STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - TRYON	70 OAK STREET , TRYON, North Carolina, 28782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/21/25 through 07/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D0DB2-H1	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted on 07/21/25 through 07/24/25. 1 of 10 complaint allegations resulted in a deficiency. Event ID: 1D0DB2-H1. The following intakes were investigated: 886935, 886963, 886960, 886958, and 886955,	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to assess a resident's ability to self-administer medications for 1 of 1 resident reviewed for self-administration (Resident #40). The findings included: Resident #40 was admitted to the facility on 4/24/25 with multiple diagnoses that included dry eye syndrome and dry mouth. The quarterly Minimum Data Set (MDS) assessment dated 7/3/25 revealed Resident #40 was cognitively intact and was independent with eating, oral hygiene, and personal hygiene. Review of Resident #40's current and active care plan dated 7/21/25 revealed no goals or interventions for self-administering medications.	F0554		

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 reverse for further 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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F0554 SS = D	Continued from page 1 A review of Resident #40's medical record revealed there was no self-administration assessment or a Physician order for Resident #40 to self-administer her medications. During an interview and observation with Resident #40 on 7/21/25 at 10:51am, the resident was observed sitting up in her recliner next to her bed fully clothed. On the bed next to Resident #40 there was a bottle of Systane (for dry eyes) eyedrops with the direction label faded and partially removed, a bottle of Olopatadine (eye drops to treat itchy eyes) eyedrops with directions to administer 1 drop each eye daily, and a bottle of Biotene (mouth spray for dry mouth) mouth moistening spray with directions to spray in the mouth twice a day. Resident #40 explained the nurse gave her these medications this morning (7/21/25) to self-administer. The resident was unable to state what the medications were for other than they were for her eyes and mouth or how often she needed to administer them. Resident #40 stated the nurse left the medications with her every morning and then would come back and pick them up. Resident #40 stated she had already administered her eyedrops and mouth spray by herself. A second observation was made of Resident #40's room on 7/21/25 at 2:42pm. The observation showed the Systane eyedrops, Olopatadine eye drops and the Biotene were still present on Resident #40's bed. On 7/22/25 at 9:30am, a third observation was made of Resident #40's room which showed the Systane eyedrops, Olopatadine eyedrops and the Biotene were present on Resident #40's bed. Resident #40 was interviewed on 7/22/25 at 11:35am. Resident #40 confirmed the nurse had left her eyedrops and mouth spray for her this morning (7/22/25) but stated "she must have come and got them because they are no longer on my bed." During an interview with Medication Aide (MA) #2 on 7/22/25 at 1:29pm, the MA explained there were no residents on the skilled unit who self-administered medication. She stated she was unaware of the policy for self-administration of medication because there were no residents who self-administered their medication. MA #2 confirmed there was no order for Resident #40 to self-administer her own medication and explained Resident #40 liked to put her own eyedrops in so she would stand next to Resident #40 while the resident administered her own eyedrops. She explained	F0554		

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F0554 SS = D	Continued from page 2 on 7/21/25 and this morning (7/22/25) were “very stressful” and she left the medication in Resident #40’s room for her to administer herself when she was ready and then forgot to pick up the medication on 7/21/25. Nurse #2 was interviewed on 7/22/25 at 3:06pm. The nurse explained if a resident wanted to self-administer their medication a Physician order was needed, and an assessment of the resident, and a care plan completed. She stated Resident #40 was not a resident who could self-administer her own medication and MA #2 should have informed nursing that Resident #40 wanted to self-administer her own medication so proper steps could be taken. Nurse #2 stated medications should not be left with a resident who was not approved to self-administer their medication. The Director of Nursing (DON) was interviewed on 7/22/25 at 1:36pm. The DON discussed the policy for self-administration of medication including an assessment, the resident’s representative would need to agree, the Doctor would need to be notified, and a care plan completed. She stated she did not know if there were any residents on the skilled units who self-administered their own medication. The DON discussed not being aware if Resident #40 had an order to self-administer her own medication and that MA #2 should not have left the medication in Resident #40’s room. The Administrator was interviewed by telephone on 7/24/25 at 2:00pm. The Administrator discussed that there was a procedure for residents to self-administer their medication. She explained she did not know if Resident #40 could self-administer her medication but stated if there was not an order, an assessment, and/or care plan then the medication should not have been left in Resident #40’s room.	F0554		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of	F0583		

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F0583 SS = D	Continued from page 3 family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews the facility failed to protect residents' healthcare information by leaving confidential medication information unattended, visible, and accessible to others on the computer screen for 1 of 4 medication carts observed (Medication cart for hall 300). A continuous observation of 300 hall medication cart occurred on 7/21/25 from 1:50pm to 1:52pm. The medication cart was in the hallway unattended, and it was observed to have the computer screen showing resident information such as medications, date of birth, room number, and diagnosis. The medication cart was observed for 2 minutes and during that time 2 staff members and 2 residents walked past the medication cart. Medication Aide (MA) #2 was interviewed at 1:53pm. MA #2 explained the computer screen containing resident information should be placed on the privacy setting when the medication cart was unattended. MA #2 confirmed she had left the computer screen open to resident information when she walked away to care for another resident. She stated she was in a hurry and	F0583		

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F0583 SS = D	Continued from page 4 "just forgot." A continuous observation of 300 hall medication cart occurred on 7/22/25 from 3:18pm to 3:26pm. The medication cart was unattended in the hallway, and it was observed to have the computer screen open to resident information such as date of birth, allergies, and diagnosis. The medication cart was observed for 8 minutes and during that time several residents, visitors, and staff walked past the medication cart. During an interview with MA #2 on 7/22/25 at 3:26pm, MA #2 confirmed the computer screen had been opened to resident information and stated she thought she had locked the screen prior to walking away from the medication cart. MA #2 explained she was nervous and should have made sure the computer screen was locked prior to walking away from the medication cart. Nurse #2 was interviewed on 7/22/25 at 3:12pm. The nurse explained that anyone working on a medication cart should fold the computer lid down or have the privacy screen showing prior to walking away from the medication cart. Nurse #2 discussed that all staff received resident privacy training yearly and that MA #2 should have had her privacy screen showing prior to walking away from her medication cart. The Director of Nursing (DON) was interviewed on 7/21/25 at 2:17pm. The DON explained the process for the nurses or Medication Aides was to make sure their computer screens were locked to the privacy window prior to leaving the medication cart. She stated MA #2 had yearly training on the medication cart which included keeping the computer screen locked on the privacy window. The DON discussed MA #2 being aware of the requirements and should have locked her computer screen on the privacy window prior to stepping away from her medication cart. The Administrator was interviewed by telephone on 7/24/25 at 2:00pm. The Administrator discussed that computer screens should show the privacy screen whenever the medication cart was unattended. She stated she did not know why MA #2 had left the computer screens showing resident information when she was not at her medication cart. The Administrator stated MA #2 should have placed the computer screen to the privacy screen prior to walking away from her medication cart.	F0583		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12	F0602		

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F0602 SS = D	Continued from page 5 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff, and law enforcement officer interviews, the facility failed to protect the resident's right to be free of misappropriation of medication for 1 of 3 residents reviewed for misappropriation (Resident #53). The findings included: Resident #53 was admitted to the facility on 09/13/23 and most recently readmitted on 06/28/24 with diagnoses that included hypertension. A physician order dated 06/28/24 read; Lisinopril 20 milligrams (mg) by mouth every day. Hold for systolic blood pressure less than 100. The order was discontinued on 08/28/24. A physician order dated 08/29/24 read; Lisinopril 10 mg by mouth every day. Hold for systolic blood pressure less than 100. The order was discontinued on 11/26/24. A physician order dated 11/26/24 read; Lisinopril 5 mg by mouth every day. Hold for systolic blood pressure less than 110. The order was discontinued on 12/10/24. A quarterly Minimum Data Set (MDS) assessment dated 12/10/24 revealed that Resident #53 was severely cognitively impaired. An interview with the local Law Enforcement Officer was conducted in person on 07/23/25 at 1:30 PM. The Law Enforcement Officer stated that on 02/09/25 Medication Aide (MA) #1 called the police station and requested a wellness check on her significant other because she had been unable to reach him. When the responding officer responded to the address, MA #1's significant other was found deceased. Law Enforcement Officer stated that there was nothing suspicious with the death and the death certificate was signed off immediately. However, on 02/11/25 the significant others family came to the police station to turn in a bottle of medication that was prescribed for Resident #53. Law Enforcement	F0602		

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F0602 SS = D	Continued from page 6 Officer stated that he took the information and started an investigation. He contacted MA #1 several times and asked her to give a statement and on 02/10/25 or 02/11/25 he reached out to the former Director of Nursing (DON) at the facility and did not get a return call. On 02/14/25 Law Enforcement Officer stated he sent an email to the former DON asking for assistance with the investigation and was met with great resistance. Law Enforcement Officer stated the former DON would not confirm or deny that MA #1 worked at the facility and kept saying via text message that the medication for Resident #53 was not a controlled substance. Law Enforcement Officer stated that he conveyed via text message to the former DON that it did not matter that it was still larceny (unlawful taking and carrying away of personal property with the intent to deprive the rightful owner of it permanently) and that he was going to press charges against MA #1. Law Enforcement Officer stated that on 03/01/25 he visited Resident #53 who was unaware that her medication had been stolen. Law Enforcement Officer stated that on 03/06/25 MA #1 returned his call and was informed that she was being charged with larceny, and she stated she would turn herself in which she ultimately did. MA #1 admitted to Law Enforcement Officer that she had taken the medication but stated she was not the only one that took medications from the facility. Law Enforcement Officer concluded by saying that MA #1 had an upcoming court date on 08/27/25. An attempt to speak to MA #1 via phone and email were attempted on 07/22/25 at 11:16 AM and were unsuccessful. A picture provided by Law Enforcement Officer was reviewed on 07/23/25. The picture revealed a bottle of medication labelled with Resident #53's name and contained the medication name Lisinopril 20 mg and direction to take one by mouth every morning. The bottle contained a previous address that belonged to the Independent Living Apartments located next to the skilled facility. The name of the pharmacy (mail order pharmacy not the facility pharmacy) that filled the prescription was noted on the bottle along with a phone number. In the picture you could see pills in the bottom of the bottle that were visible around the large white medication label that was on the bottle. Review of an evidence log provided by the local Law Enforcement Officer revealed that they had a bottle of Lisinopril 20 mg that contained 103 pills prescribed for Resident #53. The pills were verified by the Law Enforcement officer using a pill identifier application and confirmed that they were the labeled medication.	F0602		

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F0602 SS = D	Continued from page 7 An observation and interview were conducted with Resident #53 on 07/23/25 at 3:41 PM. Resident #53 was sitting in a wheelchair in the doorway of her room. She was pleasantly confused and could not recall anyone stealing her medications. An attempt to speak to Resident #53's responsible party was conducted on 07/23/25 at 8:14 PM to confirm Resident #53's previous address and was unsuccessful. An interview was conducted via phone on 07/24/25 at 8:24 AM with the pharmacy that had filled the Lisinopril 20 mg for Resident #53. The pharmacy staff indicated that they were a mail order pharmacy and confirmed the name and date of birth for Resident #53 and indicated that they had last fill the prescription in January 2025 and sent it to the member via mail. An interview conducted with Human Resources Manager on 07/22/25 at 11:26 AM revealed that MA #1 was a former employee who had worked at the facility for well over 12 years. She stated that one evening MA #1 could not reach her significant other and called law enforcement for a wellness check and when they arrived at his address he was found deceased. The officer that responded noted pill bottles that had the facility name (the bottle for Resident #53 did not contain the nursing home name) on them and reached out to the former Administration and wanted them to press charges for stealing medication. The Human Resources Manager stated that the former Administrator investigated, and MA #1 was suspended and then terminated. She stated at first MA #1 stated she did not know anything about the medication and then stated that she used to take empty pill bottles home to store things in. The Human Resources Manager stated that it could not be proven that MA #1 stole any actual medication and the resident did not miss any medication, so they proceeded with termination and to her knowledge no charges were ever filed. An attempt to speak to the former DON was conducted on 07/22/25 at 4:24 PM and was unsuccessful. The former Administrator was interviewed via phone on 07/22/25 at 4:05 PM. The former Administrator stated the local LEO contacted the former DON to notify her that they responded to a death in the community and had found bottles of medication with the facility information on it and the deceased's significant other worked at the facility. The former Administrator did not recall the medications involved or the residents involved but stated that the facility did not use	F0602		

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F0602 SS = D	Continued from page 8 medication bottles, they use unit dose packs. The former Administrator stated that when the former DON notified him, he suspended MA #1 and contacted the Nurse Consultant for advice on how to proceed and the former DON ensured the residents had no missing medications. We spoke with MA #1 who stated she would take empty pill bottles home to store things in and eventually the decision was made to separate employment with her. The Nurse Consultant was interviewed via phone on 07/22/25 at 4:27 PM and reported that she was contacted by the former Administrator who had been contacted by local Law Enforcement Office who reported that MA #1's significant other had passed away and there was bottles of medication with the facility information on them found at his residence. At the time Law Enforcement Officer would not send anything or come to the facility to discuss the issue it was basically a "cold call" to the former DON. There were bottles that had resident names on them and some of the bottles had no names on them. The Nurse Consultant recalled that the one bottle had a pharmacy name on it that filled prescriptions to their assisted living residents but through the investigation they realized that they had no missing medications. MA #1 was interviewed and stated she used to take empty pill bottles home to store things in, so the facility considered it a privacy issue and terminated MA #1. The current DON was interviewed on 07/22/25 at 3:16 PM who stated she started her employment in February 2025 and had no knowledge of the investigation and was not involved with the investigation.	F0602		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F0607		

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F0607 SS = D	Continued from page 9 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, and Law Enforcement Officer interviews, the facility failed to implement their abuse policy and procedures by failing to thoroughly investigate an allegation of misappropriation of resident medication and report to the State Survey Agency and Adult Protective Services for 1 of 3 residents reviewed for misappropriation (Resident #53). The findings included: Review of a facility policy titled, Plan for the Prevention of Elder Abuse with no date noted read in part, Investigation-all reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management. Reporting- it is the responsibility of our employees, workforce, facility consultants, physicians, family members, etc to promptly report any incident or suspected incident of neglect or resident abuse including injuries of unknown course, theft, or misappropriation of resident property to facility management. Upon receipt of an allegation of abuse or neglect, the Administrator or designee will notify the appropriate State agency immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. An interview with Nurse Consultant #1 on 07/24/25 at	F0607		

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F0607 SS = D	Continued from page 10 2:23 PM revealed that their policy titled Plan for the Prevention of Elder Abuse had been updated most recently 10/12/18 and was the only policy they had and used. Nurse Consultant #1 stated that the policy was used for Abuse, neglect, and misappropriation for each allegation that was brought to the attention of management for a thorough investigation to be completed. An interview with the local Law Enforcement Officer was conducted in person on 07/23/25 at 1:30 PM. The Law Enforcement Officer stated that on 02/09/25 Medication Aide (MA) #1 called the police station and requested a wellness check on her significant other because she had been unable to reach him. When the responding officer responded to the address, MA #1's significant other was found deceased. Law Enforcement Officer stated that there was nothing suspicious with the death and the death certificate was signed off immediately. However, on 02/11/25 the significant others family came to the police station to turn in a bottle of medication that was prescribed for Resident #53. Law Enforcement Officer stated that he took the information and started an investigation. On 02/10/25 or 02/11/25 he reached out to the former Director of Nursing (DON) at the facility and did not get a return call. On 02/14/25 Law Enforcement Officer stated he sent an email to the former DON asking for assistance with the investigation and was met with great resistance. Law Enforcement Officer stated the former DON would not confirm or deny that MA #1 worked at the facility and kept saying via text message that the medication for Resident #53 was not a controlled substance. Law Enforcement Officer stated that he conveyed via text message to the former DON that it did not matter that it was still larceny (unlawful taking and carrying away of personal property with the intent to deprive the rightful owner of it permanently) and that he was going to press charges against MA #1. An interview conducted with Human Resources Manager on 07/22/25 at 11:26 AM revealed that MA #1 was a former employee who had worked at the facility for well over 12 years. She stated that one evening MA #1 could not reach her significant other and called law enforcement for a wellness check and when they arrived at his address he was found deceased. The officer that responded noted pill bottles that had the facility name (the bottle for Resident #53 did not contain the nursing home name) on them and reached out to the former Administration and wanted them to press charges for stealing medication. The Human Resources Manager stated that the former Administrator investigated, and MA #1 was suspended and then terminated.	F0607		

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F0607 SS = D	Continued from page 11 An attempt to speak to the former DON was conducted on 07/22/25 at 4:24 PM and was unsuccessful. The former Administrator was interviewed via phone on 07/22/25 at 4:05 PM. The former Administrator stated the local LEO contacted the former DON to notify her that they responded to a death in the community and had found bottles of medication with the facility information on it and the deceased's significant other worked at the facility. The former Administrator stated that when the former DON notified him, he suspended MA #1 and contacted the Nurse Consultant for advice on how to proceed and the former DON ensured the residents had no missing medications. The former Administrator indicated they spoke with MA #1 who stated she would take empty pill bottles home to store things in and eventually the decision was made to separate employment with her. The former Administrator stated that there should be an investigation file in the facility or with the current Administrator but could not recall what was in the investigation file. The Administrator also stated that after discussion with the Nurse Consultant the decision was made that this did not need to be reported to the State Survey Agency or Adult Protective Services and so no report was made. The Nurse Consultant was interviewed via phone on 07/22/25 at 4:27 PM and reported that she was contacted by the former Administrator who had been contacted by local Law Enforcement Officer who reported that MA #1's significant other had passed away and there were bottles of medication with the facility information on them found at his residence. At the time Law Enforcement Officer would not send anything or come to the facility to discuss the issue it was basically a "cold call" to the former DON. There were bottles that had resident names on them and some of the bottles had no names on them. The Nurse Consultant recalled that the one bottle had a pharmacy name on it that filled prescriptions to their assisted living residents but through the investigation they realized that they had no missing medications. The Nurse Consultant indicated MA #1 was interviewed and stated she used to take empty pill bottles home to store things in, so the facility considered it a privacy issue and terminated MA #1. The Nurse Consultant stated that they discussed reporting the issue to the State Survey Agency to Adult Protective Services, but they had no information that was connected to our residents, so no report was made. The Nurse Consultant added that the investigation file was with the former Administrator but could not say where it landed since he no longer works at the facility.	F0607		

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F0607 SS = D	Continued from page 12 The current DON was interviewed on 07/22/25 at 3:16 PM who stated she started her employment in February 2025 and had no knowledge of the investigation and was not involved with the investigation. The current Administrator was interviewed on 07/23/25 at 4:27 PM who stated she could not locate any investigation file or report to the State Survey agency on the incident. The Administrator was shown the investigation provided by Law Enforcement Officer and the investigation he had conducted. The Administrator stated if she had all the information she would have started an investigation into the missing medications and reported the occurrence to the appropriate entities.	F0607		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to administer oxygen via nasal canula as prescribed for 1 of 1 resident reviewed for respiratory care (Resident #66). The findings included: Resident #66 was admitted to the facility on 04/28/25 with diagnoses that included pneumonia, heart failure, sleep apnea, and acute/chronic respiratory failure. The admission Minimum Data Set (MDS) assessment dated 05/04/25 revealed that Resident #66 was cognitively intact and used oxygen. The MDS also revealed that during the assessment reference period Resident #66 experienced shortness of breath with exertion and when lying flat. A physician order dated 07/14/25 read: oxygen at 4 liters via nasal canula while walking and oxygen at 1 liter via nasal canula while sitting/resting.	F0695		

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F0695 SS = D	Continued from page 13 An observation and interview with Resident #66 were conducted on 07/21/25 at 1:51 PM. Resident #66 was resting in bed watching television. He had oxygen via nasal canula being administered via oxygen concentrator that was set at 3 liters per minute. Resident #66 denied any shortness of breath at the moment and stated that the nurses kept a close eye on his oxygen and oxygen levels, and he did not touch his concentrator and let the nurses do what was necessary. An observation of Resident #66 was conducted on 07/23/25 at 9:19 AM. Resident #66 was resting in bed in no acute distress with oxygen via nasal canula being administered via oxygen concentrator at 3 liters per minute. Nurse #1 was interviewed on 07/23/25 at 1:58 PM and confirmed that she cared Resident #66 on 07/21/25 and 07/23/25. Nurse #1 stated that when Resident #66 was resting in bed he was on 2 liters of oxygen via nasal canula, but if he walked or with exertion, they could increase it to 4 liters of oxygen via nasal canula. Nurse #1 explained that over the last week therapy had been titrating his oxygen during therapy but currently remained on 2 liters at rest and 4 liters with exertion. Nurse #1 added Resident #66 was very complaint with his continuous oxygen and never bothered his oxygen concentrator. An observation of Resident #66 was made on 07/23/25 at 3:40 PM. Resident #66 was resting in bed with his eyes closed on his right side. He had oxygen via nasal canula that was being administered via oxygen concentrator set to deliver 2 liters per minute. A follow up interview with Nurse #1 was conducted on 07/23/25 at 4:56 PM. Nurse #1 was asked to review Resident #66's oxygen orders for accuracy. When she came to the oxygen order she stated, "1 liter when did they change that, it was 2 liters." Nurse #1 stated she wanted to get confirmation that was correct but that it appeared that Resident #66 should be on 1 liter of oxygen via nasal canula when at rest. An interview with Nurse #1 was conducted on 07/23/25 at 4:59 PM. Nurse #1 stated she had verified with the medical provider that Resident #66 should be at 1 liter per minute via nasal cannula when at rest. An interview with the Director of Nursing (DON) was conducted on 07/24/25 at 11:36 AM. The DON stated that the nurse on the hall was responsible for ensuring the correct dose of oxygen was being delivered after	F0695		

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F0695 SS = D	Continued from page 14 reviewing the residents' orders each shift.	F0695		
F0727 SS = C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours for 1 of 82 days reviewed for staffing (7/20/25). The findings included: The July 2025 daily posted nurse staffing sheets revealed there was no RN coverage for 7/20/25.	F0727		

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F0727 SS = C	Continued from page 15 The Director of Nursing (DON) was interviewed on 7/23/25 at 5:15pm. The DON explained she was responsible for checking the daily posted staffing sheets everyday Monday through Friday. She discussed checking the weekend daily posted staffing sheets on Monday. The DON stated either the nightshift (11:00pm to 7:00am) nurse or the dayshift (7:00am to 3:00pm) nurse would fill out the posted daily staffing sheets and she would look at it as she entered the building. She stated she was unaware the RN time needed to be 8 consecutive hours. The 7/20/25 daily posted staffing sheets were reviewed. The DON explained the facility had a regular RN that worked the weekends but that she was on vacation 7/19/25 and 7/20/25. She further explained 7/19/25 was covered and thought 7/20/25 was covered but when the DON looked at the schedule, she realized the RN scheduled would not have come to work on 7/20/25. The DON stated there was no RN coverage on 7/20/25. During an interview with the Scheduler on 7/24/25 at 10:35am, the Scheduler stated she had only been in her position for a couple of months. She explained she was informed that an RN needed to be in the facility for at least 8 consecutive hours. The Scheduler discussed the facility using contract staff when there was no RN in house to fill the need. The Scheduler explained for the weekend of 7/19/25 she was able to find RN coverage for 7/19/25 but on 7/20/25 she could not find an RN to work. She stated she had informed the DON. A follow-up interview with the DON occurred on 7/24/25 at 10:45am. The DON stated the Scheduler may have told her there was no RN coverage for 7/20/25 but she was not sure. She explained it was rare for the facility not to have an RN but if she had known there was not an RN available, she would have assisted in finding one for 7/20/25. A telephone interview occurred with the Administrator on 7/24/25 at 2:00pm. The Administrator discussed DON being responsible for checking the daily posted staffing sheets for accuracy and coverage. She also discussed being aware that an RN needed to be present in the building for at least 8 consecutive hours. The Administrator stated she was unaware there was not an RN in the building on 7/20/25 and did not know why there was not an RN present.	F0727		
F0732 SS = B	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information.	F0732		

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F0732 SS = B	Continued from page 16 §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure daily posted nurse staffing sheets were filled out completely and everyday for 6 of	F0732		

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F0732 SS = B	Continued from page 17 61 days reviewed for daily posted nurse staffing (5/5/25, 5/6/25, 5/8/25, 5/23/25, 6/16/25, and 6/23/25). The findings included: Review of the facility's daily posted nurse staffing sheets from 5/1/25 through 6/30/25 revealed the following: -On 5/5/25, 5/6/25, and 5/8/25 the daily posted staffing sheets revealed no number of hours worked for the Nurse Aides or the Nurses. -The daily posted nurse staffing sheet for 5/23/25 was not present. -The 6/16/25 daily posted nurse staffing sheet showed no hours were documented for the Nurse Aides or the Nurses. -On 6/23/25 the daily posted nurse staffing sheets revealed RN hours as 4 for the 7:00am to 3:00pm shift. During an interview with the Director of Nursing (DON) on 7/23/25 at 5:15pm, the DON discussed being responsible for making sure the daily posted nurse staffing sheets were present and correct. She explained either the nightshift (11:00pm to 7:00am) nurse or the dayshift (7:00am to 3:00pm) nurse filled out the daily posted nurse staffing sheets and she checked them for accuracy each morning when she entered the building. The DON stated she had not noticed on 5/5/25, 5/6/25, or 5/8/25 that there were no hours entered. She explained she attempted to find the daily posted nurse staffing sheet for 5/23/25 but was unable to locate the sheet. The DON discussed being unaware that the RN hours needed to show 8 consecutive hours. She stated she was not aware that on 6/16/25 the daily posted nurse staffing sheets did not contain any hours for the Nurse Aides or Nurses. The DON discussed on 6/23/25 the daily posted nurse staffing sheets were written incorrectly. She stated there were four (4) RNs on duty not that one (1) RN worked 4 hours. She stated the nurses on the nightshift and the nurses on the dayshift were educated on how to fill out the daily posted nurse staffing sheet but that it was her responsibility to make sure they were accurate. The Administrator was interviewed by telephone on 7/24/25 at 2:00pm. The Administrator discussed the DON being responsible for the daily posted nurse staffing sheets and did not know why there were errors. She stated "something went wrong" but would expect the	F0732		

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F0732 SS = B	Continued from page 18 daily posted nurse staffing sheets to be correct.	F0732		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to secure medications on an unattended medication cart that was unlocked and a drawer partially opened for 1 of 4 medication carts (hall 300). A continuous observation occurred on 7/21/25 from 11:58am to 12:00pm of the medication cart on hall 300. The medication cart was in the hallway unattended, unlocked, and with a drawer partially opened that contained resident medications. The observation occurred for 2 minutes with the staff member returning to the cart at 12:00pm. During the 2-minute observation 2 staff members were observed to walk past the medication cart. No residents were near or passed by the cart during the observation. Medication Aide (MA) #2 was interviewed on 7/21/25 at	F0761		

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F0761 SS = D	Continued from page 19 1:53pm. The MA discussed that when she was not present at her medication cart the cart should be locked with all the drawers closed. She confirmed right before 12:00pm she had walked away from her medication cart leaving a drawer open containing resident medication and that her cart was unlocked. MA #2 stated she was in a hurry and “just forgot” to close the drawer and lock her cart. During an interview with Nurse #2 on 7/22/25 at 3:16pm, Nurse #2 explained that medication carts should be locked with all the drawers closed if they were unattended. She stated MA #2 had yearly training on the importance of keeping the medication cart locked for safety. Nurse #2 discussed that MA #2 became distracted and forgot to lock her medication cart, but that MA #2 should have ensured all the drawers were closed and the medication cart was locked. The Director of Nursing (DON) was interviewed on 7/21/25 at 2:17pm. The DON explained when a nurse or Medication Aide was not at their medication cart the cart should be locked and all the drawers closed. She further explained that anyone assigned to a medication cart had yearly training which included ensuring unattended medication carts were locked and all the drawers closed. The DON discussed that MA #2 had the training and did not know why she would have left her cart unlocked or a drawer open. The Administrator was interviewed by telephone on 7/24/25 at 2:00pm. The Administrator discussed that all medication carts were to be locked, and drawers closed when unattended. She discussed not knowing why MA #2 had not locked her medication cart or left a drawer open but stated MA #2 should have ensured the drawers were closed and the medication cart was locked prior to walking away.	F0761		