had spotty employment from 2021 through 2023 and therefore did not meet the full one-year employment history to drop the one-year restrictions set forth by the NC Board of Nursing until December 2023. At that point (in December 2023) her license was restricted with

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident and staff, the facility failed to implement their abuse policy when they 1) failed to suspend a staff member who was accused of slapping a resident and 2) ensure the incident was reported to the Administrator in order that regulatory reporting timeframes to other agencies were met and an investigation was initiated on the day of the allegation. This was for 1 of 3 sampled residents who alleged abuse had occurred (Resident # 1).The findings included:Review of the facility's policy entitled Abuse, Neglect, Misappropriation, Crime which was dated 10/17/23, revealed the following information. All employees were responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury) to report to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse. Allegations of abuse would result in staff suspension, and an investigation would take place. Also, the policy directed that after notification to the Administrator of alleged abuse, the Administrator would immediately report to the state agency, but not later than two hours after the allegation is made, regarding the events that caused the abuse allegation. Adult protective services, the local ombudsman, and the appropriate local law enforcement authorities would be notified of resident abuse also. Record review revealed Resident #1 was admitted to the facility on [DATE].Review of a facility investigation report into alleged abuse for Resident # 1 revealed the alleged incident occurred on 11/18/25 and the facility Administrator became aware of the incident the following day. According to the investigation report, Resident # 1 had alleged she was hit in the face by Nurse Aide (NA # 4).Resident # 1 was interviewed on 12/3/25 at 11:25 AM regarding whether anyone had ever mistreated her or abused her in anyway. Resident # 1 reported the following. Two people would whip her. Resident # 1 did not mention being hit in the face. She could not give a specific day. When directly asked if she had been hit in the face, Resident # 1 responded she believed she had been hit in the face. Resident # 1 did not report that she had been cursed or that derogatory language had been used towards her. According to Resident # 1, the police came and then everything stopped and she felt safe and without problems currently.Nurse # 1 was interviewed on 12/3/25 at 2:08 PM and reported the following information. On 11/18/25 Resident # 1 was yelling to the point that it was disruptive to other residents and could be heard in the hallway. She was yelling, Help. Get that b. out of here. Resident # 1 did not normally yell to the degree that she was doing. She (Nurse # 1) went to check on Resident # 1 and Resident # 1 reported she did not want that b.Nurse Aide in the room and that the Nurse Aide had slapped her in the face twice. The resident was assessed and found to have no injuries. There were no marks on her face. NA # # 4, who was assigned to Resident # 1, was in the next room with NA # 1 and another resident. She (Nurse # 1) called them out of the room and asked them what happened. NA # 4 reported that the resident had said that she did not want that b. in her room while referring to her (NA # 4) when she entered the room to care for Resident # 1. NA # 4 reported to her (Nurse # 1) that she then called her back out of her name, and this meant that NA # 4 had been derogatory and not used the resident's name when replying to the resident's remark about not wanting that b. in the room. She (Nurse # 1) had also talked to NA # 1 who had been in the room, and NA # 1 reported that NA # 4 had made racial slurs and called Resident # 1 a fat b. She (Nurse # 1) reported the situation to Unit Manager # 1 and she thought the DON (Director of Nursing) was made aware of the situation. She had followed the chain of command. Unit Manager # 1 reported that she had spoken to the DON and that sometimes Resident # 1 made up things. She (Nurse # 1) was directed by the Unit Manager that two staff members needed to be in the room when providing care to Resident # 1. She (Nurse # 1) thought this was an unusual situation because it had been her experience that if a resident alleged that they were hit, then the accused staff member would not be allowed to stay. On that date, she changed the assignment after the incident so that NA # 4 was no longer assigned to Resident # 1.NA # 1 was interviewed on 12/3/25 at 1:05 PM and reported the following about the incident on 11/18/25. She had gone in the room with NA # 4 to care for Resident # 1. NA # 4 had made derogatory comments before approaching the resident by saying, Let's get this fat white racist b. done. She (NA # 1) informed NA # 4 that they were not doing this which she (NA # 1) reported meant she wanted NA # 4 to stop using unkind remarks. Resident # 1 tried to swing at NA #4, but she did not see NA # 4 hit Resident # 1. NA # 4 stood back while she (NA # 1) cared and provided care for Resident # 1 in a calm manner. After completion of care, she (NA # 1) was gathering used care items and headed out the door. NA # 4 was still behind her and

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, Registered Dietician (RD), and Nurse Practitioner (NP), the facility failed to discontinue a previous enteral feeding (tube feeding) order when a new order was initiated which resulted in the resident not receiving the enteral feeding as most recently ordered. This was for 1 of 3 sampled residents who received nutrition by an enteral feeding (Resident #12).The findings included:Record review revealed Resident # 12 was admitted to the facility on [DATE]. Resident # 12's diagnoses included stroke, dysphagia, cognitive communication problems, and renal disease. Resident # 12's admission Minimum Data Set assessment, dated 11/6/25, coded the resident as moderately cognitively impaired. Resident # 12 was also coded to receive part of his nutrition by an enteral feeding as well as receiving a mechanically altered diet. His height was 66 inches, and his weight was 134 pounds.Resident # 12's care plan, dated 11/1/25, included that the resident had an enteral feeding. The care plan directed to consult with the RD (Registered Dietician) as needed and to administer tube feedings as ordered.On 11/3/25 a physician's order was written for Novasource Renal (tube feeding formula) bolus 200 ml (milliliters) after each meal if the resident ate less than 50 percent of his meal and 200 ml at 8:00 PM. The resident was to have 50 ml of water flush before and after each bolus feeding. Resident # 12 was also ordered to receive a Renal Dysphagia diet on 11/3/25.On 11/27/25 the RD noted the following information in a progress note. The resident's current enteral feeding order was for bolus enteral feedings of 200 ml (milliliters) Novasouce Renal three times after meals and 200 ml at bedtime. She was seeing Resident # 12 because he had been refusing his bolus feedings. The resident also had some nausea. The resident had poor oral intake for the last seven days. Therefore, she recommended that the bolus feedings be discontinued and that the resident start on Novasource Renal at 60 ml/hour for fourteen hours to be infused between the hours of 8:00 PM to 10:00 AM. She also recommended Resident # 12 had a 150 ml flush every four hours.On 11/27/25 an order was entered into the electronic system for an Enteral Feeding order of Novasource Renal at 60 ml per hours times 14 hours to be infused from 8:00 PM to 10:00 AM. Resident # 12 was also ordered to have a 150 ml water flush every four hours. According to the electronic system the orders were per the physician and created in the electronic system by the RD.Review of Resident # 12's November and December 2025 MARs (Medication Administration Records) revealed beginning on 11/27/25 the MARs had both the 11/3/25 orders for bolus feedings which were contingent on his intake and the MARs also included the new 11/27/25 order for the continuous feeding to run from 8:00 PM to 10:00 AM. The 11/3/25 bolus feeding had not been discontinued off the MARs. There was no place on Resident # 12's November and December 2025 MARs for the 7:00 A and 7:00 PM nurses to document about the continuous enteral feeding order which was ordered on their shift to infuse from 7:00 AM to 10:00 AM. The specific documentation by the latest 11/27/25 enteral feeding order included a scheduled time to document at 8:00 PM by this order. The specific documentation with this order was as follows:On 11/27/25-initials for a nurse that did not correspond to a nurse's signature at the bottom of the MAR were entered.On 11/28/25 Nurse # 5 documented Resident # 12 refused.On 11/29/2 Nurse # 5 documented the enteral feeding was given.On 11/30/25 Nurse # 4 documented the enteral feeding was given.On 12/1/25 Nurse # 2 documented Resident # 12 refused.On 12/2/25 Medication Aide # 1 documented the enteral feeding was given.On 12/3/25 Nurse # 3 documented the enteral feed was given. Resident # 12 was observed on 12/4/25 at 8:07 AM. This observation time correlated to a time the resident was ordered to receive a continuous enteral feeding per the last order dated 11/27/25. It was observed at this time that there was no continuous enteral feeding infusing. Resident # 12 replied to simple questions and was able to say nurses gave him an enteral feeding but did not report if it was per bolus or continuous, and he was not able to give times.Nurse # 6 was observed to be assigned to Resident # 12 on 12/4/25. Nurse # 6 was interviewed on 12/4/25 at 8:09 AM and reported the following. Resident # 12 did not receive a continuous enteral feeding. He was ordered bolus enteral feedings and that was why there was no enteral feeding infusing.Nurse # 4, who had documented that the continuous enteral feeding was administered beginning at 8:00 PM on 11/30/25 was interviewed on 12/5/25 at 9:22 AM by phone and reported the following information. On 11/30/25 she had provided a bolus feeding at bedtime because that was what showed on the MAR to be administered. She did not recall the continuous enteral feeding order showing on the MAR to be started on 11/30/25 at 8:00 PM and therefore she had not administered the continuous feeding.Nurse # 7 had cared for Resident # 12 on 12/1/25 and 12/2/25 during the 7:00 AM to 7:00 PM shift