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	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fuquay-Varina Health and Rehabilitation Center	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and Resident Representative (RR) and staff interviews, the facility failed to provide written information about advance directive and/or an opportunity to formulate an advance directive and to an obtain advance directive and maintain the advance directives in the medical record for 2 of 4 residents reviewed for advance directives (Residents #52 and #7). The findings included: Resident #52 was admitted to the facility on [DATE]. A review of Resident #52's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. Review of the Care Plan dated 1/26/26 revealed Resident #52 had an advance directive of full code. Record reviews revealed there was no documentation in the record regarding providing information to the RR about the right to refuse medical or surgical treatment and formulate an advance directive for Resident #52. An interview with the Resident Representative (RR) on 3/31/26 at 9:30 AM revealed she had not had a representative from the facility discuss any information regarding an advance directive for Resident #52. An interview with the Social Worker was conducted on 3/31/26 at 9:40 AM, she stated she was out on leave during the time of Resident #52's admission and it would have been the previous Social Worker's responsibility to discuss advance directives with Resident #52's RR. An interview with the previous Social Worker was not obtained during this investigation process. An interview with the Administrator was held on 3/31/26 at 9:45 AM, she stated she would have expected the Social Worker to discuss advance directives with the resident or RRs within three days of admission into the facility. 2. Resident #7 was admitted to the facility on [DATE]. A care plan meeting note dated 12/5/25 revealed Social Worker #2 documented that a care plan meeting was held with Resident #7's Responsible Party by phone. During the meeting the Responsible Party confirmed Resident #7's full code status and stated he had guardianship paperwork he would bring in. (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 - Few	A Discharge Planning Psychosocial assessment dated [DATE] signed by Social Worker #2 revealed the resident was assessed to have an advance directive per the Responsible Party. A care plan meeting note dated 12/18/25 revealed Social Worker #2 documented that a care plan meeting was held with Resident #7's Responsible Party by phone. The Social Worker documented there were no changes to code status or funeral arrangements and there was no documentation that the Social Worker requested the advance directive. A Discharge Planning Psychosocial assessment dated [DATE] signed by Social Worker #2 revealed the resident was assessed to have advance directives per the Responsible Party. There was no documentation that the Social Worker requested the Responsible Party provide Resident #7's advance directives. A Discharge Planning Psychosocial assessment dated [DATE] signed by Social Worker #2 revealed the resident was assessed to have an advance directive per the Responsible Party. A care plan meeting note dated 3/12/26 revealed Social Worker #2 documented that a care plan meeting was held and Resident #7's Responsible Party did not answer the phone call, and a voice message was left. A care plan meeting note dated 3/17/26 revealed Social Worker #2 documented that a care plan meeting was held and Resident #7's Responsible Party did not answer the phone call, and a voice message was left. Resident #7's medical record on 3/29/26 revealed no advance directives were in Resident #7's medical record. During an interview on 3/30/26 at 10:19 AM Social Worker #1 stated if a resident already had an advance directive in place upon admission, the social workers request the resident or responsible party to bring the advance directive to the facility so they can keep a copy in the resident's medical records. If the resident or responsible party does not provide the advance directives prior to the next time the social workers meet with the resident or responsible party during a care conference, they again request the advance directives. With Resident #7, her Responsible Party stated during a care plan meeting on 12/5/25 that he had an advance directive for Resident #7 and Social Worker #2 requested the advance directive be brought to the facility. Social Worker #1 further stated the Responsible Party had not brought Resident #7's advance directive to the facility. Social Worker #1 stated she did not follow up with the family to acquire Resident #7's advance directive, and there was no documentation that any other staff had followed up with Resident #7's Responsible Party to acquire Resident #7's advance directive. During an interview on 3/30/26 at 3:09 PM, Social Worker #2 stated when Resident #7 first admitted , she spoke on the phone with the resident's Responsible Party who indicated at that time Resident #7 had an advance directive and would provide a copy to the facility. She stated the Responsible Party had been present on the phone for one other care conference on 12/18/25 and she did not remember but believed she did not follow up with Resident #7's Responsible Party about providing Resident #7's advance directive. She concluded that the Responsible Party was difficult to get ahold of and she had not followed up to obtain a copy of Resident #7's advance directive. During an interview on 3/30/26 at 3:03 PM the Administrator stated upon admission, the Social (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Worker discusses advance directives with the resident or responsible party to identify if the resident had advance directive in place or if they would like to create an advance directive. If the resident does have an advance directive, the staff then request a copy of the advance directive. She concluded that if the resident or responsible party does not provide a copy of the advance directives prior to the next care conference, this should be followed up during the next care conference and a copy of the advance directives should be obtained and maintained in the resident's medical records.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Number of Residents Sampled - 6Number of Residents Cited - 1Based on record reviews, and staff, Guardian and physician interviews, the facility failed to ensure a resident was not prescribed a medication to which the resident had a documented allergy for 1 of 6 residents reviewed (Resident #115).Findings included: Record review of the hospital after-care summary dated 8/27/2025 through 8/30/2025 showed an allergy to Doxycycline causing shortness of breath. Record review of allergies listed on the resident banner in the electronic medical record (EMR) included Doxycycline.Review of nursing progress notes dated 1/19/2026, written by Nurse #3, stated Resident #115 tested positive for an infectious disease. The physician was made aware and a new order for Doxycycline 100 milligrams (mg) twice daily for seven days was received.Review of physician orders dated 1/19/2026 showed a telephone order for Doxycycline 100 mg twice daily written by Nurse #3. During an interview on 3/31/2026 at 2:05 PM, Nurse #3 stated she sent the physician a text message about the positive test results and did not have the EMR open to see the resident allergies. The physician texted message back the Doxycycline 100 milligrams order. Nurse #3 reported she did not recall any allergy alert appearing when she entered the Doxycycline order into the EMR. The medication had not yet been delivered, so none was administered.During an interview on 3/31/2026 at 6:15 AM, Nurse #4 stated allergies were listed in the EMR beneath the resident name. She stated an allergy alert appears when entering a contraindicated medication.During a telephone interview with the physician on 3/31/2026 at 9:30 AM, he stated he was unaware of the allergy to the Doxycycline and that the EMR was unavailable to him. He stated nursing staff normally informs him of allergies.During a telephone interview with the resident's Guardian on 3/31/2026 at 12:10 PM, she stated she went to the facility and requested medical records that included the medication administration record (MAR). Upon review of the MAR, the Guardian noted the order for Doxycycline and notified the facility of the allergy to Doxycycline. The Guardian stated Doxycycline should never have been ordered by the physician.During an interview with the Director of Nursing (DON) on 4/1/2026 at 10:00 AM, she stated nurses should have the resident EMR open when contacting physicians and that the EMR provided allergy alerts.During an interview with the Administrator on 4/1/2026 at 10:15 AM, she stated she was aware the physician prescribed a medication to which the resident was allergic and that Nurse #3 did not inform the physician when the physician prescribed the medication.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Medical Director interviews, the facility failed to provide tracheostomy (an opening into the neck through the windpipe) care consistent with professional standards of practice when Nurse #2 cleaned and reused a single use disposable tracheostomy inner cannula when she provided tracheostomy care. This was for 1 of 3 residents reviewed for respiratory care (Resident #109).Findings included:Resident #109 was admitted to the facility on [DATE] with a diagnosis of acute respiratory failure with hypoxia (a state in which oxygen present in a tissue or the whole body is insufficient). A physician's order for Resident #109 dated 7/18/25 was for tracheostomy care every shift and as needed, clean or change inner cannula as applicable.Resident #109's comprehensive care plan revealed a focus area for her risk of complications related to tracheostomy. The goal dated as initiated on 7/22/25 was for Resident #109 to have no complications related to her tracheostomy. An intervention was tracheostomy care as ordered.Resident #109's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. She received oxygen therapy and tracheostomy care while a resident.Resident #109's August 2025 Treatment Administration Record (TAR) revealed documentation on 8/11/25 that Nurse #2 had provided tracheostomy care to Resident #109 on the night shift.A nursing progress note for Resident #109 dated 8/11/25 at 1:11 AM written by Nurse #2 revealed Nurse #2 provided tracheostomy care to Resident #109. This care had been well tolerated.Resident #109's August 2025 TAR further revealed documentation on 8/12/25 that Nurse #2 provided tracheostomy care to Resident #109 on the night shift.A nursing progress note for Resident #109 dated 8/12/25 at 3:02 AM written by Nurse #2 revealed she had provided tracheostomy care to Resident #109. This care had been well tolerated.In a telephone interview on 3/31/26 at 1:55 PM Nurse #2 stated she recalled Resident #109. She reported Resident #109's tracheostomy inner cannulas had always been the disposable single use type. She indicated she recalled providing tracheostomy care to Resident #109 on 8/11/25 and 8/12/25 on the night shifts (7PM-7AM). Nurse #2 stated tracheostomy care included changing Resident #109's disposable tracheostomy inner cannula. She went on to say Resident #109 usually had extra disposable tracheostomy inner cannulas in her room. She reported on either 8/11/25 or 8/12/25, she could not recall which, there had been no extra inner cannulas in Resident #109's room. She indicated Resident #109 had needed tracheostomy care, and so she had used a tracheostomy care kit which included sterile (completely free from living microorganisms and bacteria) gloves, sterile water, and a sterile brush to clean Resident #109's disposable tracheostomy inner cannula. She reported she then re-inserted this back into Resident #109's tracheostomy rather than disposing of it and inserting a new one. Nurse #2 stated she had felt bad doing it at the time because she knew she was not supposed to. She reported reusing a disposable tracheostomy inner cannula could risk infection. Nurse #2 stated she had been very careful to use sterile technique. She indicated she had not looked anywhere other than Resident #109's room for additional disposable tracheostomy inner cannulas. She stated she did not have access to the supply room where there might have been some. She reported she had never done this before during tracheostomy care for Resident #109 or any other resident. She indicated she had never done it again. Nurse #2 stated she thought she had reported the incident to an administrative staff member, but she could not recall who. She stated since then, she made sure she had all the supplies she needed for tracheostomy care at the start of her shift.On 4/1/26 at 9:03 AM an interview with the Director of Nursing (DON) indicated she had not been aware that Nurse #2 had cleaned and reused a disposable tracheostomy inner cannula when she provided Resident #109 tracheostomy care. She stated the facility only used the disposable type of inner tracheostomy cannula. She reported disposable inner cannulas were for one time use and should not be cleaned and reused. The DON indicated although Nurse #2 should have ensured she had the supplies she needed to perform tracheostomy care, she thought Nurse #2 used her professional (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	judgement because she didn't have another disposable inner cannula for Resident #109, and Resident #109 had needed tracheostomy care.On 3/31/26 at 2:57 PM an interview with the Administrator indicated she had not been aware that Nurse #2 had cleaned and reused a disposable tracheostomy inner cannula. She stated Resident #109's tracheostomy inner cannulas had been the disposable type. She reported these were for single use only and should not be cleaned and reused. She stated that while she did not think Nurse #2 cleaning and reusing Resident #109's disposable tracheostomy inner cannula was best practice she felt Nurse #2's goal had been to keep Resident #109 comfortable by providing the care.On 3/31/26 at 2:16 PM a telephone interview with the Medical Director indicated there would have been no risk to Resident #109 when Nurse #2 used sterile technique to clean and reuse a disposable tracheostomy inner cannula. He reported this single incident had not caused Resident #109 any harm.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to secure medications and treatment supplies in a locked wound care cart for 1 of 2 wound care carts observed (Station 2 Wound Care Cart).Findings included:During continuous observation on 3/29/26 (Sunday) from 10:29 AM until 10:36 AM the Station 2 Wound Care Cart was observed unlocked and unattended at the nursing station. There were no staff, residents, or visitors observed in sight of the wound care cart at that time. At 10:30 AM a housekeeping staff member walked past the unlocked wound care cart followed by a nurse aide who also walked past the unlocked wound care cart. At 10:31 AM three visitors walked past the unlocked wound care cart. At 10:32 AM Nurse #1 went to the nursing station, retrieved an item from the nursing station, and left visual range of the Station 2 Wound Care Cart which remained unlocked. At 10:33 AM a nurse aide walked past the unlocked wound care cart. At 10:34 AM three visitors walked by the unlocked wound care cart. At 10:35 AM a visitor walked past the unlocked wound care cart. At 10:35 AM another visitor walked past the unlocked wound care cart and a resident wheeled past the unlocked wound care cart. At 10:36 AM Nurse #1 returned to the nursing station. During an interview on 3/29/26 at 10:36 AM Nurse #1 stated the nurses on the hall completed wound care on the weekends. She stated someone must have used the cart and left it unlocked but she did not know who last accessed the Station 2 Wound Care Cart. She stated all nurses were responsible for the Station 2 Wound Care Cart and it should be locked when left unattended because there were medications in the cart and many confused residents resided in the facility so an unlocked wound care cart could be a safety issue. On 3/29/26 at 10:39 AM an observation was completed of the Station 2 Wound Care Cart with Nurse #1. The Station 2 Wound Care Cart was observed to contain calcium alginate dressing, iodoform packing strips, collagen wound filler, xeroform medicated petrolatum dressing, zinc oxide paste, Silvasorb gel, diclofenac sodium topical gel 1%, 70% Isopropyl alcohol, lidocaine ointment USP 5%, carbamide Peroxide 6.5%, Ciclopirox olamine cream USP 0.77%, Nystatin cream USP 100,000, Gentamicin Sulfate Cream USP 0.1%, and nystatin topical powder. During an interview on 3/29/26 at 12:31 PM the Director of Nursing stated wound care carts should be locked at all times when not attended by a nurse due to safety concerns for confused residents.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and staff interviews, the facility failed to post daily staffing information in an area of the facility visible to residents and visitors on 1 of 4 days of the survey (3/29/26). In addition, the facility failed to have an effective process in place to ensure staffing information data was posted daily, including on the weekend.The findings included:On 3/29/26 (Sunday) at 10:00 AM an initial tour was conducted in the facility. The posted daily staffing information sheet was observed on the counter at the reception desk in lobby and was dated 3/26/26 (Thursday).On 3/30/26 at 3:15 PM an interview with the Scheduler revealed she was responsible for posting daily staffing information sheets. She reported she had not been in the office on 3/27/26 and she didn't work on the weekends. She stated although she knew that staffing information sheets were required to be posted daily, the facility did not have a process for ensuring this happened when she was out of the office or on the weekends. She reported she had not completed and posted the daily staffing information sheets for 3/27/26, 3/28/26 or 3/29/26. The Scheduler stated she had not had a conversation with the Administrator regarding the implementation of a process to ensure daily staffing information sheets were posted as required.On 4/1/26 at 10:20 AM a review of facility's previous 30 days of daily staffing information sheets from 3/2/26 through 3/30/26 revealed them to be complete.In a follow up interview on 4/1/26 at 11:03 AM the Scheduler stated when she returned to the office, she would create the daily staff postings for the days she had been off, such as on weekends or when she was out of the office, based on the staffing schedules for those days to ensure the record of them was complete and accurate. She reported this is what she had done when she completed the daily staffing postings for 3/27/26, 3/28/26, and 3/29/26 when she returned to the facility on 3/30/26.On 3/31/26 at 2:57 PM an interview with the Administrator revealed the Scheduler was responsible for posting the daily staffing information sheets. She reported she was unaware that staffing information sheets were not being posted when the Scheduler was out of the office. The Administrator reported that anytime she reviewed the daily staffing information sheets, she found them to be complete. She stated the facility did not have a process in place to ensure staffing information sheets were posted when the Scheduler was out of the office or the weekends.