DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345413**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fleshers Fairview Health Care	**3016 Cane Creek Road , Fairview, North Carolina, 28730**

(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 9/15/25 through 9/22/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D6499-H1.	E0000		10/09/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/15/25 through 9/22/25. Event ID# 1D6499-H1. The following intakes were investigated 803210, 803208, 803201, 803199, 803197. 6 of the 8 complaint allegations resulted in deficiency. 10/08/25 After the initial posting of the 2567 a correction had to be made. 2567 amended and reposted.	F0000		10/09/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services	F0550	From staff interviews and dining observations conducted by the Administrator, it is the consensus that the resident that was identified as not receiving her tray at the same time as the other residents at the table, does not normally come to the main dining room for lunch. The resident does have a mild cognitive impairment but is able to make simple decisions for herself including where she would like to eat. Since her admission to the facility on 8/5/25, she has preferred to eat her meals in her room. From the summary of the statement of deficiencies this incident occurred on 9/15/25, which was the first day this resident decided she wanted to eat lunch in the dining room. Since that date she has chosen to regularly eat her lunch in the main dining room. The facility dietary manager has permanently moved this resident's tray card so her tray will be delivered to the dining room. Also, the dining room and rooms of residents that need assistance with eating have been observed by the Administrator to ensure there is available seating for the staff to be able to assist residents with eating on eye level. The resident identified in the statement of deficiencies that was not fed at eye level and states a	10/21/2025

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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F0550 SS = D	Continued from page 1 under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to serve a meal to all residents sitting at the same dining table, prior to serving other tables (Resident #42). Additionally, the facility failed to provide feeding assistance while sitting at eye level (Resident #30). This was for 2 of 22 residents reviewed for dignity (Residents #42 and #30). A reasonable person concept was utilized for Resident #42 and would want to have her meal served along with other residents at the dining table. Findings included: 1.Resident #42 was admitted on 8/5/25 with diagnoses that included dysphagia, type 2 diabetes and protein calorie malnutrition. Resident #42's Admission Minimal Data Set (MDS) coded her with moderate cognitive impairment. The MDS review also found she needed setup or clean up assistance with eating. A review of Resident #42's care plan revealed she was care planned for nutrition on 8/14/25. Interventions included providing and serving her diet as ordered, monitoring her meal intake and recording the intake amount for every meal. A continuous observation in the dining room occurred on	F0550	Continued from page 1 chair was available in her room, does have a personal recliner in her room, However, it cannot be moved for a staff member to use to be able to assist resident with meals at eye level. The Administrator has ensured there are foldable chairs available near resident care areas that can be moved for a staff member to sit at eye level to assist a resident. The facilities Food services Director has reviewed all tray cards to ensure that every resident that eats their meals in the dining room will have their tray delivered there. This will ensure that residents eating in the dining room will receive their tray at their table within a reasonable amount of time of the other residents at the table. In-service training is being conducted by the DON, ADON, SDC, and the RN Weekend supervisor reviewing the proper standard of practice of meal tray delivery and feeding assistance. This training will be complete by 10/21/25. The facility Administrator, DON, or designee will monitor the compliance of residents being fed at eye level as well as all residents at the same table being served at the same 3x/week x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the DON/ADON where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion Date 10/21/25	

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F0550 SS = D	Continued from page 2 9/15/2025 beginning at 12:21 PM. Three residents were observed at a dining room table, 2 of 3 residents sitting at the dining table were served meals. Resident #42 was observed raising her hand at 12:25 PM while saying she was hungry. The Hospitality Aide was observed reassuring Resident #42 her food was coming out soon. The observation continued at 12:29 PM and Resident #42 was observed raising her hand again and saying she was hungry. The Hospitality aide again reassured the resident her food was coming soon. At 12:37 PM, Resident #42 received her food and the Hospitality Aide apologized to the resident that her food was delivered to her late. The Hospitality Aide was interviewed on 9/15/25 at 12:45 PM. She stated normally all residents at the same table were served food at the same time, and she was unaware why Resident #42's meal was delayed. The Dietary Manager was interviewed on 9/15/25 at 1:08 PM. The Dietary Manager stated the kitchen had a staff call-out for the morning and another member of staff had come in late. She stated the resident meal tickets became disorganized, and Resident #42's meal tray was sent to her floor. The Dietary Manager said initially they did not realize Resident #42 did not have a meal in the dining room and were informed by a staff member from the dining room that her meal was missing. She stated the resident's meal needed to be retrieved from the hall and delivered to the dining room. The Dietary Manager said Resident #42 should have received her meal when the table was served and should not have waited so long to receive her meal. The Administrator was interviewed on 9/19/25 at 4:04 PM. The Administrator stated all residents eating at the same table should be served together within a couple minutes. She stated Resident #42 should not have to wait almost 20 minutes for her meal to be served to her. 2. Resident #30 was admitted to the facility on 10/27/05. Her active diagnosis included Alzheimer's Dementia and dysphagia (difficulty swallowing). Resident #30's quarterly minimum data set dated 6/11/25 revealed she had severe cognitive impairment, and she required supervision/touching assistance for eating. Resident #30's care plan revised on 6/19/24 revealed a focus of impaired nutrition related to malnutrition, dementia, poor appetite and hypokalemia. Interventions	F0550		

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F0550 SS = D	Continued from page 3 included that the resident usually needs to be fed but sometimes will feed self. An observation on 9/15/25 at 12:56 PM revealed Nursing Assistant (NA) #1 standing on the side of Resident #30's bed feeding her lunch. NA #1 was not at eye level with the resident. A chair was available in the room, and the NA did not use it. An interview on 9/15/25 at 3:01 PM with NA #1 revealed she was aware she was supposed to sit to feed Resident #30 and did not know why she had not sat down. An interview on 9/19/25 at 2:39 PM with the Administrator revealed that staff were supposed to sit when feeding residents and she did not know why NA #1 had not sat down.	F0550		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of	F0565	Each department responds to resolve each area of concern discussed by the residents in the resident council minutes. Much time is spent by the facilities Administrator and each department to resolve complaints. The steps taken to resolve complaints and areas of concern should be documented. DON had addressed resident #17 complaints with staff and resident regarding her ice water being passed too early. DON followed up with this resident on 10/13/25 to find out if this was still an ongoing problem. Resident states "Oh that was fixed months ago, I just hear other residents getting their ice water early. They bring me my ice water later in the mornings now". This follow up has been documented on the resident council minutes response. Administrator has frequently worked to resolve resident #39's complaint about call bell answering time. Steps taken include ringing resident's call bell to observe answering time, having resident give specific times that he felt he waited too long and watched cameras to time answering time, and physically watched call bell answering time. Resident continues to disagree with what he feels to be a reasonable amount of time for call bell to be answered. These interventions have now been documented on the resident council minutes response section. DON/ADON have completed observations to address complaints of cell phone usage in resident areas. The resident council response section of the resident	10/15/2025

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F0565 SS = E	Continued from page 4 the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns voiced by residents during the Resident Council meetings for 8 of 12 months reviewed (November 2024, December 2024, January 2025, March 2025, April 2025, May 2025, June 2026, and July 2025). The findings included: Review of the Resident Council minutes for the period of 09/23/2024 through 08/09/25 revealed the following: a. The Resident Council meeting minutes dated 11/25/24 noted the cell phone use while working was still an issue and the NAs (certified nursing assistants) on second shift were not answering call bells as fast as they could. The Resident Council Response form on the back of the 11/25/24 meeting minutes noted a resolution that they have addressed the cell phone usage and appropriate call bell times with the NAs and will continue to monitor. b. The Resident Council meeting minutes dated 12/14/24 noted the NAs were always on their phones while at work and the second shift NAs were still not answering the call bells as quickly as they should be. The Resident Council Response form dated 12/2024 and attached to the Resident Council meeting minutes noted a resolution that the cell phone usage had been addressed and was continuing to be monitored. The call bell response times have been monitored via the cameras and have been answered in a timely manner. c. The Resident Council meeting minutes dated 01/17/25 noted the call bells on second shift were still not being answered very quickly.	F0565	Continued from page 4 council minutes has been updated to reflect these observations. In monthly QA meeting on 9/30/25, the facilities Administrator discussed with department managers the importance of documenting all interventions and steps taken to resolve residents' concerns in resident council. In-servicing was also completed with department managers on 10/15/25 by the administrator regarding the importance of documentation and the importance of following up with the specific complaint or issue. A response section has been added to the master form for resident council minutes for the Administrator to add documentation. The Administrator will ensure all follow ups are completed and all concerns addressed. This will be monitored 1x/week for 1 month or until compliance is met. The facility Administrator will monitor the compliance department manager follow ups of resident council concerns each month going forward. These follow ups will also be prevented presented at the QAPI meetings by the Administrator where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion Date 10/15/25	

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F0565 SS = E	Continued from page 5 The Resident Council Response form on the back of the 01/17/25 meeting minutes noted a resolution that they will continue to monitor. d. The Resident Council meeting minutes dated 03/26/25 noted NAs were still on their phones too much. The Resident Council response on the back of the 03/26/25 minutes noted a resolution that they will address the cell phone usage. e. The Resident Council meeting minutes dated 04/21/25 noted they were still on their cell phones too much. The Resident Council response on the back of the 04/21/25 minutes noted a resolution that they have addressed cell phone usage with the staff multiple times and will continue to monitor. f. The Resident Council meeting minutes dated 05/30/25 noted the NAs were still on their cell phones while sitting behind the desk and they should not be on their cell phones in the residents' rooms. The minutes also stated that 6:30 AM was too early to pass ice because it woke the residents up. The Resident Council response on the back of the 05/30/25 minutes noted a resolution that they will talk to the NAs about appropriate times to pass ice and they will continue to monitor cell phone usage. g. The Resident Council meeting minutes dated 06/26/25 noted the NAs were still passing ice too early. The residents do not want the ice passed before breakfast. The NAs were still on their cell phones. The Resident Council response on the back of the 06/26/25 meeting noted a resolution that they will talk with the staff about passing out ice a little later and they will continue to monitor the cell phone usage. h. The Resident Council meeting minutes dated 07/30/25 noted that ice passing was still waking the residents up in the mornings and the staff were still on their cell phones while they were feeding the residents. The Resident Council response on the back of the 07/30/25 meeting noted a resolution that they have discussed the concerns with the staff and were still monitoring for improvement. A Resident Council group interview was conducted on 09/17/25 at 2:00 PM with Residents #1, 7, 9, 14, 17,	F0565		

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F0565 SS = E	Continued from page 6 19, 32, 39, 49 and #54 in attendance. Resident #17 was vocal about the ice being passed too early in the morning despite their repeated concerns about how it woke the residents up too early before breakfast. Resident #49 expressed that the wait time for his call bell to be answered, especially on second shift, was too long despite his repeated reporting of the concern. Residents #1, #17 and Resident #39 reported that NAs were still on their cell phones in the residents' rooms and in the dining rooms when they should be taking care of the residents. The Residents stated they felt the facility did not take their concerns seriously because they get the same response to their concerns every month like "we are working on it, will continue to monitor and educate" and nothing was resolved. During an interview with the Activity Director (AD) on 09/19/25 at 11:24 AM the AD explained the department managers took turns attending and recording the monthly Resident Council meetings and if the assigned department manager was unable to attend the Resident Council meeting it was up to the AD to attend the meeting in the place of that manager. The AD stated she has attended about 4 Resident Council meetings thus far this year. The AD continued to explain that the Resident Council meeting minutes were given to the department managers to investigate before the next meeting. The AD explained that there were months that the residents voiced the same repeated concerns during the meetings and voiced disappointment that their concerns were not taken seriously and resolved to their satisfaction. An interview was conducted with the Administrator on 09/19/25 at 6:00 PM. The Administrator explained that there were cameras mounted throughout the facility and had addressed their concerns about the second shift staff taking too long to answer their call lights nor was she able to identify any staff member being their cell phones during resident care times. The Administrator had no response to the ice being passed out too early but indicated that she needed to document and investigate the residents' concerns more thoroughly.	F0565		
F0578 SS = E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F0578	Upon admission to the facility, the Social Services Director is to go over advance directives, residents' rights, the facility policy regarding advance directives, and collects any paperwork regarding advance directives that the resident/responsible party has. This is then scanned into the residents medical record.	10/20/2025

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F0578 SS = E	Continued from page 7 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff, and Resident Representative interviews, the facility failed to allow residents/representatives the opportunity to formulate an advance directive. Additionally, the facility failed to provide residents/representatives with written information regarding advance directives and the right to accept or refuse medical or surgical treatment for 2 of 4 residents reviewed for advance directives (Resident #11 and Resident #3). The findings included: Review of the facility's "Advance Directive" policy	F0578	Continued from page 7 Resident #3 and Resident #11 admission agreements both state that they acknowledge the facility policy regarding their rights to formulate and issue advance directives. They were also given and acknowledged that they were given a copy of the resident's rights which includes, (483.10 (c) Planning and Implementing Care (6) The right to request, refuse, and or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. An advance directive check list has been added to the admission packet along with the "5 Wishes" document to be given out to any resident/responsible party that does not have advance directives in place. The facilities Social Services Director has been educated on the importance of going over these parts of the admission paperwork. This was done on 10/13/25. The residents affected by not being given the opportunity to go over the advance directive checklist, or to formulate an advance directive as part of their admissions packet, have had this check list gone over with them with the facilities Social Services Director and discussed their plan for advance directives. Other residents that could have been affected by not having advance directives formulated, have been identified by doing a record review for every resident which was completed on 10/13/25. Any resident that has not had advance directives formulated, the facilities Social Services Director is in the process of reaching out to the resident/responsible party to discuss. This will be completed by 10/20/25. The facility Administrator will monitor the compliance of correction of residents not having advance directives formulated, as well as advance directives being formulated for any new admissions x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the Administrator where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion date 10/20/25.	

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F0578 SS = E	Continued from page 8 revised “3/17” revealed, the facility would at the time of admission give the following information to all resident’s and/or responsible party. “1. provide written information to resident and/or responsible party regarding the resident’s rights under state law to direct the course of their medical care, to refuse treatments, and to execute advance directives, 2. Will inform residents and/or responsible party in writing of the facilities policies regarding the implementation of these rights.” a. Resident #11 was admitted to the facility on 1/3/25. A significant change Minimum Data Set (MDS) assessment dated 7/17/25 indicated Resident #11 had moderate cognitive impairment. Review of Resident #11’s medical record revealed no advance directive checklist, or signed acknowledgment of receipt, or evidence the facility provided Resident #11’s Resident Representative with written information pertaining to their right to accept or refuse treatment and to formulate an advance directive, on the resident's behalf. Review of the facility’s admission packet revealed there was no written information included regarding advance directives or the right to accept or refuse medical treatment or to formulate an advance directive. The admission packet did not contain an advance directive acknowledgment check list. A telephone interview was attempted on 9/22/25 at 9:03 AM with Resident #11’s Resident Representative. Resident #11’s Resident Representative was not available for interview. b. Resident # 3 was admitted to the facility on 4/8/25. A quarterly MDS assessment dated 7/16/25 indicated Resident #3 was cognitively intact. Review of Resident #3’s medical record revealed no advance directive checklist, or signed acknowledgment of receipt, or evidence the facility provided Resident #3's or his Resident Representative with written	F0578		

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F0578 SS = E	Continued from page 9 information pertaining to their right to accept or refuse treatment and to formulate an advance directive, on the resident's behalf. Review of the facility's admission packet revealed there was no written information included regarding advance directives or the right to accept or refuse medical treatment or to formulate an advance directive. The admission packet did not contain an advance directive acknowledgment check list. An interview was conducted with Resident #3 on 9/19/25 at 4:00 PM. He did not know what an advanced directive was and stated he had not received any information from the facility about advance directives. An interview was conducted on 9/22/25 at 10:14 AM with Resident #3's Resident Representative. He stated he did not receive any written information from the facility about formulating an advanced directive. He reported he signed admission paperwork but did not remember what all was included specifically in the admission paperwork, he said he did not remember anything about advance directives other than the Medical Order for Scope of Treatment (MOST) form being discussed. He did not know exactly what an advance directive was. He stated Resident #3 had a regular will but did not think he had a living will and said he was not sure what the difference was between the two. An interview was conducted with the Social Worker (SW) who was also the facility's Admission Coordinator on 9/18/25 at 1:30 PM. The SW stated when she reviewed advance directives on admission it was mostly the MOST form that she reviewed with the resident or family. The SW stated she did not give anything in writing to the residents or their representative about advance directives or the right to refuse medical or surgical care. She stated the facility did not include written literature in the admission packet about advance directives or right to refuse medical or surgical care. She stated if a resident did not have a living will or advance directive listed in their medical record then they did not have one. An interview was conducted with the Administrator on 9/18/25 at 5:11 PM. The Administrator stated she had spoken with the SW earlier today and the SW had told her about the Advance Directives information not being	F0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
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F0578 SS = E	Continued from page 10 included in the admission packets. The Administrator stated the facility was not aware they needed to provide information in writing about advanced directives or the right to refuse medical or surgical care to residents or their Resident Representative or that the resident or Resident Representative needed to acknowledge they had been provided with the information verbally and in writing.	F0578		
F0580 SS = G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F0580	Nursing staff should timely notify the residents provider (Medical Director/NP/PA) of any change in condition including weight loss and change in skin condition. The facilities Medical Director, Nurse Practitioner, Wound Care PA, and dietician have been notified of the listed residents changes in condition. The ADON is responsible for notifying the RD and the provider for significant weight changes. A significant weight loss is defined as having a 5% loss in 30 days or a 10% loss in 180 days, and a weight gain is defined as 5% gain in 30 days or 10% gain in 180. The facilities Medical Director and Nurse Practitioner were given current and historical weights, which includes any significant changes, for all residents on 10/3/25. This documentation was also given to the dietician on 10/6/25. The dietician did not order any recommendations based on these weights. The Medical Director, Nurse Practitioner were also given a list of current wounds on these dates. Education is being provided to all Nurses on the importance of notifying the residents provider immediately with any changes in resident condition including weight loss and new/changing wounds. Education also includes using the facility standing orders for new wounds. The education provided to the nurses has been provided to Nurse #8 and the wound care nurse. This education started on 10/16/25, is ongoing, and will be completed by 10/21/25. The electronic medical records software that the facility uses will trigger any weight that is a significant weight gain/loss. The Director of Nursing has shown the Medical Director where this triggers in the system. ADON will now routinely send the Medical Director, Nurse Practitioner, and Dietician a spreadsheet of all monthly weights with color coding for significant weight changes. The ADON was trained on her responsibility to notify the provider and RD with significant weight changes when taking on the ADON role in October of 2024. DON has provided education to the ADON on the expectation of reporting significant weight changes to the provider and RD. This education given by	10/22/2025

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F0580 SS = G	Continued from page 11 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff, Nurse Practitioner and Medical Director interviews, the facility failed to consult with the physician about a new pressure ulcer that developed on 08/22/25 on Resident #8's right heel. The pressure ulcer was observed 08/22/25 with no notification to the physician until 09/09/25 when the pressure ulcer to Resident #8's right heel was assessed and documented as an unstageable wound to the right heel with black eschar (dry, black, or brown crust that forms on the surface of wounds) with foul odor and measuring 3.5 centimeters (cm) by 3.5 cm. The facility also failed to consult the physician when Resident #2's diabetic foot ulcer was identified on 09/10/25. In addition, the facility also failed to consult the physician when Resident #16's stage II pressure ulcer was identified on 08/31/25 and when Resident #29 experienced significant weight loss. This deficient practice affected 4 of 4 residents reviewed for notification (Resident #2, #8, 16 and #29). The findings included: 1. Resident #8 was admitted to the facility on 07/17/25 with diagnoses that included history of cerebral vascular accident and diabetes mellitus. Resident #8's admission Minimum Data Set (MDS) assessment dated 07/21/25 revealed the Resident's cognition was severely impaired, required substantial to maximal assistance with most of her activities of daily living and she did not have pressure ulcers on admission. An interview was conducted with Nurse Aide (NA) #1 on	F0580	Continued from page 11 the DON was completed on 10/3/25. The importance of notifying the residents provider of changes in residents' condition is being added to new hire and annual training for nurses. Director of Nursing will monitor the compliance of provider being notified for any change in condition including weight loss or change in skin condition 3x/week x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the Director of Nursing where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion date 10/22/25.	

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F0580 SS = G	Continued from page 12 09/18/25 at 2:35 PM. The NA explained that on 08/22/25 she was preparing to give Resident #8 her shower when she tried to remove her right sock, but it was stuck to her heel and would not come off until she wet the sock first. The NA continued to explain that she noted a red raw area approximately the size of a quarter on her right heel with bloody dried hard drainage on the sock. The NA got Nurse #1 to come to the shower room where she observed Resident #8's right heel and put a dressing over the heel as well as obtained a heel protector to put on after she finished the shower. An interview was conducted with Nurse #1 on 09/18/25 at 4:10 PM and 09/18/25 at 5:30 PM. The Nurse explained that she remembered NA #1 asking her to come to the shower room on 08/22/25 where NA #1 showed her Resident #8's right heel. The wound was pink, and she could not remember if there was drainage. The Nurse continued to explain that she did not measure the pressure ulcer or notify the physician, but she did apply a dry foam dressing to the heel and put a note on the board in the medication room for the Wound Nurse to follow up on the next day. On 09/18/25 at 8:45 AM an interview was conducted with NA #5 who explained that on the night of 09/04/25 she noted an area of drainage on Resident #8's bed sheet while she was providing care to the Resident and when she tried to remove the Resident's right sock, the sock was stuck to her heel. The NA stated she got Nurse #7, and the Nurse cleansed Resident #8's right heel and applied a dressing on her heel. During an interview with Nurse #7 on 09/18/25 at 8:50 AM the Nurse explained that on the night of 09/04/25 NA #5 reported that she could not get Resident #8's sock off her right heel because it was stuck to her heel. The Nurse stated she had to soak the Resident's right heel with wound cleanser in order to remove the sock. The Nurse continued to explain that Resident #8's right heel had a blood-filled blister that was not open, and the area looked like the skin was layered. The Nurse reported that she did not measure the pressure ulcer or notify the physician, but she did apply a foam dressing to the Resident's right heel and applied heel protectors to Resident #8' feet. Nurse #7 also reported that she put a note in the wound communication book for follow up by the Wound Nurse. An interview was conducted with Wound Nurse on 09/16/25 at 2:39 PM, 09/18/25 at 11:45 AM and 09/19/25 at 7:30 AM. The Wound Nurse explained that she first became aware of Resident #8's right heel pressure ulcer on 09/09/25. The pressure ulcer was unstageable with black	F0580		

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F0580 SS = G	Continued from page 13 eschar, malodorous and measured 3.5 x 3.5 centimeters. The Wound Nurse continued to explain that the pressure ulcer had a treatment set up but when she noted that it was black with hard eschar and the drainage was malodorous, she decided to notify the Medical Director and asked for crushed metronidazole (antibiotic) which was what she normally did with a malodorous ulcer. The Medical Director also ordered an X-ray to rule out osteomyelitis which was negative. The Nurse stated she also obtained an order for a wound consult and Resident #8 was seen by the Wound Care Nurse Practitioner on 09/11/25. Nurse #4 reported that she did not see the note on the board in the medication room left by Nurse #1 on 08/22/25. She stated that 08/22/25 was a Friday and she did not work on Fridays and neither did she work on the weekends. Resident #8's medical record from 07/17/25 through 09/09/25 revealed there was no documentation in the medical record of the Medical Director being notified of pressure ulcer development. During interviews with the Medical Director on 09/18/25 at 10:25 AM and 09/19/25 at 3:08 PM. The Medical Director explained that he was first made aware of Resident #8's right heel pressure ulcer when the Wound Nurse #4 called and reported it on 09/09/25. He reported that he ordered crushed metronidazole to be applied to the wound daily for the malodor and to follow up with a wound consultation. The Medical Director also stated that based on the description by Wound Nurse he ordered an X-ray to rule out osteomyelitis which was negative. The Medical Director was not informed of the pressure ulcer first being discovered on 08/22/25 and no orders were obtained to follow up with treatment and the Medical Director stated that it was unfortunate because if the orders had been initiated then the pressure ulcer may not have gotten to the point it had. On 09/19/25 at 6:00 PM an interview was conducted with the Director of Nursing (DON) with the Administrator present. The DON explained that there were standing orders for wound care and when the pressure ulcer was first noted on Resident #8 the standing order should have been set up with specific treatment, and the Medical Director should have been notified in case there were further orders to be followed. 2. Resident #2 was admitted on 2/9/18 with diagnoses of vascular dementia and hemiparesis and hemiplegia of left side following a stroke.	F0580		

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F0580 SS = G	Continued from page 14 A progress note written by Wound Nurse dated 9/10/25 at 2:05 PM wrote she found an open area on Resident #2's left heel. The note read the open area was unstageable and measured 2 centimeters (cm) x 1.5(cm). The Wound Nurse wrote the area around the open area was red with blanchable redness. The wound did not contain an odor, and the area was cleaned, and a dressing was applied. On 9/18/25 at 1:15 PM the Wound Nurse was interviewed. The Wound Nurse stated she first saw the heel wound on 9/10/25 and documented the wound in a progress note. The left heel wound measured 2 (cm) x 1.5 (cm) and did not contain an odor or drainage. The Wound Nurse said she treated the left heel wound with standing wound orders and notified the Wound Nurse Practitioner the following day. Additionally, she thought she had communicated the wound to the Nurse Practitioner (NP) when she found it 9/10/25. On 9/11/25 the Wound Nurse Practitioner evaluated the left heel dorsal wound. The Wound Nurse Practitioner treatment note read that given the dorsal location of this wound, it was consistent with a diabetic etiology. The wound was deep and full of necrotic slough (dead tissue) and suspected the wound had been present for some time. The treatment note also included the estimated depth to bone was less than 2 millimeters. Additionally, the Wound Nurse Practitioner wrote that a medically necessary sharp debridement was indicated and performed for the removal of excessive necrotic tissue and for the promotion of wound healing. The note continued with treatment orders to cleanse left heel wound with a full-strength antiseptic solution and then apply full strength (0.5%) antiseptic solution moistened gauze to the full depth of the wound bed. Finally, the wound was to be covered with a silicone bordered super absorbent dressing. The treatment was to be completed daily and PRN (as needed). An additional order was for a wound culture and sensitivity and x-ray of left heel for evaluation of evidence for presence of osteomyelitis (infection in a bone) and underlying pathology. The Wound Nurse Practitioner also wrote for labs of complete blood count, C reactive protein, and erythrocyte sedimentation rate. The Wound Nurse Practitioner also wrote that the resident was to always wear a podus boot (foot brace to prevent bedsores) for offloading. On 9/15/25 the Wound Nurse Practitioner treated the resident's left heel. A review of the treatment note found the measurements for the left heel diabetic ulcer were 2 cm x 1.5 cm x 1.5 cm. The wound contained 80% necrotic tissue with yellow seropurulent (discharge of serum and pus) drainage. The treatment note included	F0580		

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F0580 SS = G	Continued from page 15 the left heel wound had not improved from the previous treatment day, but the adherent slough that was present last week (9/11/25) was mostly liquefied and ran out of the wound when the dressing was removed. The Wound Nurse Practitioner assessed with certainty if the drainage included purulent drainage mixed with liquified yellow green slough. Furthermore, the Wound Nurse Practitioner's note wrote that a medically necessary sharp debridement was indicated for the removal of excessive necrotic tissue and for the promotion of wound healing. The wound was anesthetized, and debridement was performed. Resident #2's NP was interviewed on 9/17/25 at 11:00 AM. He stated Resident #2 had been placed on comfort measures due to an overall decline and Resident #2 had poor nutritional status and would refuse nutritional supplements. The NP stated he was aware that Resident #2 had wounds on her back and sacrum area but did not know she had a wound on her left heel. He stated he was not notified that Resident #2 had a wound on her left heel. The NP stated he was not notified of any lab results ordered by the Wound Nurse Practitioner on 9/11/25 and was not aware of her treatment orders. The NP stated it was important to be notified of new wounds and any interventions for Resident #2 so treatment could be started and to see what other interventions Resident #2 had in place. He stated Resident #2's left heel wound would be unavoidable due to her overall decline. The NP stated he should have been notified of Resident #2's left heel wound when it was found on 9/10/25. Additionally, the NP stated normally the Wound Nurse Practitioner would have been notified with results of any labs or diagnostics first because she had ordered them, and the results would be placed in his folder to review or would have been called in to him. The Medical Director was interviewed on 9/18/25 at 11:25 AM. The Medical Director stated he was notified by the nursing staff through the nursing communication book or by a phone call when a resident had a new wound. The Medical Director stated he was not notified that Resident #2 had a wound on her left heel. On 9/19/25 at 4:04 PM the DON stated the Medical Director and NP should have been notified for Resident #2's diabetic foot wound on 9/10/25 when found by the Wound Nurse. 3. Resident #29 was admitted to the facility on 2/21/24. Her diagnoses included dementia, hypothyroidism, nutritional deficiency, protein-calorie	F0580		

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F0580 SS = G	Continued from page 16	F0580		

malnutrition.

Resident #29’s electronic record documented the following weights

-7/29/25- 132.1 pounds (lbs.)

-8/26/25- 114.4 lbs.

A progress note dated 8/31/25 by the Registered Dietitian (RD) #1 indicated Resident #29 was reviewed. The note indicated she had a significant weigh loss of 13.6 % in a month. The note indicated Resident #29 received a regular diet with mechanical soft texture and her intakes ranged from 0-50% of most meals. The note indicated she was receiving Med Pass (nutritional supplement) 60 milliliters (ml) twice daily and a mighty shake (nutritional supplement) three times daily. The note indicated the RD recommended obtaining a reweight for weigh loss verification and increasing her Med Pass to 90 ml twice daily to promote weight stability.

RD #1 was not available for interview.

A reweigh weight was not located in Resident #29’s electronic medical record.

An interview was conducted with the Director of Nursing (DON) on 9/18/20 at 10:20 AM. She said if a resident had significant weight loss it was the Assistant Director of Nursing (ADON) who was responsible for ensuring the provider was notified and said it should be documented somewhere. The DON stated when someone had significant weight loss the physician should be notified.

Review of Resident #29’s medical record revealed there was no documentation the physician was notified of the weight loss.

An interview was conducted with the ADON on 9/18/25 at 11:01 AM. The ADON reported she was responsible for keeping up with the facility weights and ensuring they were completed. The ADON stated she had not notified the physician of Resident #29’s significant weight loss. She said the Physician should be notified if a resident had significant weight loss so they could check the resident medically to see if there was a reason for the weight loss. The ADON stated Resident #29’s reweight not being reported or entered until 9/18/25 by Unit Clerk #1 was a little late. The ADON said she noticed Resident #29’s weight loss at the end of August but was waiting on the reweight before she

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F0580 SS = G	Continued from page 17 notified the Physician. The ADON said she should have followed up on Resident #29's reweight but had gotten busy. The ADON thought she was the person who would be responsible for notifying the Physician of significant weight loss. She stated she had just got busy and forgot because she was working on the floor. An interview was conducted on 9/19/25 at 10:45 AM with RD #2. RD #2 reported that the Physician should also be notified if a resident had significant weight loss. RD #2 said she was not aware of who notified the physician at the facility. RD #2 stated she was not told by anyone at the facility the RD was the person who notified the Physician. RD #2 reported it was important to notify the Physician of significant weight loss so the Physician could review the resident from a medical standpoint. An interview was conducted with the Medical Director on 9/18/25 at 9:53 AM. He stated he was aware Resident #29 had some prior weight loss in the past but had not been notified in the last month about her having significant weight loss. He said if a resident had significant weight loss it would trigger for him to review and see them. The Medical Director said if he had been notified of Resident #29's significant weight loss he may have done labs and checked a TSH level because Resident #29 took Synthroid (thyroid medication). The Medical Director said the facility should have followed the RD recommendations and obtained a reweight to confirm her weight loss and ensured the weight was reported. The Medical Director said he would have asked for a reweight to be obtained too. The Medical Director explained there was no reason not to notify him immediately when the facility became aware someone had significant weight loss. He further explained if he was off, the facility could notify him through the provider's communication book, and the information would be there for him to review when he returned. The Medical Director stated he had not seen a note about Resident #29 having weight loss in the provider communication book. The Medical Director said he would expect to be notified within a week. An interview was conducted with the Administrator on 9/18/25 at 5:11 PM. The Administrator stated the ADON had notified her about Resident #29's weights today. The Administrator stated the Physician should be notified if a resident had significant weight loss. She said previously the RD notified the Physician if a resident had significant weight loss. She reported that it was still the process. The Administrator explained RD #1 went on medical leave at the end of August and said she thought that was why there was a breakdown in	F0580		

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F0580 SS = G	Continued from page 18 communication. 4. Resident #16 was admitted to the facility on 3/29/21 with diagnoses including multiple sclerosis, hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle wasting and atrophy, muscle weakness. An interview was conducted on 9/15/25 at 9:23 AM with Resident #16. He reported he had a pressure ulcer to the back of his right thigh. A nursing note dated 8/31/25 by Nurse #8 read: “Nurse notified by resident of bleeding spot on the back of his thigh. Possible stage 2 pressure injury noted to right outer back thigh. Wound bed pink, scant red drainage noted on resident's reusable chuck on his manual wheelchair. No signs of infection. Nurse cleansed wound with wound cleanser, covered wound bed with silver alginate and covered with adhesive dressing. Resident will be added to acute book for this issue and nurse will enter wound care orders until wound care nurse can assess.” An order dated 8/31/25 was entered by Nurse #8 and read: Cleanse wound with wound cleanser, cover wound bed with silver alginate (highly absorbent wound dressing embedded with silver particles to fight infection), place dry adhesive dressing over wound, two times a day for pressure injury for 7 days. The order ended on 9/7/25. There were no additional wound care orders after 9/7/25. An interview was conducted with Nurse #8 on 9/17/25 at 2:57 PM. She recalled finding the stage 2 pressure ulcer to the back of Resident #16’s right thigh on 8/31/25. Nurse #8 stated she had not notified the Physician when she found Resident #16’s wound to obtain treatment orders, she said that was not the process. Nurse #8 explained what she understood was the facility’s process when a wound was found. She said the nurse entered a treatment order for the wound, made a nursing note, and entered a note in the nursing “acute book” so everyone would know about the wound and document on the wound for 72 hours. An interview was conducted with the ADON on 9/17/25 at 11:00 AM. The ADON reported she reviewed Resident #16’s orders and stated Resident #16 had a treatment order for the stage 2 pressure ulcer entered on 8/31/25. She said when a wound was found the nurse was supposed to notify the provider by placing a note in the provider’s	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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F0580 SS = G	Continued from page 19 communication book or by calling them. The ADON reviewed the provider's communication books and stated there was not a note left to notify the provider about Resident #16's wound. An interview was conducted on 9/17/25 at 12:11 PM with the Nurse Practitioner (NP). He said he was not aware Resident #16 had a wound and that he had not been asked to look at the area. He said Nurse #8 should have notified a provider when the wound was found to obtain wound care orders. He stated if he had been notified, he would have ordered Resident #16 to be seen by the Wound Care Provider. An interview was conducted with the Medical Director on 9/18/25 at 9:46 AM. The Medical Director stated he was not aware that Resident #16 had developed a wound. He stated the nurse should have notified him or the NP of Resident #16's wound and to get wound care orders when the wound was identified. An interview was conducted with the Director of Nursing (DON) and Administrator on 9/19/25 at 6:00 PM. The Administrator reported that Nurse #8 should have notified the provider when she found Resident #16's wound. The Administrator stated she did not know why Nurse #8 did not notify the Physician about the wound.	F0580		
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 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	F0583	Resident's personal information which includes information on medication cards and narcotic control sheets should not be left uncovered and visible. The nurse that left the residents information visible, immediately covered the resident's confidential medical information and removed the cards from the top of the cart. Other residents could have the potential to be affected by this. Upon discovery of the narcotic control sheet being left uncovered and unattended, the Director of Nursing immediately checked other medication carts to ensure no confidential medical records were accessible. None were found. Education is being provided to all nursing staff regarding not leaving confidential medical information visible, unattended, or accessible. This education is ongoing and will be completed by 10/21/25. HIPPA education is provided to all new hires and yearly during required yearly education. Not leaving confidential medical information visible, unattended,	10/21/2025

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F0583 SS = D	Continued from page 20 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 record review, observations and staff interviews, the facility failed to protect residents' personal health information by leaving confidential medical information unattended, visible and accessible to others on top of the medication cart for 1of 4 medication carts observed for privacy and confidentiality (500 hall). Findings included: On 09/16/25 at 8:48 AM an observation was made of the unattended 500 hall medication cart with the narcotic book which was open to a resident's narcotic sheet for a controlled medication. The narcotic sheet noted the resident's name, name of medication, directions of use, how often the resident had used the medication, the indication of use and the count left in the medication card. The observation also included 2 empty medication cards of 2 additional residents with residents' names, names of the medications and the directions of use for the medication. There was no nurse attending the medication cart. Two staff members and one resident walked by the unattended medication cart while the medical information was visible. On 09/19/25 at 8:54 AM Nurse #3 arrived at the 500-hall medication cart. The Nurse was asked about the open narcotic book and 2 medication cards left on top of the medication cart and immediately closed the book and stated she forgot to close the narcotic book, and she was going to reorder the medication from the pharmacy. The Nurse explained that she should not have left the medical information on top of the medication cart for the public to see because it was a violation of the residents' privacy and confidentiality.	F0583	Continued from page 20 or accessible, will also be added to the new hire and annual skills list to go over with nurses. Director of Nursing will monitor the compliance of protecting residents' personal health information 2x/week x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the Director of Nursing where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion date 10/21/25.	

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F0583 SS = D	Continued from page 21 An interview was conducted with the Director of Nursing (DON) with the Administrator present at 6:00 PM on 09/19/25. The DON indicated that it was a HIPAA (health insurance portability and accountability act) violation to leave the residents' medical information unattended and accessible for the public to see. The staff were educated on HIPAA during orientation and yearly afterwards and Nurse #3 should not have left the information visible to the public on top of the medication cart.	F0583		
F0584 SS = B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F0584	The laundry building that is not connected to the facility as well as the laundry/housekeeping area in the facility are to be kept clean and free from dust. Items on or in the medication cart should be kept clean and in good working order. Housekeeping carts should not be kept next to clean linen. The rack of clothing listed in the statement of deficiencies with the housekeeping cart next to it has clothing on it that it is not being dispersed to residents. They are either unlabeled clothing or donated clothing. Anything on this rack would be laundered before going out to a resident's closet. However, this rack has been moved to the clean side of the laundry room and covered. This was completed on 10/4/25. The laundry building that is not connected to the facility has storage shelves that are parallel to the folding worktable, not over it. The storage shelves that have trim stored on them have been covered with tarp. The facilities Environmental Services Director and Laundry Aide have conducted a deep cleaning of the laundry building including. All of this was completed as of 10/13/25. All pill crushers on the medication carts have been thoroughly cleaned. Education was provided to the laundry aide by the facilities Administrator on 10/9/25 regarding keeping the laundry building clean and free of dust. The facilities Enviornmental Services Director has continued to do training to all housekeeping staff on the organization of the laundry/housekeeping room onsite to ensure clean storage including linens/personal items are kept separate. This education was completed on 10/15/25. Education to nurses regarding keeping the medication carts, including pill	10/21/2025

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F0584 SS = B	Continued from page 22 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure the residents' clothing was stored in a sanitary manner in the laundry room inside the facility and failed to ensure the laundry room outside the facility was free of dust. Additionally, the facility failed to ensure a pill crusher's surfaces were free from what appeared to be a dried light brown liquid substance on the end of the pill crusher and had dark brown particles embedded in the dried liquid. The deficient practice affected 2 of 2 laundry rooms and 1 of 4 pill crushers (100 hall) reviewed for safe, clean and homelike environment. The findings included: 1a. On 09/18/25 at 4:00 PM an observation was made of the laundry room that was in a building separate from the facility where the facility laundered the linen and residents' personal clothing. The observation yielded strings of dust hanging off dryer #2 and the tops of the two washers were dusty as evidence by fingerprints being left on the tops of the washers when touched. The clean side of the laundry room had linens and residents' personal clothing stored on the worktable with a stack of base board trim thick with dust being stored on a shelf above the worktable that the residents' personal clothing was stored on. An interview was conducted with the Environmental Services Supervisor on 09/18/25 at 4:00 PM. The Supervisor explained that the laundry room should be cleaned every day by the laundry aid on duty which included dusting the equipment in the laundry room. The Supervisor stated the separate laundry room tended to be a storage place for the facility and old furniture and personal items of residents that have expired and stated the items should not be stored near the clean laundry. An interview was conducted with the Administrator on 09/19/25 at 6:00 PM. The Administrator explained that she expected the laundry room separate from the	F0584	Continued from page 22 crushers, clean and in working order is ongoing and will be complete by 10/21/25. The importance of keeping the medication carts clean is being added to new hire and annual training for nurses. The importance of keeping the laundry building and onsite laundry areas clean, as well as keeping clean linen and supplies separate, has been added to the new hire and annual training for housekeeping and laundry staff. The facility Administrator, Environmental Services Director, or designee will monitor the cleanliness of the laundry building, and onsite laundry/housekeeping area 3x/week x 4 weeks or until compliance is met. The Director of Nursing, or designee will monitor the cleanliness of the pill crushers 2x/week x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the Administrator/Environmental Services Director and Director of Nursing where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion Date 10/21/25	

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F0584 SS = B	Continued from page 23 facility to be cleaned the same as the laundry room inside the facility. She stated she did not routinely tour the laundry room in the separate building, but she would make that a routine. b. On 09/18/25 at 4:10 PM an observation was made of the laundry room inside the facility accompanied by the Environmental Services Supervisor. The observation yielded a housekeeping cart stored next to a rack of residents' personal clothing that had been laundered and ready for transport. The Supervisor explained that the housekeepers store their housekeeping carts in the space next to the rack of residents' personal clothes after they were finished with their housekeeping duties for their shift. The Supervisor stated the housekeeping carts were not deep cleaned every day but if they were visibly soiled then they were wiped down. The Supervisor stated she would wash the residents' clothing again and put a cover over them until they were ready to be taken to the residents. During an interview with the Administrator on 09/19/25 at 6:00 PM the Administrator explained that she did not routinely tour the laundry room enough to notice the housekeeping carts being parked next to the residents' personal clothing, but she would increase her surveillance of the laundry rooms. The Administrator indicated that the housekeeping carts should not have been stored near the residents clean clothing. She stated the rack of clothes should have been put in another room or the rack of clothing should have been covered to prevent them coming in contact with the housekeeping cart. 2. On 09/16/25 at 9:16 AM an observation was made of the pill crusher on the 100-hall medication cart. The pill crusher had what appeared to be a dried light brown liquid substance on the end of the pill crusher and had dark brown particles embedded in the dried liquid. On both sides of the crusher there was dark brown debris deep in the crevices that looked like dirt. An interview was conducted with the Wound Nurse on 09/18/25 at 2:20 PM. The Wound Nurse who was assigned to the 100-hall medication cart on 09/16/25 first shift was asked who was responsible for cleaning the medication carts and pill crushers and the Wound Nurse stated the nurse on the hall was responsible for cleaning the pill crushers. The Wound Nurse was shown the pill crusher on the 100-hall medication cart and stated it looked like it had been a long time since it was cleaned and needed to be cleaned. She stated every nurse should wipe down the pill crushers along with the	F0584		

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F0584 SS = B	Continued from page 24 medication cart before they leave the shift. An interview was conducted with Nurse #1 on 09/19/25 at 11:50 AM who was scheduled to work on 100-hall medication cart. Nurse #1 was asked who was responsible for cleaning the medication carts and pill crushers and the Nurse explained that each nurse should keep the medication carts clean. The Nurse was shown the pill crusher on the 100-hall medication cart, and she stated that it looked like it had not been cleaned in a long time. Nurse #1 stated she would clean the pill crusher. An interview was conducted with the Director of Nursing (DON) on 09/19/25 at 6:00 PM. The DON indicated that cleaning the pill crusher was part of cleaning the medication cart and it should be done by the weekend supervisor.	F0584		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and Medical Director interviews, the facility failed to protect a resident's right to be free from physical abuse when an employee (Staff #13) slapped Resident #44 on the hand with an open hand during care. This deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #44). Findings included: Resident #44 was admitted to the facility on 6/24/24. Her diagnoses included dementia, anxiety.	F0600	All residents have the right to be free from physical abuse. An in-house investigation was completed on the allegation of abuse. This investigation was completed on 6/4/25. Allegation of abuse was reported to the Director of Nursing by nurse #13 on 5/29/25. Nurse stated that the incident was reported to her by a CNA late the night before (around shift change at 11pm). The CNA that reported incident to Nurse #13 states she was in the resident's room as a witness. DON immediately called the CNA that was a witness to get her statement. In her statement she states that she was doing rounds with the Nurse Aide that was accused of abuse. She states while providing care to resident #44, resident became resistant to care and attempted to push them away. She states that NA #13 got upset and slapped at resident's hand. DON along with ADON then called NA #13. She stated to DON and ADON that resident was becoming combative and resistant to care, and instinctively slapped back at resident. She states she knew that she should have left the room and removed herself from the situation. Resident's plan of care discussing her tendency to become combative with care. Interventions in place on plan of care include verbal reassurance, talk to resident during care, approach in a calm manner, and use diversion. This allegation was reported to NCDHHS. NA #13 that was alleged with abuse was immediately (on 5/29/25) suspended from work pending investigation for the protection of other residents. Also, on 5/29/25 the Administrator called the Buncombe County Sherrif's Office regarding this incident and gave a report to dispatch. Later that day the Administrator received a call from a deputy whom the Administrator gave him the information that the facility was aware of as of this	09/23/2025

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F0600 SS = D	Continued from page 25 A quarterly Minimum Data Set (MDS) assessment dated 4/5/25 indicated Resident #44 had severe cognitive impairment. The MDS documented that she did not have behaviors or rejection of care. The MDS reported she was incontinent of bladder, required staff assistance with activities of daily living (ADL), and was dependent on staff for personal hygiene and toileting. A care plan revised on 4/9/25 for impaired mobility, Activity of Daily Living (ADL) deficit related to dementia and debility was in place. The care plan interventions included Resident #44 required assistance with most ADL and that the amount of assistance needed varied from task to task and day to day. The care plan included that Resident #44 was usually combative and frequently refused care. A care plan revised on 4/9/25 for potential for impaired skin integrity was in place. The care plan interventions included cleanse peri-area in the morning and evening and following each episode of incontinence episode. A care plan revised on 4/9/25 was in place for behavior problems, refusing care, screaming related to dementia. The care plan interventions included explaining all procedures before starting and allow to adjust to changes. Approach/ speak in a calm manner, divert attention, remove from situation and take to alternate location as needed. Praise for appropriate behavior. Caregivers to provide opportunities for positive interaction, attention. A care plan revised on 4/9/25 was in place for impaired thought process related to dementia, anxiety, depression with behaviors, and combative with care. The care plan interventions included offer verbal reassurance, use touch for reassurance as appropriate, reassure that situation must be difficult, talk to resident during care. Review of a facility reportable incident indicated on 5/28/25 Nurse Aide (NA) #12 reported to Nurse #13 during shift change at 11:00 PM that she witnessed Staff #13 hit Resident #44 during care. The report did not state what time the alleged abuse occurred on 5/28/25 or what type of care was being provided when it occurred. The report stated Nurse #13 reported the abuse allegation to the Director of Nursing the following morning on 5/29/25. The facility reported the incident to the local police department and state agency on 5/29/25 after they became aware of the alleged abuse allegation. The facility investigation	F0600	Continued from page 25 day. A deputy did not come to the facility that day. On 6/2/25 a Detective from the Buncombe County Special Investigation unit came to the facility to discuss the investigation with the Administrator and DON, and also talked to the resident. He stated he felt satisfied with how the investigation was going. He also told the Administrator that his agency had notified APS. The day the incident was reported as well as daily thereafter, the ADON assessed resident #44. She found no signs of injury or change in mood/behavior. Upon completion of the facility investigation, the allegation was substantiated, and NA #13 was terminated on 6/2/25. A representative from NCDHHS continued the investigation which included coming on site for follow up (came onsite 7/16/25). Upon the completion of this, the employee was posted to the NC personnel registry. Resident's In person training was completed by the Director of Nursing starting on 6/2/25 to all nursing staff on how to properly care for a resident that is exhibiting difficult behaviors. Online training was also assigned on 6/3/25 to all staff in every department on identifying and reporting abuse and neglect. Education included timely reporting. Online training also included a post test that staff had receive a passing score of 80% to be marked as completed. This training on identifying and reporting, as well as residents' rights (which includes abuse training), has been added to new hire orientation as well as yearly orientation that is completed by all staff in all departments every year in August. Monitoring of staff completing care of residents with known difficult behaviors during care was completed by the DON starting on 6/4/25. Monitoring including the DON monitoring one hall per day 3x/week for 4 weeks of staff preforming care of residents with known difficult behaviors. No incidents noted during monitoring period. Documentation of the monitoring was presented in the July QAPI meeting. It was decided no further action was needed. Completion Date 09/23/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345413**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/22/2025**
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F0600 SS = D	Continued from page 26	F0600		

revealed NA #12, Staff #13, and Nurse #13 were interviewed by the Director of Nursing. The investigation revealed Staff #13 admitted to hitting Resident #44 during care. The abuse allegation was substantiated by the facility and Staff #13 was terminated on 6/2/25. The report indicated the facility reported Staff #13 to the health care personnel investigations.

An interview was conducted on 9/16/25 at 3:02 PM with Nurse Aide (NA) #12. She recalled the incident from 5/28/25 with Resident #44 and Staff #13. NA #12 stated between 8:00 and 9:00 PM she and Staff #13 entered Resident #44's room to provide incontinence care. She said they were in her room for about 10 minutes providing care. NA #12 reported she was on one side of Resident #44's bed and Staff #13 was on the other side of the bed. She reported Resident #44 had been sleeping when they entered the room and had just been woken up. She said when they began to provide incontinence care Resident #44 started saying “stop”, “no”, and was pushing their hands away. She stated Staff #13 “got really angry” at Resident #44 and she was not sure why Staff #13 had gotten angry. NA #12 reported Staff #13 grabbed both of Resident #44's wrists and yelled at her to “stop” and then slapped Resident #44 on the hand. She did not remember which one of Resident #44's hands Staff #13 slapped but said she had slapped her with an open hand. She reported she did not remember seeing any mark on Resident #44's hand after Staff #13 slapped her but said she had not looked. NA #12 said Resident #44 acted startled when Staff #13 slapped her on the hand, she said she thought Resident #44 had yelled out when Staff #13 slapped her. NA #12 said she was not sure if Resident #44 was scared in the moment but afterwards Resident #44 acted differently and scared when people came into her room. She explained Resident #44 would ask a lot of questions like “what are you going to do”, “what are you doing in here” and acted suspicious of what staff were doing or going to do. NA #12 said they had been about halfway through care when the incident occurred. She reported they had finished providing incontinence care and then left the room. She did not know what Staff #13 did after leaving the room or where she went. NA #12 said she reported the incident to Nurse #13 at the end of her shift at 11:00 PM.

An interview was conducted on 9/16/25 at 3:10 PM with Nurse #13. She recalled the incident on 5/28/25 with Resident #44. Nurse #13 said it was 11:10 PM and she had already done report and had done shift change with Nurse #7 when NA #12 told her what had happened. She stated NA #12 reported she had seen Staff #13 hit Resident #44 during bedtime care. Nurse #13 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fleshers Fairview Health Care	3016 Cane Creek Road , Fairview, North Carolina, 28730

(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
F0600 SS = D	Continued from page 27 asked NA #12 what she meant, and NA#12 acted out how Staff #13 swatted Resident #44's hand. She stated NA #12 said Staff #13's hand had been open when she hit Resident #44. Nurse #13 reported she went to Resident #44's room before she left to check on her and, make sure she was okay. She stated she did not see any marks on Resident #44. Nurse #13 said she reported the abuse allegation the next morning to the Director of Nursing (DON). An interview was conducted on 9/17/25 at 1:25 PM with Nurse #7. She reported she worked night shift (11pm-7am). Nurse #7 recalled the abuse incident from 5/28/25 with Resident #44. She said it had been shift change around 11:00 PM and her and Nurse #13 were doing shift change over when an NA (NA #12) came and reported another NA (staff #13) she was working with had slapped Resident #44. She stated she could not remember the names of the NAs. A written statement (undated) by the DON indicated she contacted Staff #13 on 5/29/25 about the incident. The statement said Staff #13 said Resident #44 "had become agitated during personal care the night before." Staff #13 said Resident #44 "was combative and resistant to care and had slapped her and instinctively she slapped her back on her arm." The statement reported that Staff #13 said, "she knew that she should have left the room when [Resident #44] began getting irritated with her to prevent the situation from occurring." The DON statement reported Staff #13 was immediately suspended pending further investigation and then was terminated on 6/2/25. Staff #13 was not available for interview. An interview was conducted with NA #9 on 9/17/25 at 3:37 PM. NA #9 reported she was the assigned NA for Resident #44 the day after a staff member had hit her. She stated she did not remember the staff member's name. NA #9 recalled when she went to provide care for Resident #44 the following day (5/29/25) Resident #44 acted afraid and said, "what are you going to do" "please don't hurt me". An interview and care observation was conducted on 9/18/25 at 9:18 AM of NA #15 and NA #16 with Resident #44. Resident #44 was observed in bed. NA #15 and NA #16 approached Resident #44 to provide incontinent care. They explained to Resident #44 what they were going to do. They removed her soiled brief and discarded the brief into a trash bag. NA #15 and NA #16 talked to Resident #44 during care and provided reassurance throughout entire care. NA #15 applied	F0600		

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F0600 SS = D	Continued from page 28 peri-care wash to a washcloth and explained to Resident #44 “this may be a little cold”. Resident #44 said “oh” and grabbed onto NA #15’s wrist but then let go after NA #15 provided reassurance. They provided peri-care using proper techniques and applied a new brief. They repositioned Resident #44 in her bed, adjusted her blankets, and gave her stuffed animals to her to hold when care was completed. Resident #44 did not exhibit any behaviors during care. NA #15 and NA #16 explained they usually had two NAs to provide care because sometimes Resident #44 was combative during care, NA #16 said today was a good day. NA #16 explained when they assisted Resident #44 with dressing, changed her, or did any type of care she could be combative and would hit, kick, and scream during care. NA #15 stated they try to talk to her during care to help keep her calm, reassure her, and divert her attention during care and those things usually worked to keep her calm during care. They stated when she was combative and they would give her a break, wait about 15 minutes, and then go back and see if her mood was different and better. An interview was conducted with the Administrator and Director of Nursing (DON) on 9/19/25 at 6:00 PM. The Director of Nursing stated that the abuse allegation for Resident #44 was first reported to her on the morning of 5/29/25 at 9:37 AM by Nurse #13. She said Nurse #13 reported NA #12 told her Staff #13 had slapped Resident #44 on the arm the night before. The DON said she immediately reported it to the Administrator and then called NA #12. The DON stated she interviewed NA #12 on the phone about the incident. The DON reported NA #12 said she and Staff #13 were providing care to Resident #44, and she was being resistive to care. The DON stated NA #12 had not said what type of care they were providing. The DON said NA #12 did not say what time they were in Resident’s room providing care and said she was not sure she asked her. The DON reported NA #12 told her Staff #13 was upset because Resident #44 was being resistive to care. The DON stated NA #12 did not say what Resident #44 had done specifically to upset Staff #13 just that she was being resistive to care. The Administrator stated her understanding was that Resident #44 was being combative. The DON explained NA #12 told her Staff #13 slapped Resident #44 on the hand. She stated it was reported the slap was open handed. The DON stated NA #12 reported Staff #13 said to Resident #44 “stop you’re not going to treat me like that”. The Administrator stated Staff #13 had admitted to hitting Resident #44 during care when she was interviewed about the incident. The Administrator reported the facility had substantiated the abuse allegation and that Staff	F0600		

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F0600 SS = D	Continued from page 29 #13 was terminated. The Administrator said the facility reported Staff #13 to the health care personnel investigations.	F0600		
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, §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 and staff interviews, the facility failed to implement their abuse policy and procedure in the areas of prevention, protection, reporting, and investigating. The facility failed to immediately implement protection and report abuse when Nurse Aide (NA) #12 witnessed Staff #13 grab both of Resident #44's wrists followed by slapping the	F0607	The facility staff that typically oversee investigations are the Director of Nursing and Assistant Director of Nursing. The facility policy should be followed when completing these investigations to ensure they are completed thoroughly and should include interviewing and assessing other residents that could have been affected. An in-house investigation was completed on the allegation of abuse. This investigation was completed on 6/4/25. Allegation of abuse was reported to the Director of Nursing by nurse #13 on 5/29/25. Nurse stated that the incident was reported to her by a CNA late the night before (around shift change at 11pm). The CNA that reported incident to Nurse #13 states she was in the resident's room as a witness. DON immediately called the CNA that was a witness to get her statement. In her statement she states that she was doing rounds with the Nurse Aide that was accused of abuse. She states while providing care to resident #44, resident became resistant to care and attempted to push them away. She states that NA #13 got upset and slapped at resident's hand. DON along with ADON then called NA #13. She stated to DON and ADON that resident was becoming combative and resistant to care, and instinctively slapped back at resident. She states she knew that she should have left the room and removed herself from the situation. Resident's plan of care discussing her tendency to become combative with care. Interventions in place on plan of care include verbal reassurance, talk to resident during care, approach in a calm manner, and use diversion. This allegation was reported to NCDHHS. NA #13 that was alleged with abuse was immediately (on 5/29/25) suspended from work pending investigation for the protection of other residents. Also, on 5/29/25 the Administrator called the Buncombe County Sherrif's Office regarding this incident and gave a report to dispatch. Later that day the Administrator received a call from a deputy whom the Administrator gave him the information that the facility was aware of as of this day. A deputy did not come to the facility that day. On 6/2/25 a Detective from the Buncombe County Special Investigation unit came to the facility to discuss the investigation with the Administrator and DON, and also talked to the resident. He stated he felt satisfied with how the investigation was going. He also told the Administrator that his agency had notified APS. The day the incident was reported as well as daily thereafter, the ADON assessed resident #44. She found no signs of	10/15/2025

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F0607 SS = D	Continued from page 30 resident's hand during care on 5/28/25 between 8:00 PM and 9:00 PM and did not immediately intervene and report the abuse to administration. Staff #13 continued to provide resident care to Resident #44 and worked on the floor for the remainder of her shift. On 5/28/25 at approximately 11:00 PM NA #12 reported the incident to Nurse #13 and Nurse #7 and the administration was not notified of the incident until the following morning (5/29/25) when Nurse #13 reported the allegation to the Director of Nursing (DON). The facility failed to thoroughly investigate the allegation of abuse when they did not interview or assess other residents who had the potential to be abused by Staff #13. This deficient practice affected 1 of 3 residents reviewed for abuse and had the potential to affect other facility residents (Resident #44). Findings included: A policy and procedure dated "3/17" entitled "Resident Rights, Resident Abuse" indicated the policy prohibited abuse neglect, and exploitation of residents and misappropriation of resident property. The policy included the following information: - Physical abuse included hitting, slapping, pinching, and kicking. -Prevention: the facility tries to identify, correct, and intervene in situations in which abuse is more likely to occur by having trained, qualified, registered, licensed, and certified staff in sufficient numbers to meet the needs of the residents. -Investigation: anyone who witnesses or has knowledge of an act or suspected act of abuse shall notify his/her charge nurse, immediate supervisor, Director of Nursing, Social Services, Administrator, or any other management personnel that they feel comfortable reporting to. Once management personnel have received such a report they shall go immediately to the Administrator, DON, or Social Service Director, who will start the investigation process. - The facility will report allegations of resident abuse immediately but not later than 2 hours after the allegation is made. - The facility will collect statements from each witness, resident victim, and alleged perpetrator; and interview other residents in the same location where the alleged violation occurred.	F0607	Continued from page 30 injury or change in mood/behavior. Upon completion of the facility investigation, the allegation was substantiated, and NA #13 was terminated on 6/2/25. A representative from NCDHHS continued the investigation which included coming on site for follow up (came onsite 7/16/25). Upon the completion of this, the employee was posted to the NC personnel registry. Other residents have the potential to be affected by not having a thorough investigation completed. The Administrator (who is also a Registered Nurse) and Director of Nursing completed chart reviews of residents that had the potential to be affected. Charts reviewed were of the residents NA #13 would have provided care to. This was isolated to one wing of the building. Charts reviewed warranted no changes that would be concerning that these residents were affected by a thorough investigation not being completed. Review of these residents' charts including looking for injury/bruising of unknown origin, changes in behavior, and changes in reaction to staff care. Record review was completed on 10/15/25. Review of the investigations completed in the last year was reviewed by the Administrator. 1 out of 5 did not follow the part of the facility policy that involves completing a thorough investigation. The one that did not follow the facility policy for thoroughness, was accurate in its conclusion, but did not involve interviews with other staff and residents. This could have added more information to the investigation. Since the Director of Nursing, Assistant Director of Nursing, and SDC complete facility complaint investigations, education was provided to them by the Administrator on 10/15/25. This training was a review of the facilities Resident Abuse policy and specifically the policy on how to conduct a thorough investigation. In person training was completed by the Director of Nursing starting on 6/2/25 to all nursing staff on how to properly care for a resident that is exhibiting difficult behaviors. This training was completed on 6/9/25. NA #12 attended this training. Online training was also assigned on 6/3/25 to all staff in every department on identifying and reporting abuse and neglect. Education included timely reporting. This training of reporting, specifically timely reporting, reflects the facilities policy and procedures that states any suspicion or knowledge of resident abuse should be reported immediately. Online training also included a post test that staff had receive a passing score of 80% to be marked as completed. NA #12 and Nurse #7 completed this training.	

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F0607 SS = D	Continued from page 31 -Protection: The facility will protect the residents and other residents from further acts of abuse; protection could include responding immediately to protect the alleged victim. Resident #44 was admitted to the facility on 6/24/24. Her diagnoses included dementia. A facility reportable incident investigation report dated 6/4/25 had been prepared by the Assistant Director of Nursing (ADON). The investigation report indicated the facility had become aware of the abuse allegation on 5/29/25 and submitted an initial allegation report to the State agency. The investigation stated on 5/28/25 NA #12 reported to Nurse #13 during shift change at 11:00 PM that she witnessed Staff #13 hit Resident #44 during care. The report did not state what time the alleged abuse occurred on 5/28/25. The report stated Nurse #13 reported the abuse allegation to the DON the following morning on 5/29/25. The facility reported the incident to the local police department and State Agency on 5/29/25 after they became aware of the alleged abuse allegation. The investigation revealed NA #12, Staff #13, and Nurse #13 were interviewed by the DON. The facility investigation did not indicate if the facility assessed or interviewed other residents regarding abuse that Staff #13 had provided care for. The investigation revealed Staff #13 admitted to hitting Resident #44 during care. The abuse allegation was substantiated by the facility and Staff #13 was terminated on 6/2/25. The allegation was reported to the local department of social services on 6/2/25. Review of Staff #13's time record indicated she left at the end of her shift on 5/28/25 at 11:05 PM. There were no recorded time punches after 5/28/25. Staff #13 was not available for interview. An interview was conducted on 9/16/25 at 3:02 PM with Nurse Aide (NA) #12. She recalled the incident from 5/28/25 with Resident #44 and Staff #13. NA #12 stated between 8:00 and 9:00 PM she and Staff #13 entered Resident #44's room to provide incontinence care. She said they were in her room for about 10 minutes providing care. She said when they began to provide incontinence care Resident #44 started saying "stop", "no", and was pushing their hands away. NA #12 reported Staff #13 grabbed both of Resident #44's wrists and yelled at her to "stop" and then slapped Resident #44 on the hand. She did not remember which one of Resident #44's hands Staff #13 slapped but said she had slapped	F0607	Continued from page 31 Training was completed on 7/9/25. On 5/29/25 when nurse #13 reported the incident to DON, DON educated nurse #13 on reporting abuse immediately. Training on identifying and reporting, residents' rights (which includes abuse training), and how to care for residents with difficult behaviors, has been added to new hire orientation as well as yearly orientation that is completed by all staff in all departments every year in August. The Administrator will oversee any active investigations and review completed investigations to ensure the investigation involves all aspects of the facility policy. Documentation of the monitoring will be maintained and presented by the Administrator at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Monitoring will continue until compliance maintained for one month or longer if the QAPI committee recommends. Completion date 10/15/25.	

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F0607 SS = D	Continued from page 32 her with an open hand. NA #12 said they had been about halfway through care when the incident occurred. She reported they finished providing incontinence care and then left the room. She did not know what Staff #13 did after leaving the room or where she went. NA #12 said she reported the incident to Nurse #13 at the end of her shift at 11:00 PM. She stated the oncoming shift nurse (Nurse #7) was also present when she reported the incident. NA #12 explained she waited until the end of the shift to report the abuse because she had been startled by what happened and said she had not had training on what to do. She explained this was her first job as an NA and what happened had shocked her. NA #12 said she did not know she had to report abuse immediately until after the incident. An interview was conducted on 9/16/25 at 3:10 PM with Nurse #13. She recalled the incident on 5/28/25 with Resident #44. Nurse #13 said it was 11:10 PM and she had already completed her off-going report to the next shift nurse, Nurse #7, when NA #12 told her what had happened. She stated NA #12 reported she had seen Staff #13 hit Resident #44 during bedtime care. Nurse #13 stated she asked NA #12 what she meant, and NA#12 acted out how Staff #13 swatted Resident #44’s hand. She stated NA #12 said Staff #13’s hand had been open when she hit Resident #44. Nurse #13 reported she went to Resident #44’s room before she left to check on her and make sure she was okay. She stated she did not see any marks on her. Nurse #13 said she reported the abuse allegation the next morning to the DON. Nurse #13 stated Staff #13 had already left and at the time she did not feel like it was her shift but said in hindsight the incident had happened on her shift. Nurse #13 said she was not sure what to do being told after it had happened. She explained she could not get statements or do anything at that point because the accused staff member (Staff #13) had already left. Nurse #13 stated she could not imagine seeing that happen and working the rest of the shift without telling anyone. Nurse #13 thought NA #12 had waited around intentionally for the other girl (Staff #13) to be gone before reporting the incident. Nurse #13 said she regretted how she handled the situation. She explained at the time she did not know what to do other than to tell NA #12 to write a statement and that she would tell the managers in the morning. Nurse #13 stated she was scheduled to come back to work the next morning. She explained she and Nurse #7 had talked about the abuse allegation and reporting it and decided together to tell the managers in the morning because Nurse #13 did not know what to do. Nurse #13 again said she should have handled the situation differently, but she was upset that NA #12 had not told her what	F0607		

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F0607 SS = D	Continued from page 33 happened, when it happened, and had let Staff #13 work the entire rest of the shift. Nurse #13 stated when an abuse allegation was reported she was supposed to send the accused staff member home, take statements, and call the DON and Administrator to report the abuse allegation immediately. An interview was conducted on 9/17/25 at 1:25 PM with Nurse #7. Nurse #7 recalled the abuse incident from 5/28/25 with Resident #44 and indicated she worked the night shift that evening (11:00 PM to 7:00 AM). She said it was around 11:00 PM and she and Nurse #13 were doing shift change over when NA #12 reported Staff #13 had slapped Resident #44. Nurse #7 stated she thought NA #12 had been waiting for people to leave and said she thought NA #12 had been scared to speak up. She said they (Nurse #7 and Nurse #13) told NA #12 to write down a statement of what had happened. Nurse #7 said it was not her shift when the abuse allegation had happened, and she assumed Nurse #13 reported the abuse allegation. Nurse #7 stated she did not go to Resident #44's room to check on her or see if there were any marks after the incident was reported. She said she did not know if Nurse #13 had gone and checked on Resident #44 or not. Nurse #7 explained she and Nurse #13 had a conversation about the incident needing to be reported and Nurse #13 had said she would take care of it in the morning because Nurse #13 was working again the following morning. Nurse #7 stated she had received abuse training and that she was supposed to notify the DON and Administrator immediately of an abuse allegation. Nurse #7 said reporting the abuse allegation the following morning would not be considered immediately. Nurse #7 stated at the time she had thought it was okay to report it in the morning. Nurse #7 stated the abuse allegation should have been reported immediately that night and she should have gone and checked on Resident #44 to see if she had any marks and was okay after the abuse allegation was reported. A written statement (undated) by the DON indicated she contacted Staff #13 on 5/29/25 about the incident. The statement said Staff #13 said Resident #44 "had become agitated during personal care the night before." Staff #13 said Resident #44 "was combative and resistant to care and had slapped her and instinctively she slapped her back on her arm." The statement reported that Staff #13 said, "she knew that she should have left the room when [Resident #44] began getting irritated with her to prevent the situation from occurring." The DON's statement reported Staff #13 was immediately suspended pending further investigation and then was terminated on 6/2/25.	F0607		

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F0607 SS = D	Continued from page 34 An interview was conducted with the Administrator and DON on 9/19/25 at 6:00 PM. The Administrator stated Staff #13 admitted to hitting Resident #44 during care on 5/28/25 when she was interviewed on 5/29/25 about the incident. The Administrator reported Staff #13 was terminated and the facility had reported Staff #13 to healthcare personnel investigations. The DON stated that the abuse allegation for Resident #44 was first reported to her on the morning of 5/29/25 at 9:37 AM by Nurse #13. She said Nurse #13 reported NA #12 told her Staff #13 had slapped Resident #44 on the arm the night before. The DON said she immediately reported it to the Administrator and then called NA #12. The DON stated she interviewed NA #12 on the phone about the incident. The DON said NA #12 did not say what time they were in Resident #44's room providing care and said she was not sure she asked her. The DON explained NA #12 told her Staff #13 slapped Resident #44 on the hand. She stated it was reported the slap was open handed. The DON and Administrator stated they had thought the incident had occurred at the end of Resident #44's care. The DON stated she had not asked when during care the incident had happened. The DON said it was unknown how much longer NA #12 and Staff #13 were in the room after Staff #13 slapped Resident #44. The DON and Administrator stated they did not know what time the incident had happened but thought the incident occurred during last rounds and said that it would be between 9:30 pm and 10:00 pm. They were not aware NA #12 said the incident occurred between 8:00 pm and 9:00 pm until the Surveyor notified them today. They said it should not have happened that Staff #13 remained at the facility for 2 to 3 additional hours potentially providing resident care. The DON stated she could not say for sure that she asked during any of the interviews if Staff #13 provided care for any residents after the incident. The Administrator stated she could not say because she did not do the interviews. The Administrator reported Nurse #13 had been notified of the abuse allegation around shift change (11:00 PM) by NA #12 and said Nurse #7 had been present. The DON stated she felt like she had asked NA #12 why she had waited to report the abuse allegation but could not say for sure what NA #12 had said. The DON said abuse was supposed to be reported immediately. She explained Staff #13 slapping Resident #44 was abuse and should have been reported immediately. The DON said if it had been reported Staff #13 would have been suspended immediately and not allowed to work the remainder of the shift. The DON said because Staff #13 had worked the remainder of her shift she could have struck another resident. The DON and Administrator said they were not sure if Nurse #13 or Nurse #7 had assessed and	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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F0607 SS = D	Continued from page 35 checked on Resident #44 after the incident happened, but the Administrator stated she assessed the resident the next morning and she did not see any marks. When asked if someone should have assessed the other residents that Staff #13 had access to, the DON and Administrator said yes. The DON and Administrator stated they had not assessed or interviewed any other residents about abuse during their investigation. They reported a skin assessment was completed for Resident #44 but not for any other residents. They agreed they should have assessed and interviewed other residents. The Administrator stated they did not effectively implement their abuse policy.	F0607		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute	F0641	The facilities MDS nurse immediately submitted modification assessments on the residents identified with PASRR and wound coding inaccuracy. All residents in the facility had the potential for being affected by the inaccurate coding on the MDS assessment. MDS coordinator has audited every resident's recent MDS assessment for coding accuracy of PASRR and wound coding. This audit was completed on 10/15/25. In-service training was completed by the Administrator with the MDS coordinators on 10/15/25 involving the importance of accurately coding the MDS. DON or designee will monitor all new assessments for coding accuracy of residents PASRR as well as wound coding. Any discrepancies will be addressed with the MDS Coordinators immediately. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Monitoring will continue until compliance maintained for one month or longer if the QAPI committee recommends. Completion Date 10/15/25	10/15/2025

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F0641 SS = D	Continued from page 36 a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Preadmission Screening and Resident Review (PASRR) Level II (Resident #4 and Resident #2) and Pressure Wound (Resident #2) for 2 of 19 residents reviewed for MDS accuracy (Resident #2 and Resident #4). The findings included: 1. Resident #4 was admitted to the facility on 4/12/21. Her active diagnoses included bipolar disorder. Resident #4's electronic health record contained a PASRR Level II determination notification dated 12/07/23 with no end date. The annual MDS dated 4/20/25 indicated Resident #4 was not coded for Level II PASRR. An interview on 9/17/25 at 8:21 AM with MDS Nurse #1 revealed Resident #4's PASRR was coded as Level I and should have been coded as Level II. She stated it was a human error mistake. An interview on 9/18/25 at 11:40 AM with the Administrator revealed she did not know why Resident #4's PASRR was coded as Level I when it should have been coded as Level II. She stated it must have been a coding error. 2.Resident #2 was admitted on 2/9/18 with an active diagnosis of bipolar disorder. A review of Resident #2's electronic health record found a PASRR Level II determination notification dated 6/12/23 with no end date. A review of Resident #2's Annual Minimum Data Set (MDS) dated 6/3/25 found she was not coded for Level II PASRR. An interview with MDS Nurse #1 was conducted on 9/19/25 at 12:41 PM. MDS Nurse #1 stated Resident #2 has a	F0641		

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F0641 SS = D	Continued from page 37 level II PASARR determination and should have been coded for a level II PASARR on her annual MDS assessment. The Administrator was interviewed on 9/19/25 at 4:40 PM. The Administrator stated Resident #2's annual MDS should have coded the level II PASARR. The Administrator said the level I PASARR was coded in error. 3.Resident #2 was admitted on 2/9/18 with diagnoses of vascular dementia and hemiparesis and hemiplegia of left side following a stroke. A review of Resident #2's quarterly Minimum Data Set (MDS) dated 9/2/25 coded Resident #2 as having 1 stage 1 pressure ulcer. A review of Resident #2's electronic health record found Resident #2 developed a pressure ulcer on 9/5/25. An interview with the MDS Nurse #1 was conducted on 9/19/25 at 12:41 PM. MDS Nurse #1 stated Resident #2 did not have a pressure wound when the quarterly MDS was completed 9/2/25. She stated Resident #2 should not have been coded for a pressure wound and it was an input error. The Administrator stated on 9/19/25 at 4:40 PM Resident #2's MDS should accurately reflect her conditions. The Administrator stated Resident #2 should not have been coded for a pressure wound, and it was an error.	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F0657	Review of resident record including her care plan dated 7/31/25. Care Plan was revised on 9/8/25 which added a goal of "resident will demonstrate improved skin integrity, AEB no increase in size of Right Heel Wound through next review date. Interventions added: 9/8/25-Wound care consult for right heel wounds. Doxycycline x 10 days. 9/11/25 right Heel wound is an unstageable PU. 9/15/25-Per wound care. Right heel is a DTI with developing eschar. 9/22/25-Supplements added to aid wound healing including Med Pass and Pro-stat (care plan in attachments). Other residents have the potential to be affected by not having a wound addressed on their care plan. MDS coordinator has audited all residents with wounds and ensured they are addressed appropriately on their care plan. This was completed on 10/15/25. In-service training was completed by the Administrator	10/15/2025

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F0657 SS = D	Continued from page 38 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observation, and staff interviews, the facility failed to revise the care plan in the area of pressure ulcers (Resident #8) for 1 of 3 residents reviewed for pressure ulcers. The findings included: Resident #8 was admitted to the facility on 07/17/25 with diagnoses that included history of cerebral vascular accident (CVA) and diabetes mellitus. Review of Resident #8's admission Minimum Data Set (MDS) assessment dated 07/21/25 revealed the Resident's cognition was severely impaired, required substantial to maximal assistance with most of her activities of daily living and she did not have pressure ulcers on admission. Review of Resident #8's care plan dated 07/31/25 revealed Resident #8 had the potential for impaired skin integrity related to decreased mobility, incontinence and poor appetite. The goal that Resident #8 would maintain skin integrity as evidence by no development of pressure ulcers or peri area excoriation through the next review. The goal would be attained by utilizing interventions such as assisting and turning frequently, monitoring her skin for any open areas and notifying the nurse immediately and providing treatments as ordered. Review of Resident #8's medical record revealed a progress note dated 09/09/25 at 11:56 AM written by the Wound Nurse read in part…an unstageable wound was found to Resident #8's right heel of black eschar and measuring 3.5 centimeters (cm) x 3.5 cm with foul	F0657	Continued from page 38 with the MDS coordinators on 10/15/25 involving the importance of timely updating each resident's care plan. DON or designee will monitor the care plans for any residents with wounds for accuracy and timely updates 3x/week until compliance maintained for one month or longer if the QAPI committee recommends. Any discrepancies will be addressed with the MDS Coordinators immediately. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Monitoring will continue Completion Date 10/15/25	

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F0657 SS = D	Continued from page 39 smelling odor. Obtained new treatment orders and to wear soft boot at all times. The note also revealed the Medical Director was notified and orders were received to start an antibiotic, obtain an X-ray on the right heel and to obtain a Wound Consult. There was no revised care plan for the development of the unstageable pressure ulcer to Resident #8's right heel. An interview was conducted with the Minimum Data Set (MDS) Nurse # 1 on 09/19/25 at 2:25 PM. The MDS Nurse explained that the care plans were updated quarterly and as needed when situations arise. She continued to explain that pressure ulcer development was an issue that was care planned "pretty quick" because the nurses were good to inform us on those developments and we will revise the care plan. She also indicated that she was informed of new pressure ulcer developments in the morning clinical meeting and she will update the care plan when she returned to her office. The MDS Nurse continued to explain that she vaguely remembered learning of Resident #8's new pressure ulcer in the morning clinical meeting but somewhere between the meeting room and her office she had forgotten to update the care plan. The MDS Nurse stated it was important for the care plan to be updated to reflect the Resident's status so that appropriate care can be delivered. On 09/19/25 at 6:00 PM an interview was conducted with the Administrator who explained that it was the MDS Nurses' responsibility to revise the care plans for new developments including new pressure ulcers right away in order to deliver quality care to the residents. The Administrator indicated it was her expectation that the care plans be revised as soon as issues arise.	F0657		
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to provide activity of daily living (ADL) care for dependent residents when Resident #28 and Resident #11 did not receive showers. This deficient practice affected 2 of	F0677	Dependent residents should receive assistance from staff with ADL's including bathing. Residents identified in statement of deficiency (#28 and #11) were assisted with showers as scheduled since 9/23/25. Neither have refused a shower or missed a scheduled day. Other residents have the risk to be affected by this deficient practice if they were not offered assistance with showers. The facility policy states residents are to be offered and assisted with a shower twice per week. Record review has been completed on all residents in the facility. This was completed by the ADON on 10/7/25 to observe 2 weeks of scheduled showers. All residents were offered and given showers other than 12	10/16/2025

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F0677 SS = E	Continued from page 40 4 residents reviewed for ADL care (Resident #28 and Resident #11). Findings included: a. Resident #28 was admitted to the facility on 1/19/24. His diagnoses included muscle weakness, difficulty walking, age related physical disability, osteoarthritis, cerebral infarction (stroke), and intervertebral disc disorder (spine disorder that can lead to back problems that can cause pain, numbness and weakness in the legs or arms). The quarterly Minimum Data Set (MDS) assessment dated 9/6/25 indicated Resident #28 was cognitively intact. The MDS stated he required supervision and touching assistance with showers. He used a wheelchair and needed setup/ clean up assistance with feeding and oral hygiene. The MDS documented Resident #28 did not have behaviors or rejection of care. A care plan last revised on 6/25/25 was in place for impaired mobility and ADL deficit related to debility and muscle weakness. The care plan goal was for Resident #28 to maintain current mobility and ADL status through the next review. The care plan interventions included assisting with hygiene by setting up supplies and assisting as needed to complete tasks. The care plan included he used a wheelchair for mobility and could usually dress himself. He had a fall risk care plan last revised on 6/25/25 in place related to debility, weakness, and cardiac medications that said to give verbal reminders to not transfer without assist when feeling weak and unsteady. Resident #28's scheduled shower days were on Monday and Thursday. The last time a shower was documented as provided was 9/11/25. Review of shower sheets revealed there was no documentation Resident #28 received a shower on 8/4/25, 8/18/25, 8/21/25, 9/8/25. An interview and observation were conducted on 9/15/25 at 3:49 PM with Resident #28. He stated that he did not receive showers often at the facility because they were short of help. He explained that the shower team Nurse Aides (NAs) were pulled to work on the floor when the facility was short staffed or there were call outs. Resident #28 stated this happened frequently and when it happened showers were not given, and he did not get his showers. He said the facility did not give showers the next day to make up the shower if it was missed. He explained if he missed a shower he had to wait until his next scheduled shower day to get a shower if they	F0677	Continued from page 40 times that a shower was refused by a resident. The Administrator has in-serviced the Director of Nursing and Assistant Director of Nursing on the necessity to monitor the shower schedule/documentation to ensure residents are being assisted with showers. This training was completed on 10/15/25. Systemic process changes that have been put into place include DON and ADON will call in additional staff, assign showers to Nurse Aides on the floor for first and second shifts, or adjust resident shower schedules to different days of the week to ensure residents are offered, and are assisted with showers twice per week. The Director of Nursing will monitor the compliance of residents receiving assistance from staff with ADL's including bathing 2x/week x 4 weeks or until compliance is met. This will be overseen by the Administrator. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the Director of Nursing where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion date 10/16/25	

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F0677 SS = E		F0677		

Continued from page 41
had staff to do it. Resident #28’s hair was trimmed short; there was no body odor noted.

b. Resident #11 was admitted to the facility on 1/3/25. With diagnoses that included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle weakness, need for assistance with personal care, abnormalities of gait and mobility, transient ischemic attack (TIA) (temporary episode of stroke-like symptoms)

A significant change MDS assessment dated 7/17/25 indicated Resident #11 had moderate cognitive impairment. The MDS recorded she was dependent on staff for showers. The MDS documented Resident #11 did not have behaviors or rejection of care.

A care plan revised on 7/25/25 was in place for impaired mobility and ADL deficit related to TIA with right sided weakness, debility, and fractured left ankle. The care plan interventions included “Resident will do as able, if unable to complete task assist resident to finish them”.

Resident #11 was supposed to receive a shower on Mondays and Thursdays. The last time a shower was documented as provided was 8/25/25. Review of shower sheets revealed there was no documentation Resident #11 received a shower on 8/4/25, 8/14/25, 8/18/25, 8/21/25, 9/1/25, 9/4/25, 9/8/25, 9/11/25

An observation and interview were conducted with Resident #11 9/15/25 at 11:30 AM she stated recently she had not been getting showers. She was observed in her bed, her hair was uncombed and greasy, there was no odor noted.

An interview was conducted on 9/16/25 at 11:26 AM with the shower team, NA #1 and NA #3. They explained the facility had one shower team and they were the only shower team NAs. They further explained they both worked Monday, Tuesday, Thursday, and Friday from 7:00 AM to 5:00 PM. They said residents were supposed to receive two showers a week. The shower team NAs reported all the residents on halls 100, 200, and 300 were supposed to receive a shower every Tuesday and Friday and all the residents on halls 400, 500, and 600 were supposed to receive a shower every Monday and Thursday. NA #1 and NA #3 stated on average they each gave 15 to 17 showers every shower day. NA #1 and NA #3 reported last week they had been pulled 3 out of 4 of the days they were supposed to give showers to work on

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F0677 SS = E	Continued from page 42 the floor and that over the last couple of weeks it had been the same. NA #1 said yesterday (9/15/25) both her and NA #3 had been pulled to the floor to work, and no showers were given. NA #1 stated today (9/16/25) one of them was getting pulled at 12:30 PM and the other was going to be pulled at 3:00 PM to work on the floor for the remainder of their shift. They reported they would not be able to give showers to all the residents who were supposed to get them today because they were being pulled. NA #1 explained when they knew ahead of time, they were going to be pulled they tried to give showers to the residents who they knew would complain about not getting their showers first, before they gave other residents their showers. They both stated they did not feel like 2 NAs on the shower team were enough staff to be able to complete all the residents showers each shower day even if they were not pulled to the floor. NA #3 and NA #1 said they had been asking for another shower team to help because they could not get all the showers done. NA #1 and NA #3 said they had talked to the Assistant Director of Nursing (ADON) and Director of Nursing (DON) about needing extra help to get all the resident showers completed. NA #1 and NA #3 reported they each had 15 showers they were supposed to give on Mondays/ Thursdays and 18 showers each they were supposed to give on Tuesdays/ Fridays. They both explained that even if they were not pulled to the floor and they were both giving showers it was difficult to get all the showers completed each day and sometimes they were not able to get to all the residents who were supposed to get a shower. NA #1 and NA #3 said the NAs on the floor did not give showers and that if they were pulled to work the floor showers were not given that day. NA #3 and NA #1 reported if a shower was missed it was a missed shower until the resident's next scheduled shower. NA #1 and NA #3 both said recently they had been getting pulled almost every day. NA #1 and NA #3 said typically both were being pulled from showers to work the floor. Shower Team NA #1 and NA #3 stated they recalled many times when Resident #28 and Resident #11 did not get their showers because she and NA #3 had been pulled to the floor. They reported if there was not a shower sheet for a specific day or a resident's name was not highlighted on the shower sheet then the residents had not received a shower that day. An interview was conducted with NA #9 on 9/17/2025 at 3:37 PM. She reported that the shower team was pulled to work on the floor a lot and when that happened residents did not get showers. She explained the floor NAs did not give showers or baths to residents when the shower team was pulled.	F0677		

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F0677 SS = E	Continued from page 43 An interview was conducted with NA #10 on 9/19/25 at 9:30 AM. NA #10 explained she was the unit clerk. She said she and the shower team NAs were pulled quite a bit to work on the floor. NA #10 stated if the shower team was pulled to the floor, then no showers would be given. An interview was conducted on 9/19/25 at 9:00 AM with NA #11. She reported that staffing was a struggle sometimes. She said showers were given when the shower team was not pulled to the floor to work. She explained the shower team NAs were pulled to the floor when they were short staffed. She said the shower team NAs were frequently pulled and that resident showers did not get done when the shower team was pulled to the floor and they were short staffed. An interview was conducted with the Assistant Director of Nursing (ADON) on 9/17/25 at 10:49 AM. She stated the shower team NAs were pulled to work on the floor a lot and that when they were pulled showers were not given by the floor staff. She reported there was not a process in place for residents to receive showers when the shower team was pulled. An interview was conducted on 9/18/25 at 5:11 PM with the Administrator, Director of Nursing (DON) and ADON. The Administrator stated she was unsure how often the shower team was pulled to work on the floor. The DON stated recently it had happened more frequently because staff had been out for various reasons. The DON explained there were two Shower Team NAs, NA #1 and NA #3 and they worked four days a week on Monday, Tuesday, Thursday, and Friday. The DON reported the ADON was supposed to monitor showers. The DON explained that the shower team gave a list of showers completed each day to the ADON. The DON stated Residents were supposed to receive showers twice a week unless they preferred otherwise. The DON and the ADON said residents should be getting showers. The DON reported residents were not getting showers because the shower team NAs were being pulled to the floor to work or one of the shower team NAs was out and not all the showers could be completed. The DON explained that if one of the shower team NAs was out, they tried to fill the shift with another NA by offering the shift as an extra shift NAs could pick up. The DON, ADON, and Administrator stated there was not a process to ensure residents received showers if the shower team NAs were pulled to work the floor. The DON said she was aware the shower team NAs were getting pulled but was not aware of the extent. The ADON stated she was aware residents did not receive showers when the shower team was pulled to the floor and that some residents had complained about not getting showers. The	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345413**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/22/2025**

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F0677 SS = E	Continued from page 44 DON said residents had not complained to her about not receiving showers. The DON and Administrator reported they did not realize the extent of residents not receiving showers or that it was as big of an issue. The Administrator stated residents should receive showers and there needed to be a better process for showers to ensure residents received showers.	F0677		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews with staff, Wound Nurse Practitioner, Nurse Practitioner (NP), and Medical Diractor the facility failed to provide skin assessments, failed to identify a new wound on the heel at the onset, and failed to ensure necessary medical treatment when positive culture and sensitivity results were available Resident #2. This delayed the treatment for an infected wound. This was for 1 of 2 residents (Resident #2) reviewed for quality of care. Findings included: The findings included: Resident #2 was admitted on 2/9/18 with diagnoses of vascular dementia and hemiparesis (one-sided muscle weakness) and hemiplegia (one-sided paralysis or weakness of the face, arm and leg) of left side following a stroke. A review of Resident #2's quarterly Minimum Data Set (MDS) dated 9/2/25 coded her with severe cognitive impairment. Resident #2 was coded for one (1) stage one pressure ulcer, needing maximal assist with rolling, and total dependence on transfers. Resident #2 was care planned for do not resuscitate with comfort measures(1/24/25). Interventions included	F0684	All residents should receive quality care based on professional standards of practice. Resident #2 has continued to be followed by the wound care PA weekly and has provided the facility with weekly updates and progress notes. Antibiotics were started on 9/17/25. Other residents have the potential to be affected if they have not had a head-to-toe skin assessment completed. DON and ADON are completing and documenting head to toe skin assessments on all resident in the facility. This will be completed by 10/17/25. DON, ADON, SDC, and Weekend Supervisor are completing in-service training to all nurses on the importance of completing timely initiation of wound treatment and notifying providers of lab results, including cultures and sensitivities. In-service training also includes leaving communication the wound care book regarding any new skin issues. DON has also educated the unit clerk on emailing all lab results, even if they have not been completed, to the Medical Director daily. In-service education will be completed by 10/21/25. DON or designee will be checking the wound care communication book daily to ensure all new skin issues have appropriate interventions initiated. The DON or designee will also monitor to ensure the Medical Director has been notified of all new wounds and abnormal labs timely. This monitoring will be 3x/week until compliance is maintained for one month or longer if the QAPI committee recommends. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Completion Date 10/21/25	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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F0684 SS = G	Continued from page 45 to notify the residents family and MD if resident condition worsened (7/4/24). A care plan for skin related to hemiplegia and wound on bottom (4/24/25). Interventions included excoriation on buttocks treated with zinc (3/27/25), air overlay discontinued per resident request (3/27/25), assist and turn frequently (7/9/24), cleanse peri area in AM and PM following each episode of incontinence episode (7/9/24), follow in-house wound care(7/9/24), cushion to chair and panacea mattress(pressure reducing mattress) to bed (1/2/25), monitor nutrition (7/9/24), and monitor skin for any redden or open areas. Notify nurse immediately (7/9/24). A review of Resident #2's medical record found there were no weekly skin assessments documented for Resident #2. On 9/5/25 the Medical Director saw Resident #2 and his progress note was reviewed. The Medical Director wrote there was a 5-centimeter (cm) erythematous plaque (raised, flat skin area that is red in color) on Resident #2's upper left back and a similar wound on her sacrum. The Medical Director wrote the chronicity and characteristics of the wounds suggested a potential for infection and poor healing. The plan from the Medical Director was to consult wound care specialist for further evaluation and treatment recommendations and ordered alginate (dressing used to keep wound moist for healing) dressing for wound management on both wounds. A review of Resident #2's September 2025 physician orders included an order dated 9/8/25 to float heels every shift. On 9/18/25 at 4:10 PM a Nurse Aide (NA) #3 who was on the shower team was interviewed. She stated Resident #2 had received a shower on 9/9/25, and she completed a skin assessment for Resident #2. NA #3 said Resident #2 did not have an open wound on her left heel, but only a red area on it. NA #3 stated she communicated the red area to Resident #2's assigned nurse on the second shift. Resident #2's assigned second shift nurse on 9/9/25, Nurse #6, was interviewed on 9/18/25 at 5:12 PM. Nurse # 6 stated she did not recall NA #3 telling her about a red area on Resident #2's left heel on 9/9/25. Nurse #6 stated she became aware of the left heel wound on 9/10/25 from the Wound Nurse. A progress note written by Wound Nurse dated 9/10/25 at 2:05 PM wrote she found an open area on Resident #2's	F0684		

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F0684 SS = G	Continued from page 46 left heel. The note read the open area was unstageable and measured 2 (cm) x 1.5 (cm). The Wound Nurse wrote the area around the open area was red with blanchable redness. The wound did not contain an odor, and the area was cleaned and a dressing was applied. On 9/18/25 at 1:15 PM the Wound Nurse was interviewed. The Wound Nurse stated she first saw Resident #2's heel wound on 9/10/25 and documented the wound in a progress note. The left heel wound measured 2(cm) x 1.5 (cm) and did not contain an odor or drainage. The Wound Nurse said she treated the left heel wound with standing wound orders and notified the Wound Nurse Practitioner the following day, as she was scheduled to be in the facility. Additionally, she thought she had communicated the wound to the medical provider when she found it 9/10/25. On 9/11/25 the Wound Nurse Practitioner evaluated the left heel dorsal wound. The Wound Nurse Practitioner treatment note read that given the dorsal location of this wound, it was consistent with a diabetic etiology. The wound was deep and full of necrotic slough (dead tissue) and suspected the wound had been present for some time. The treatment note also included the estimated depth to bone was less than 2 millimeters. Additionally, the Wound Nurse Practitioner wrote that a medically necessary sharp debridement was indicated and performed for the removal of excessive necrotic tissue and for the promotion of wound healing. The note continued with treatment orders to cleanse left heel wound with a full-strength antiseptic solution and then apply full strength (0.5%) antiseptic solution moistened gauze to the full depth of the wound bed. Finally, the wound was to be covered with a silicone bordered super absorbent dressing. The treatment was to be completed daily and PRN (as needed). An additional order was for a wound culture and sensitivity and x-ray of left heel for evaluation of evidence for presence of osteomyelitis (infection in a bone) and underlying pathology. The Wound Nurse Practitioner also wrote for labs of complete blood count, C reactive protein, and erythrocyte sedimentation rate. The Wound Nurse Practitioner also wrote that the resident was to always wear a podus boot (foot brace to prevent bedsores) for offloading. The Wound Nurse Practitioner was interviewed via phone on 9/18/25 at 1:30 PM and stated Resident #2 was evaluated by her on 9/11/25 for the first time. Resident #2 was evaluated for 3 wounds with one being the left heel diabetic wound. The Wound Nurse Practitioner stated the left heel wound had yellow necrotic slough and it was difficult to measure the	F0684		

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F0684 SS = G	Continued from page 47 depth but suspected it was to the bone. The provider said she could not state how long the left heel wound had been present. She stated Resident #2 had comorbidities including poor nutrition, and it would be plausible for her heel wound to develop quickly from a small area to the way it presented when evaluated. Furthermore, the Wound Nurse Practitioner stated she had ordered a culture and sensitivity for the left heel wound, along with other labs and an x-ray to determine if osteomyelitis was a factor on 9/11/25. On 9/11/25 at 2:37 PM the Wound Nurse wrote Resident #2 had 3 wounds. An opened area to the upper left section of her back on a bony prominent area that was covered with alginate for three days. Resident #2 also has a wound on her sacral area and on her left heel that were both covered. On 9/11/25 at 12:47 PM a Unit Clerk progress note read the ordered labs for Resident #2's CBC (complete blood count), CRP (C reactive protein), and ESR (erythrocyte sedimentation rate), were drawn and awaiting lab pick up. On 9/11/25 at 12:48 PM the Unit Clerk wrote a progress note. The note read that the orders for Resident #2's wound culture of left heel were collected by the Wound Nurse Practitioner and awaiting pick up. Lab results reviewed found a wound culture and sensitivity lab result for Resident #2. The lab result included the ordered date of 9/11/25 and the verified final date of 9/14/25. The wound culture and sensitivity results found moderate proteus mirabilis (bacteria) and scant staphylococcus aureus (bacteria). Results for an x-ray of Resident #2's left heel ordered on 9/11/25 and completed on 9/11/25 found no osteomyelitis. On 9/15/25 the Wound Nurse Practitioner provided treatment to the residents' left heel. A review of the treatment note found the measurements for the left heel diabetic ulcer were 2 centimeters (cm) x 1.5 cm x 1.5 cm. The wound contained 80% necrotic tissue with yellow seropurulent (discharge of serum and pus) drainage. The treatment note included the left heel wound had not improved from the previous treatment day, but the adherent slough that was present last week (9/11/25) was mostly liquefied and ran out of the wound when the dressing was removed. The Wound Nurse Practitioner wrote she was unable to assess with certainty if the drainage included purulent drainage mixed with liquified yellow green slough. Additionally, the Wound	F0684		

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F0684 SS = G	Continued from page 48	F0684		

Nurse Practitioner wrote the Wound Nurse reported the wound culture obtained last Thursday (9/11/25) was negative. The Wound Nurse Practitioner noted a subsequent culture was obtained today because she had a high suspicion that the previous culture result was inaccurate. The treatment note indicated to cleanse the wound with full strength wound cleanser with antimicrobial and debridement actions solution and pat dry. Then skin prep (skin protectant) the wound edges and apply full strength wound cleanser with antimicrobial and debridement actions moistened gauze to the entire depth of the wound bed and cover with a silicone bordered super absorbent dressing. The frequency of the treatment order was to change daily and PRN (as needed). In addition, the Wound Nurse Practitioner documented that a medically necessary sharp debridement was indicated for the removal of excessive necrotic tissue and for the promotion of wound healing. The wound was anesthetized, and debridement was performed.

On 9/15/25 at 12:09 PM the Wound Nurse wrote a progress note for order to repeat the wound culture and sensitivity (left heel wound).

The Nurse Practitioner (NP) was interviewed on 9/17/25 at 11:00 AM. He stated Resident #2 had been placed on comfort measures due to an overall decline, but the resident did not elect to go with a hospice program. The NP stated Resident #2 had poor nutritional status and would refuse nutritional supplements. The NP stated he was aware that Resident #2 had wounds on her back and sacrum area but did not know she had a wound on her left heel. He stated he was not notified Resident #2 had a wound on her left heel. The NP stated he was not notified of any lab results ordered by the Wound Provider on 9/11/25 and was not aware of her treatment orders. He stated Resident #2's left heel wound would be unavoidable due to her overall decline. The NP stated he should have been notified of Resident #2's left heel wound when it was found on 9/10/25. Additionally, the Medical Provider stated normally the Wound Nurse Practitioner would have been notified with results of any labs or diagnostics first because she had ordered them, and the results would be placed in his folder to review or would had been called in to him.

A follow-up interview was conducted with the NP on 9/17/25 at 2:30 PM. He stated Resident #2's culture and sensitivity lab had been reviewed by him today. The NP stated the culture and sensitivity for the wound was positive for moderate proteus mirabilis and scant staphylococcus aureus on the results dated 9/14/25. He

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F0684 SS = G	Continued from page 49 then added orders were written for 2 antibiotics (Bactrim 400/80 milligrams by mouth twice daily for 14 days, Ceflin 250 milligrams by mouth one time daily for 14 days) for the infected heel wound, based on the culture and sensitivity results. Resident #2 had physician orders written on 9/17/25 for Ceflin (antibiotic) 250 milligrams by mouth once daily for 14 days for wound infection and Bactrim (antibiotic) 400/ 80milligrams by mouth twice daily for 14 days for wound infection. The Medical Director was interviewed on 9/18/25 at 11:25 AM. The Medical Director stated he was notified by the nursing staff through the nursing communication book or by a phone call when a resident had a new wound. The Medical Director stated he was not notified that Resident #2 had a wound on her left heel. He said on 9/5/25 he had seen Resident #2 for an upper back wound and a sacrum wound and was not aware Resident #2 had a heel wound. He said Resident #2 was followed by the NP and was unaware if they were notified of the heel wound. The Medical Director further stated the culture and sensitivity lab was verified on 9/14/25 and the facility should have notified the Wound Nurse Practitioner or the NP on 9/15/25 of the results. The Medical Director said Resident #2's labs had indicated an infection of the left heel, but not a high infection and Resident #2 had missed one (1) day of antibiotic treatment with the Wound Nurse Practitioner not receiving the wound culture and sensitivity results. On 9/18/25 at 1:15 PM the Wound Nurse stated Resident #2 did not have scheduled or routine skin assessments to be completed by herself or a nurse. She stated when a resident received a shower, the shower team would also do a skin check and report any skin issues to the residents assigned nurse. The Wound Nurse stated that when lab results were completed and sent to the facility, the labs were faxed to the provider that had ordered them. She would then wait on the provider to write orders and send back to the facility. The Wound Nurse said she had not sent any lab results to the Wound Nurse Practitioner or the NP. 9/18/25 at 1:30 PM the Wound Nurse Practitioner said on 9/15/25, she treated Resident #2 and was told by the Wound Nurse that the culture and sensitivity had come back negative. The Wound Nurse Practitioner stated she had not seen the results of the culture and sensitivity, labs or x-ray. The Wound Nurse Practitioner went on to state she had suspected an infection of the left heel wound and was surprised the results were negative. She ordered another culture and	F0684		

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F0684 SS = G	Continued from page 50 sensitivity to be sent to the lab. The Wound Nurse Practitioner said she was only able to see lab results if they were uploaded to the resident's electronic chart or handed to her in person. The surveyor informed the Wound Nurse Practitioner the wound culture and sensitivity was completed on 9/14/25 and sent to the facility and the NP had seen the results on 9/17/25 and had ordered antibiotics for the infected heel wound. The Wound Nurse Practitioner responded, Resident #2 had missed at least one (1) day of antibiotic treatment because she had been provided with incorrect information for the culture and was not provided with the results on 9/15/25. The Wound Nurse Practitioner said the wound culture and labs should have been made available for her to review. Additionally, the Wound Nurse Practitioner stated the Dakin's solution ordered for treatment on 9/11/25 did provide some broad-spectrum antibiotic treatment to the wound and the one (1) day of missed antibiotic treatment would not have made a great difference in the healing of the wound. The Wound Nurse stated on 9/18/25 at 1:15 PM she did not know why she communicated to the Wound Nurse Practitioner that the left heel wound culture was negative on 9/15/25. The Wound Nurse said she had not seen the results of the culture and sensitivity that was ordered on 9/11/25. The Director of Nursing (DON) was interviewed on 9/18/25 at 12:45 PM. She stated labs or culture results were not given to the providers until all the results had been completed and returned to the facility from the lab. The DON stated Resident #2's lab results were not completed fully until 9/16/25 and the resident's medical provider's would not see the results until that day. DON said the culture and sensitivity results had been completed by the lab on 9/14/25 but was not sure at what time on 9/14/25 the results were faxed to the facility. Additionally, the DON stated the Wound Nurse Practitioner should have been shown the results of the culture and sensitivity results at her visit on 9/15/25, because it was a positive result for infection. The DON stated she was not aware the Wound Nurse had told the Wound Nurse Practitioner the results of the wound culture were negative on 9/15/25. On 9/19/25 at 4:04 PM a follow-up interview with the DON stated she did not know why the Wound Nurse had told the Wound Nurse Practitioner the heel wound culture results were negative. The DON stated the results of the left heel wound culture and sensitivity should have been communicated to the Wound Nurse Practitioner on 9/15/25 and to Resident #2's NP for	F0684		

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F0684 SS = G	Continued from page 51 review.	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, interviews with the Wound Care Nurse Practitioner, Medical Director and staff, the facility failed to obtain treatment orders for two (2) pressures ulcers (Resident #8 and Resident #16) when first identified resulting in numerous days that the pressure ulcers went without treatment and worsening to unstageable for Resident #8 and a stage 2 for Resident #16. Resident #8's pressure ulcer was first identified on 08/22/25 as a red open area but an assessment or treatment was not documented. The pressure ulcer was later identified on 09/04/25 and treatment was initiated but no assessment was documented. The pressure ulcer was assessed and documented on 09/09/25 as unstageable wound to the right heel with black eschar (dry, black, or brown crust that forms on the surface of wounds) with foul odor and measuring 3.5 centimeters (cm) by 3.5 cm. The facility failed to routinely assess Resident #16 for being at risk of pressure ulcer, failed to implement measures to prevent Resident #16 from developing a pressure ulcer and then failed to provide ongoing assessment and treatment for Resident #16's pressure ulcer. Resident #16 was identified on 8/31/25 to have a stage 2 pressure wound to the back of his right thigh, there were no wound measurements completed until 9/3/25. After 9/3/25 there was no assessment or measurement documented for the wound. Resident #16 had an initial treatment order entered on 8/31/25 for his	F0686	All residents should receive quality care based on professional standards of practice. Affected residents have continued to be followed by the wound care PA weekly and has provided the facility with weekly updates and progress notes. Resident #8's wound is showing signs of improvement and resident #16's wound has resolved. Resident #8 has had the following interventions/diagnostics ordered: 9/18-Vascular consult, 9/22/25-supplements ordered, 9/23/25-Vitamins ordered, 10/14/25-Treatment orders changed, 10/18/25-Treatment orders changed, 9/28/25 and 10/17/25 lab work ordered. Resident #16 has had the following interventions/diagnostics ordered:9/23/25-Vitamins ordered for wound healing, 9/23/25-Consult for wound care PA to follow, 10/16/25-Lab work ordered. Other residents have the potential to be affected if they have not had a head-to-toe skin assessment, or a Braden scale completed. DON and ADON are completing and documenting head to toe skin assessments on all resident in the facility. This will be completed by 10/17/25. During these assessments, the DON and ADON ensured residents had appropriate interventions in place for pressure ulcer prevention. Per facility policy, Braden scale assessments should be completed on Admission, every quarter, and with significant changes. These assessments are completed in the facilities EMAR system by the MDS Coordinator. DON completed a routine audit of all residents' charts which included ensuring Braden scales had been completed. This audit was complete on 9/5/25. The facility policy states that head to toe skin assessments will be completed on admission, quarterly, and with any significant change. Weekly a wound care Physician Assistant comes to the facility to see all residents with wounds. She sees all but one resident who has a chronic wound and receives Hospice services. The wound care nurse, or DON designee, is responsible for measuring and documenting this resident's weekly wound measurement in the EMAR. DON, ADON, SDC, and Weekend Supervisor are completing in-service training to all nurses on the importance of completing timely initiation of wound treatment. In-service training also includes leaving communication the wound care book regarding any new skin issues, as well as using the facilities standing order for wound treatments. Wound care nurse also completed this	10/28/2025

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Fleshers Fairview Health Care	**3016 Cane Creek Road , Fairview, North Carolina, 28730**

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F0686 SS = G	Continued from page 52 stage 2 pressure ulcer that was for 7 days and stopped on 9/7/25. After 9/7/25 there were no additional treatment orders for the wound. The facility failed to complete accurate head to toe skin assessments to identify new or existing pressure ulcers that include the location, type of wound, length, width, depth, and stage of pressure ulcers. This deficient practice occurred for 2 of 3 residents reviewed for pressure ulcers (Resident #8 and Resident #16). The findings included: 1. Resident #8 was admitted to the facility on 07/17/25 with diagnoses that included history of cerebral vascular accident (CVA) and diabetes mellitus. Review of Resident #8's Admission Nursing Assessment dated 07/17/25 written by Nurse #5 revealed there were no pressure ulcers identified on the assessment. An interview was conducted with Nurse #5 on 09/19/25 at 5:10 PM. The Nurse confirmed that he conducted the admission nursing assessment on Resident #8 on 07/17/25 and explained that he did not recall any issues with pressure ulcers on her heels or anywhere on her body. Review of Resident #8's admission Minimum Data Set (MDS) assessment dated 07/21/25 revealed the Resident's cognition was severely impaired, required substantial to maximal assistance with most of her activities of daily living and she did not have pressure ulcers on admission. Review of Resident #8's care plan dated 07/31/25 revealed Resident #8 had the potential for impaired skin integrity related to decreased mobility, incontinence and poor appetite. The goal that Resident #8 would maintain skin integrity as evidence by no development of pressure ulcers or peri area excoriation through the next review. The goal would be attained by utilizing interventions such as assisting and turning frequently, monitoring her skin for any open areas and notifying the nurse immediately and providing treatments as ordered. Review of Resident #8's medical record for skin assessment documentation from admission on 07/17/25 to present 09/19/25 revealed there were no skin assessments documented. Review of Resident #8's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for July 2025 and August 2025 revealed there were no treatments set up for pressure ulcers on the MARs or	F0686	Continued from page 52 training. In-service education will be completed by 10/21/25. MDS Coordinator and Wound Care nurse were in-serviced on 10/24/25 on the facility's policy and process for wound assessments and Braden scale completions. Systemic process changes... DON, ADON, and Weekend supervisor will be checking the wound care communication book daily to ensure all new skin issues have appropriate interventions initiated. The DON has created skin check/alert sheets that are available to the shower team and all nurse aides to alert a nurse of any concerns in skin conditions that may arise. This process will allow for a flow ending with the DON to ensure appropriate interventions and/or treatments are in place. After the nurse as addressed the concern, it then goes to the DON to sign and ensure all appropriate treatments and interventions are in place. DON will be educating the NA's on this form to ensure they know how to use them, and the appropriate process. DON/ADON are also educating nurses on this form to ensure they know they need to initiate the interventions and then give the form to the DON. Education will be complete 10/28/25. This process is added to the skills competency checklist that is required for new hires and annually for Nurses and CNA's. This checklist includes skin care and wound prevention. This will be expanded to include for nurses, use of standing orders, wound measurements, and skin issue communications And for NA's, skin issue communication. Weekly skin assessments will be added to the nurse's routine weekly charting. This will ensure that all residents have head to toe assessment completed and documented once per week. DON/ADON will complete education to all nurses on this process change and the nurses responsibility to perform the head-to-toe skin assessment, and document, as part of their weekly documentation. DON or designee will be checking the wound care communication book daily, reviewing skin alert sheets, acute charting books, and new telephone orders (to look for wound orders/standing orders being initiated) to ensure all new skin issues have appropriate interventions initiated. They will make corrections as needed. This monitoring will be 3x/week until compliance is maintained for 12 weeks or longer if the QAPI committee recommends. DON or designee will also be monitoring that all weekly head to toe skin assessments are complete, all Braden scales are complete, and weekly wound measurements are documented. This monitoring will be 3x/week until compliance is maintained for 12 weeks or longer if the QAPI committee recommends. Documentation of all monitoring will be	

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F0686 SS = G	Continued from page 53 TARs. An interview was conducted with Nurse Aide (NA) #1 on 09/18/25 at 2:35 PM. The NA explained that on 08/22/25 she was preparing to give Resident #8 her shower when she tried to remove her right sock, but it was stuck to her heel and would not come off until she wet the sock first. She noted a red raw area approximately the size of a quarter on her right heel and there was bloody hard (dried) drainage on the sock. The NA remarked she showered Resident #8 on 08/15/25 and there were no issues with her heels. The NA got Nurse #1 to come to the shower room where she observed Resident #8's right heel and put a dressing over the heel as well as obtained a heel protector to put on after she finished the shower which the NA completed. An interview was conducted with Nurse #1 on 09/18/25 at 4:10 PM and 09/18/25 at 5:30 PM. The Nurse explained that she remembered NA #1 asking her to come to the shower room on 08/22/25 where NA #1 showed her Resident #8's right heel. The wound was pink, and she could not remember if there was drainage. The Nurse continued to explain that she applied a dry foam dressing to the heel and put a note on the board in the medication room for the Wound Nurse #4 to see the next day. The Nurse stated she did not put a note in the wound communication book because she did not know about the wound communication book. The Nurse continued to explain that she did not assess, measure the pressure ulcer or notify the Medical Director of the pressure ulcer because she thought the Wound Nurse would do it on her follow up. On 09/18/25 at 8:45 AM an interview was conducted with NA #5 who explained that on the night of 09/04/25 she noted an area of drainage on Resident #8's bed sheet while she was providing care to the Resident and when she tried to remove the Resident's right sock, the sock was stuck to her heel. The NA stated she got Nurse #7, and the Nurse cleansed Resident #8's right heel and applied a dressing on her heel. During an interview with Nurse #7 on 09/18/25 at 8:50 AM the Nurse explained that on the night of 09/04/25 NA #5 reported that she could not get Resident #8's sock off her right heel because it was stuck to her heel. The Nurse stated she had to soak the Resident's right heel with wound cleanser in order to remove the sock. The Nurse continued to explain that Resident #8's right heel had a blood-filled blister that was not open, and the area looked like the skin was layered. The Nurse reported that she applied a foam dressing to the Resident's right heel and applied heel protectors to	F0686	Continued from page 53 maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Completion Date 10/28/25	

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F0686 SS = G	Continued from page 54 Resident #8' feet and wrote orders to clean open area to right heel with wound cleanser and apply border foam every two days and apply heel protectors while in bed. Nurse #7 also reported that she put a note in the wound communication book for follow up and reported the pressure ulcer to the Assistant Director of Nursing. During a telephone interview with the Assistant Director of Nursing (ADON) on 09/19/25 at 5:43 PM the ADON explained that she could not remember the exact day she found out about Resident #8's pressure ulcer but when she did become aware of it she went to see it and before she got to the Resident's door she could smell the foul odor coming from the Resident's room. The ADON stated that she obtained an order from the MD for an antibiotic, and the Wound Nurse came in the next day (09/09/25) and got an order for crushed metronidazole (antibiotic) to be applied to the pressure ulcer to control the odor. The ADON continued to explain that the nurses do not do routine skin assessments, but the Wound Nurse used to do them quarterly and she would inform the management team about them in the morning meeting if she knew about them. the ADON indicated the nurses depended on the shower team to inform them of the skin issues, and the nurses should follow up on them. An interview was conducted with the Wound Nurse on 09/18/25 at 11:45 AM and 09/19/25 at 7:30 AM. The Wound Nurse explained that she first became aware of Resident #8's right heel pressure ulcer on 09/09/25. The pressure ulcer was unstageable with black eschar, malodorous and measured 3.5 cm x 3.5 cm. The Wound Nurse continued to explain that the pressure ulcer had a treatment set up but when she noted that it was black with hard eschar and the drainage was malodorous, she decided to notify the MD and asked for crushed metronidazole which was what she normally did with a malodorous ulcer. The MD also ordered an X-ray to rule out osteomyelitis which was negative. The Wound Nurse stated she also obtained an order for a wound consult and Resident #8 was seen by the Wound Care Nurse Practitioner on 09/11/25. The Wound Nurse reported that she did not see the note on the board in the medication room left by Nurse #1 on 08/22/25. She stated that 08/22/25 was a Friday and she did not work on Fridays and neither did she work on the weekends. The Wound Nurse stated the next time she would have seen the note would be on 08/25/25 and that was if she worked on the medication cart that was parked in front of the board in the medication room. She indicated the best place to put notes about pressure ulcers was in the wound communication book and she would see them when she worked as the Wound Nurse.	F0686		

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F0686 SS = G	Continued from page 55 Review of Resident #8's MAR and TAR for September 2025 revealed orders for: -09/09/25 ceftriaxone sodium (antibiotic) 1 gram intramuscularly one time a day for 7 days for wound infection. -09/10/25 metronidazole (antibiotic) 500 milligrams (mg) crush tablet and apply to right heel wound bed every day for wound infection. Review of Resident #8's September 2025 MAR and TAR revealed the orders for the heel protector and foam boarder dressing were initialed as completed. Review of a Wound Care Consult dated 09/11/25 provided by the Wound Care Nurse Practitioner revealed Resident #8 had a pressure ulcer to her right heel measuring 3.5 cm x 3.0 cm x 1.0 cm with 30% black necrotic tissue that was unstageable and had no drainage and no odor. An interview conducted with the Wound Care Nurse Practitioner 09/19/25 at 1:30 PM. The Wound Care Nurse Practitioner explained that she had consulted on Resident #8's right heel twice with the first time being on 09/11/25 and she found the wound having black necrotic tissue and no drainage that she could recall. She stated that the pressure ulcer was not at the point of needing debridement (surgical removal of dead tissue), but she anticipated that would need to occur. The Wound Care Nurse Practitioner reported she could not say if the pressure ulcer was avoidable or unavoidable because of company policy but she did disclose that she did not feel the pressure ulcer was chronic. On 09/16/25 at 2:49 PM an observation of Resident #8's right heel pressure ulcer treatment was conducted and performed by the Wound Nurse. The pressure ulcer was approximately the size of a fifty-cent piece with black eschar. A raw area approximately the size of a pea was noted in the eschar. On 09/19/25 at 6:00 PM an interview was conducted with the Director of Nursing (DON) with the Administrator present. The DON explained that there were standing orders for wound care and when the pressure ulcer was first noted on Resident #8 the standing order should have been set up with specific treatment, and the physician should have been notified in case there were further orders to be followed. She stated the pressure ulcer should have been assessed, measured and documented on weekly through wound assessments in order	F0686		

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F0686 SS = G	Continued from page 56 to follow whether the pressure ulcer improved or worsened in case the treatment needed to be changed. The DON indicated skin assessments were done monthly on normal skin and the shower team should notify the nurses if they discovered any skin issues in between. The DON stated she did not know why Nurse #1 did not initiate the standing orders for the pressure ulcer because she had been at the facility for a number of years. The Administrator also stated Nurse #1 should have initiated the standing orders for the pressure ulcer because if she had, it was possible that the pressure ulcer would not have gotten to the point it was and if Resident #8 had gotten the services she needed the pressure ulcer could have been healed by now. During interviews with the Medical Director on 09/18/25 at 10:25 AM and 09/19/25 at 3:08 PM. The Medical Director explained that he was first made aware of Resident #8's right heel pressure ulcer when the Wound Nurse called and reported it on 09/09/25. He reported that he ordered crushed metronidazole to be applied to the wound daily for the malodor and to follow up with a wound consultation. The Medical Director also stated that based on the description by the Wound Nurse he ordered an X-ray to rule out osteomyelitis (infection in the bone) which was negative. The Medical Director was not informed of the pressure ulcer first being discovered on 08/22/25 and no orders were obtained to follow up with treatment and the Medical Director stated that it was unfortunate because if the orders had been initiated then the pressure ulcer may not have gotten to the point it had. The Medical Director remarked that he considered the pressure ulcer to be considered avoidable. 2. Resident #16 was admitted to the facility on 3/29/21 with diagnoses including multiple sclerosis, hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle wasting and atrophy, muscle weakness. A care plan dated 7/1/24 for skin was in place. The care plan goals were for Resident #16 to maintain skin integrity as evidence by no development of pressure ulcers or peri-excoriation through the next review date. The care plan interventions included: float heels while sleeping, pressure relief cushion to wheelchair or recliner, monitor skin for any reddened open areas, monitor nutrition, use recliner for sleep and to reduce pressure, treatments as/if ordered.	F0686		

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F0686 SS = G	Continued from page 57 A Braden scale assessment (assessment for predicting pressure ulcer risk) dated 2/18/25 indicated Resident #16 was at risk for developing pressure ulcers. An annual Minimum Data Set (MDS) assessment dated 8/14/25 indicated Resident #16 was cognitively intact. The MDS documented he had impairment of his upper and lower extremities on one side. The MDS indicated he was independent with his activity of daily living (ADL) tasks and mobility but required partial/ moderate assistance with showers. The MDS documented that he did not have a pressure ulcer but that he was at risk for developing a pressure ulcer. The MDS further documented that he had a pressure relieving device to his chair. An interview was conducted on 9/15/25 at 9:23 AM with Resident #16. He was observed resting in a recliner chair in his room. The recliner chair was observed in the reclined position and Resident #16 was positioned lying on his right side. The recliner chair was covered with a sheet and had a folded pad in the recliner seat. There was no cushion noted in the seat of his recliner. His wheelchair was positioned next to the recliner; a cushion was present in his wheelchair. Resident #16 stated he slept in his recliner chair and that was his preference. He reported he had a pressure ulcer to the back of his right thigh. A review of Resident #16's electronic medical record revealed that weekly skin assessments had not been completed. There were no skin assessments documented. A nursing note dated 8/31/25 by Nurse #8 read: "Nurse notified by resident of bleeding spot on the back of his thigh. Possible stage 2 pressure injury noted to right outer back thigh. Wound bed pink, scant red drainage noted on resident's reusable chuck on his manual wheelchair. No signs of infection. Nurse cleansed wound with wound cleanser, covered wound bed with silver alginate and covered with adhesive dressing. Resident will be added to acute book for this issue and nurse will enter wound care orders until wound care nurse can assess." An order dated 8/31/25 was entered by Nurse #8 and read: Cleanse wound with wound cleanser, cover wound bed with silver alginate (highly absorbent wound dressing embedded with silver particles to fight infection), place dry adhesive dressing over wound, two times a day for pressure injury for 7 days. The order ended on 9/7/25. There were no additional wound care orders after 9/7/25.	F0686		

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F0686 SS = G	Continued from page 58 Review of the Treatment Administration Record (TAR) dated September 2025 revealed a twice daily treatment order that read, cleanse wound with wound cleanser, cover wound bed with silver alginate, place dry adhesive dressing over wound. for 7 days, started 8/31. The treatment was signed to indicate it was administered as ordered. The order stopped on 9/7/25. There was no additional treatment orders present on the TAR for the stage 2 pressure ulcer after 9/7/25. Review of the Wound Care communication book revealed on 8/31/25 Nurse #8 made a note about Resident #16 that read: “right posterior thigh stage 2 pressure injury”. There was a column labeled Wound Care Nurse initials. The notation was not initialed by the Wound Care Nurse. Facility wound care standing orders for a stage 2 pressure ulcer read, cleanse open area with wound cleanser and apply bordered foam dressing, change every 2 days and as needed. A nursing note dated 9/1/25 by Nurse #8 read: “Resident in acute book for stage 2 pressure injury to left posterior thigh. Dressing was removed. Wound bed is pink/beefy, scant dry drainage noted on dressing. No signs of infection present. Wound cleansed with wound cleanser, silver alginate placed on wound bed and wound covered with dry adhesive dressing. Will continue to monitor.” An additional nursing note dated 9/3/25 by Nurse # 8 read: Right posterior thigh pressure injury wound care completed as ordered: dressing removed, moderate amount of drainage present on dressing. Wound bed appears pink, beefy. No signs of infection present. Wound bed cleansed with wound cleanser. Wound measures 2 centimeters (cm) (length) x 1 cm (width). Wound bed covered with silver alginate and secured in place with adhesive dressing. Resident tolerated well.” There was no additional documentation in the medical record about Resident #16’s pressure ulcer being assessed after 9/3/25. Resident #16 was not followed by the Wound Care Provider. An interview was conducted with Nurse #8 on 9/17/25 at 2:57 PM. She recalled finding the stage 2 pressure ulcer to the back of Resident #16’s right thigh on 8/31/25. Nurse #8 stated Resident #16 told her he had a wound, and that the back of his leg was hurting. She remembered he had some bloody colored drainage on the pad in his chair. Nurse #8 reported she looked at the	F0686		

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F0686 SS = G	Continued from page 59 wound and recalled it was an open area to back of his right thigh. She remembered the wound bed was pink and the area was moist with a small amount of drainage. Nurse #8 stated she assumed the wound had come from the pad on his chair being folded and creating pressure. She said Resident #16 always slept in his recliner chair and had a folded pad in his recliner chair. Nurse #8 stated she did not measure the wound when she found it but had documented in a nursing note what she had seen. She explained she had planned to talk to the Wound Care Nurse (Nurse #4) the next day and that the Wound Care Nurse would assess the wound when she looked at it. Nurse #8 reported she did not talk to the Wound Care Nurse the next day but had left a note about Resident #16's wound in "the wound book" at the nursing station. Nurse #8 could not remember if she entered treatment orders for Resident #16's wound but said she probably did. Nurse #8 explained the facility protocol was for the nurse to enter an order for whatever was being used to treat the wound at that time until the Wound Care Nurse looked at the wound to see if it needed something else or a different treatment. Nurse #8 explained silver alginate was part of the facility's wound care standing order for stage 2 pressure ulcers and it was what she had seen other nurses put on those types of wounds. Nurse #8 further explained, there were not really standing orders for each piece of material that was used to treat a wound and that the standing orders were vague and not specific. Nurse #8 explained what she understood was the facility's process for wound care orders, she said nurses used their prior knowledge of what treatments they had seen work for wounds and from what wound care supplies the facility had on hand for wound dressings and then entered an order for that. She reported then the Wound Care Nurse would assess the wound and if she thought the treatment needed to be changed then she would change it. Nurse #8 stated there was not a weekly skin assessment scheduled or completed by staff. She reported there was not a process or schedule for nurses to perform routine skin assessments. An interview was conducted with the Wound Care Nurse (Nurse #4) on 9/17/25 at 9:48 AM. The Wound Care stated she was supposed to do wounds but was usually not able to do them because she was being pulled to the floor/medication cart to work due to the facility being short staffed. The Wound Care stated over the last month she had been pulled almost every day she worked to work a medication cart on the floor. The Wound Care stated when she was pulled to work a floor assignment the nurse on the hall was responsible for doing wounds and the treatments for their assigned group of residents. She reported there was not a process in	F0686		

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F0686 SS = G	Continued from page 60 place at the facility where nurses did routine resident skin assessments. The Wound Care explained there was not a schedule or assigned skin assessments for residents that were done on a routine basis by the nurses. The Wound Care said other than the NAs looking at skin during showers and care there were no skin assessments and that the NAs were supposed to tell the nurses if they saw something. The Wound Care said she was not aware of Resident #16 having a pressure ulcer because she had been working on the floor/medication cart. She reported that she heard he may have a wound and said the nurse was going to look at it but that she had not looked at the wound. She did not remember who the nurse was. An interview was conducted with Assistant Director of Nursing (ADON) on 9/17/25 at 10:00 AM. She reported she was not aware of Resident #16 having a pressure ulcer or wound and that Wound Nurse was responsible for keeping up with who had wounds. An observation was completed on 9/17/25 at 10:49 AM with the ADON of Resident #16's wound. Resident #16 was observed in his room in his recliner chair. The chair was in the reclined position, and he was lying on his right side. The recliner chair was covered by a sheet, and a folded pad was in the seat the recliner. There was no cushion in the recliner seat. The ADON asked Resident #16 if he had a wound and he stated, "yes it's on the back side of my leg". Resident #16 rolled onto his left side and pulled down his pants exposing the back of his right upper thigh. There was a dressing in place dated 9/14/25. The ADON removed the dressing and confirmed the dressing in place was xeroform (wound treatment) covered with a border gauze dressing. Resident #16 was observed to have an open area to the back of his right thigh, the wound bed was pink, the wound edges appeared rolled and thick, there was a small amount of yellow/ tan colored drainage. An interview was conducted with the ADON on 9/17/25 at 11:00 AM. The ADON reviewed the wound care communication book at the nursing station and reported Nurse #8 had made a note on 8/31/25 that Resident #16 had a stage 2 pressure ulcer to his right posterior (back) thigh. The ADON stated the note had not been reviewed by the Wound Care Nurse because it had not been initialed. The ADON reported she reviewed Resident #16's orders and stated Resident #16 had a treatment order for the stage 2 pressure ulcer entered on 8/31/25 for 7 days but that it had been discontinued after the 7 days. She did not know why the order was only for 7 days. The ADON explained the process for what was supposed to be done when a wound was found. She said	F0686		

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F0686 SS = G	Continued from page 61 the facility had standing orders for wound care. She stated when a wound was found the nurse was supposed to use the standing orders for wound care according to the type of wound that was identified. She said the nurse who found the wound was supposed to enter the order into the electronic computer system according to the standing orders, place a note about the wound in the wound communication book so the Wound Care Nurse could follow up on the wound, and notify the provider by placing a note in the provider communication book. The ADON reviewed the provider’s communication books and stated there was not a note left to notify the provider about Resident #16’s wound. The ADON reported the wound care standing orders for a stage 2 pressure ulcer were to clean the wound with wound cleanser, apply a boarder foam dressing, and change the dressing every 2 days and as needed. She said the wound care orders entered on 8/31/25 for Resident #16’s stage 2 pressure ulcer did not follow the facility wound care standing orders. The ADON stated she did not know about Resident #16’s wound specifically but had heard in the morning meeting that “he had a spot there”. The ADON said she had asked the wound Care Nurse to look at Resident #16 and see what was going on and what was there. She did not remember the day it was mentioned in the morning meeting or that she had asked the wound Nurse to look at Resident #16. The ADON stated wounds should be measured and assessed once a week. She explained if a resident was not being followed by the Wound Care Provider, then the Wound Nurse was responsible for measuring, assessing, and documenting on the wound weekly. The ADON said Resident #16’s wound was last measured on 9/3/25 and that it should have been measured and assessed before today (9/17/25). The ADON acknowledged The Wound Care Nurse was pulled to work on the floor most days but said on Thursdays, if no one called out she only worked on the floor from 7:00 am to 11:00 am and then was pulled off the floor from 11:00 am to 3:00 pm to do rounds with the Wound Care Provider and follow up on “other wound care stuff”. The ADON said the NAs looked at resident skin during showers/ care and if they saw something then they were supposed to alert the nurse. The ADON stated NAs could not assess a resident’s skin but could see if something was open or if there was a rash. The ADON reported there was no schedule or process for the nurses to do routine skin assessments on residents. The ADON said skin assessments were important to identify new skin issues. The ADON could not say why there was no formal process or documented scheduled skin assessments completed by the nurses, she said they had never really done it like that. The ADON said she thought normally it would be the Wound Care Nurse who was responsible for doing resident Braden assessments. She reported the Wound Nurse would not do the Braden	F0686		

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F0686 SS = G	Continued from page 62 assessments when she was working on the floor and said she was not sure who would do them but thought it might be the MDS nurse. The ADON said she saw today where Resident #16 had not had a Braden assessment completed since February 2025, she reported they were supposed to be completed quarterly, and she was not sure why his had not been done. An order was entered on 9/17/25 at 1:30 PM by the ADON for a foam boarder dressing, apply to back of right upper thigh every day shift every two days for wound and as needed for wound soiling. An interview was conducted on 9/17/25 at 1:40 PM with Nurse #3. Nurse #3 stated she was the floor nurse assigned to Resident #16’s wing. She reported that when she measured Resident #16’s wound today it measured 1.5 cm x 0.75 cm x 0.25 cm. She said she would not have known Resident #16 had wound unless he had treatment order in place for the wound. She reported wound care orders were entered today for Resident #16’s wound according to the wound care standing orders for stage 2 pressure ulcer. An interview was conducted on 9/17/25 at 12:11 PM with the Nurse Practitioner (NP). He said he was not aware Resident #16 had a wound and that he had not been asked to see the area. The NP said the normal protocol was for wounds to be measured and assessed weekly to see if they were improving or healing. He reported skin assessments were important because they could identify skin issues such as infection and wounds early so there could be an intervention. He said it was hard to say if the initial treatment (silver alginate) put into place for Resident #16 was an appropriate wound care order for his stage 2 wound because he had not seen the wound. An interview was conducted with the Medical Director on 9/18/25 at 9:46 AM. The Medical Director said treatment orders should be in place if a resident has a wound and that there should be a standard protocol for wound orders. He stated wound assessments should be completed weekly. He said the wound assessment should include the characteristics of the wound and wound measurements. The Medical Director explained wound assessments were important to determine if a wound was improving and to guide treatment. He thought basic standard of care was that nurses should do skin assessments at least weekly to identify skin issues. The Medical Director said NAs could help look at resident skin during care and report to the nurse if they saw something but that the facility should have a process in place for nurses to assess residents’ skin and not rely on NAs only. The	F0686		

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F0686 SS = G	Continued from page 63 Medical Director stated he was not aware that Resident #16 had developed a wound. An interview was conducted with the MDS nurse on 9/19/25 at 5:30 PM. She stated she did not complete the Braden assessments. She was unsure who completed the Braden assessments but said she thought it might be the ADON. An interview was conducted with the Director of Nursing (DON) and Administrator on 9/19/25 at 6:00 PM. The Administrator stated when Resident #16's pressure ulcer was found the nurse should have initiated the standing orders, assessed the wound, and documented the wound assessment in the nursing notes. The Administrator stated the wound assessment should include measuring the wound. She reported that the nurse should notify the provider about the wound and obtain wound care orders from the provider if the wound needed a different treatment from the wound care standing orders. The Administrator stated wounds should be assessed and monitored weekly to see if the wound was improving or worsening and so the treatment plan could be changed if needed. The Administrator stated the weekly assessment should include what the wound looked like, if there was any draining, any signs of infection, and the wound measurements. The Administrator stated she did not know why Nurse #8 did not follow the wound care standing orders or put ongoing treatment orders in for Resident #16's wound. The Administrator and DON reported the shower team NAs looked the residents' skin when they did showers. The DON said the NAs could not assess resident skin but could notify the nurse if they saw something. The Administrator stated NA skin checks during showers should not replace skin assessments completed by a nurse. The Administrator stated if a resident was assessed to be at risk for skin breakdown, then they should have skin assessments completed weekly. The Administrator explained the Braden assessment identified if a resident was at risk. The Administrator stated the Braden assessment should be done quarterly. The DON said the Wound Nurse was responsible for doing the Braden assessments but if she could not get to them the MDS nurse should do them. The DON said the MDS Nurse should have been checking and auditing to ensure the Braden assessments were completed quarterly. The Administrator said she had spoken with the MDS Nurse earlier today and the MDS Nurse had not known she was supposed to be checking that the Braden assessments were done and doing them if they had not been completed. The Administrator stated Resident #16 should have had a Braden assessment completed since February. The DON and Administrator reported they were not aware	F0686		

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F0686 SS = G	Continued from page 64 skin assessments were not being completed by nurses. The Administrator and DON stated they were not sure what happened with the skin assessments but that it had slipped through the cracks. The Administrator explained the purpose of skin assessments was to prevent wounds, identify wounds, and intervene early if they developed. The Administrator stated if a resident ended up with a wound it could lead to other comorbidities such as infection and pain. The Administrator reported she was not sure about pressure ulcer interventions for Resident #16 or if he had any but said she thought his recliner chair needed to be looked at to see if it was a contributing factor to his wound and appropriate interventions implemented.	F0686		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to provide supervision to prevent a fall with injury and failed to implement effective fall interventions for a resident (Resident #11) who had repeated falls. Resident #11 experienced 12 falls from 1/22/25 to 7/24/25. On 7/24/25 Resident #11 sustained a left ankle fracture when she was left unsupervised in the bathroom and fell. Additionally, the facility failed to supervise a cognitively impaired resident (Resident #10) who wandered and exited the facility unsupervised on two separate occasions. This deficient practice occurred for 2 of 3 residents reviewed for supervision to prevent accidents. Findings included: Resident #11 was admitted to the facility on 1/3/25 with diagnoses that included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis	F0689	Any resident that is at risk for falls should have appropriate fall interventions in place, have adequate supervision, and be as free from accidents as possible. Interventions should also be in place facility wide to provide safety for residents with wandering behaviors to prevent the risk of elopement. Resident #11 has been evaluated by DON to ensure all fall interventions were in place. Care plan was updated on 10/15/25 stating she hasn't had a fall since 7/24/25, continue all fall interventions. Intervention was also added that resident is not to be left unattended in bathroom. For resident #10, the Maintenance Director had Cross Connect (manages the facilities call bell system and alarms for exit doors) come to facility on 9/23/25 to ensure all exit door alarms are in correct working order. There are back up squealer alarms on each exit door that are to be turned on anytime the alarm system is down. The Maintenance department has double checked all of these alarms to ensure all are operational. Other residents that are at risk of being free from accidents have been evaluated by the Administrator, DON, ADON, and MDS Coordinator to ensure appropriate interventions are in place, safe practices were followed, and that all exit door back up alarms are in correct working order. Evaluation included reviewing EMAR User Defined Assessments for residents that are at risk for falls. Falls risk assessments are completed in the EMAR on every resident on admission, every quarter, and with significant change. Any resident that scored greater than 10 on their last fall risk assessment are considered at risk for falls. Review then was done by the ADON to ensure all residents that scored "at risk" had a falls risk care plan in place. Review also included reviewing all incidents for the last quarter to ensure incidents were reflected on the residents' care plan with appropriate interventions in place, as well and making sure they are in place. This was	10/27/2025

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F0689 SS = G	Continued from page 65 (decreased control and strength on one side of the body) following cerebral infarction affecting right dominant side, muscle weakness, need for assistance with personal care, abnormalities of gait and mobility, transient ischemic attack (TIA) (temporary episode of stroke-like symptoms). A progress note dated 7/6/25 indicated Resident #11 had a change in level of consciousness, elevated blood pressure, and was sent to the emergency room. A hospital discharge summary dated 7/10/25 indicated Resident #11 was admitted to the hospital on 7/6/25. Her discharge diagnoses included stroke like symptoms and acute renal failure. A progress note dated 7/12/25 indicated Resident #11 was readmitted to the facility from the hospital on 7/12/25. A significant change MDS assessment dated 7/17/25 indicated Resident #11 had moderate cognitive impairment. The MDS reported she used a wheelchair and was dependent on staff for showers and toileting. She required partial/moderate assistance with dressing and transfers. The MDS documented Resident #11 did not have behaviors or rejection of care. She was not documented on the MDS for falls. A care plan dated 1/25/25 was in place for impaired mobility and ADL deficit related to TIA with right sided weakness, and debility. The care plan interventions included “Resident will do as able, if unable to complete task assist resident to finish them”. A care plan dated 1/15/25 was in place for fall risk related to TIA, right sided weakness, and history of falls. The care plan goal was for Resident #11 to not sustain significant fall related injury as evidence by no injury more serious than a bruise, abrasion, or skin tear. The care plan included the following interventions dated 1/25/25, attempt to maintain environment adequate lightening, free of clutter, free of safety hazards, and free of glare. Encourage to use appropriate assistive devices, wear non-skid soled shoes when out of bed, give reminders to not transfer without assistance if feeling weak or unsteady, observe for adverse effects of medications, administer anticonvulsant as ordered, place frequently used items in reach. An incident report dated 7/24/25 at 12:38 PM was	F0689	Continued from page 65 completed on 10/27/25. Residents have been identified as being at risk for elopement if they exhibit exit seeking or wandering behaviors. Residents identified have had an elopement risk assessment completed in the EMR. If the score on the elopement risk assessment is greater than 1, then the resident is considered at risk. Residents scoring at risk have been verified to have a care plan in place, and their face sheet is in the elopement risk book at the receptionist desk. This was completed on 10/24/25. DON is providing education to all nursing staff about the importance of not leaving residents unattended that require supervision to prevent accidents. Administrator is providing education to all staff about the facilities policies and procedures regarding residents that are at risk for elopement. This education will be complete on 10/21/25. The Administrator has educated the MDS Coordinator on ensuring all incidents are addressed on the residents care plan with resident centered approaches and interventions to prevent injury. Training completed on 10/24/25. Administrator educated the MDS Coordinators on the process change of completing elopement risk assessments on all residents on Admission, Quarterly, and with any Significant change. Resident is considered at risk if they score greater than a 1 on the risk assessment, if a resident triggers at risk, they should have a care plan in place, if a resident newly triggers at risk (didn’t previously trigger), print a face sheet to give to the receptionist to be put in the elopement risk binder. Systemic process changes...Elopement risk assessments are available in the facility's EMR system. This assessment will be completed on admission and quarterly for any resident at risk for elopement starting on 10/23/25. These will be completed by the MDS Coordinator. An elopement risk assessment will be completed for every resident by 10/27/25. If the assessment indicates they are at risk for elopement (scoring greater than 1), a resident face sheet printed in color with the resident's picture will be added to an elopement risk binder kept at the front reception area, and the residents care plan will be updated. Checking the backup door alarms has been added to the maintenance departments weekly preventative maintenance check list. Also, any resident incident is discussed in morning clinical meeting. This now includes the entire IDT coming up with effective interventions, not just the falls committee. These interventions are then added to the resident's care plan after the meeting.	

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F0689 SS = G	Continued from page 66 completed by Nurse #2. The incident report stated therapy assisted Resident #11 onto the toilet. Resident attempting to transfer from toilet to wheelchair independently, her legs buckled and she was sitting with her left ankle twisted beneath her. Head to toe assessment completed. The left foot started to swell within 20 minutes. She was able to rotate the ankle but stated it was painful. Three staff assisted Resident #11 into her wheelchair. The incident report indicated the provider was notified and an x-ray was ordered. A nurse note dated 7/24/25 entered at 2:11 PM by Nurse #2 said Resident #11 "was on the floor in front of the toilet. Therapy assisted Resident onto the toilet. Resident attempting to transfer from toilet to wheelchair (w/c) independently, her legs buckled, and she was sitting with her left ankle twisted beneath her. Head to toe assessment completed. The left foot started to swell within 10 mins. She was able to rotate the ankle, she did state it was painful. 3 staff assisted Resident into w/c". The note indicated that Resident #11's family member was notified of the fall, the MD was informed, and an X-ray had been ordered. An Occupational Therapy treatment note dated 7/24/25 at 1:07 PM by Occupational Therapy Assistant (OTA) #1 was reviewed. Under precautions the note stated "one to one (1:1) supervision required (falls). Fall risk and confusion". Under the response to treatment section the note read, "At end of therapy toileting ADL session notified NA on duty of patient need for assist to transfer off toilet once done defecating, NA verbally confirmed understanding of patient need for assist. This therapist instructed patient to pull alert cord when ready for assistance and placed cord in patient's hand." An interview was conducted on 9/18/25 at 2:27 PM with Occupational Therapy Assistant (OTA) #1. She reported she had been working with Resident #11 on 7/24/25. OTA #1 reported she assisted Resident #11 to transfer to the toilet. She stated she needed about 50 % assistance with the transfer. OTA #1 explained that included hand placement on the grab bars, foot placement, weight shifting over, and clothing assistance. OTA #1 stated Resident #11 needed more time on the toilet. She explained she was out of occupational therapy treatment time and needed to leave. OTA #1 reported she put the call light in Resident #11's hand and reiterated to her not to transfer on her own and to use the call light. OTA #1 said she then found the NA on the hallway, she could not remember who the NA was. OTA #1 stated she told the NA Resident #11 was on the toilet, she would need assistance, and she had the call light to call for	F0689	Continued from page 66 New hires will be educated on the facilities POC by receiving the elopement education on hire as part of new hire orientation. New hire orientation also includes training on the facilities policy on what to do in case of an elopement. This new hire orientation is also assigned yearly to all employees. New hires will be educated on where to find fall interventions on the resident's care plan. This has been added to the new hire and annual skills checklist. The Administrator already reviews the preventative maintenance checklist that the maintenance department completes weekly. This checklist now includes checking the backup door alarms. Administrator will document her reviews of the checklist weekly (since the preventative maintenance checklist is completed weekly) X12 weeks or longer until compliance is met. This monitoring will be presented monthly by the Administrator to the QAPI committee. DON, MDS Coordinator, or designee will be monitoring any incidents including falls and elopement attempts to ensure policies and standards of care are followed, as well as an intervention put into place, and placed on the residents' care plan. This monitoring will continue for every incident, and monitoring documented at least 3x/week until compliance is maintained for one month or longer if the QAPI committee recommends. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. The Administrator will monitor resident records to ensure there is an up-to-date elopement risk assessment in place, if a residents score on this assessment indicates they are at risk that there is a care plan in place, and their face sheet is in the elopement risk binder. This monitoring will continue 2x/week X12 weeks or longer until compliance is met. This monitoring will be presented monthly by the Administrator to the QAPI committee where corrective action will be evaluated for effectiveness and changes made as needed. Completion Date 10/27/25	

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F0689 SS = G	Continued from page 67 assistance when she was done. OTA #1 reported the NA was right outside of Resident #11's room door and confirmed understanding. OTA #1 said Resident #11's balance and strength was okay for her to be able to safely sit on the toilet by herself. She stated she thought Resident #11 was physically able to pull the call bell string and said she thought Resident #11 seemed to have the mental ability to use it. OTA #1 explained at the time she was not sure if she was supposed to stay there with Resident #11 if she was over her treatment time and had thought she would get in trouble if she stayed. OTA #1 said she knew Resident #11 had falls that occurred from the bed but did not think she had falls in the bathroom before this fall. An interview was conducted on 9/18/25 at 12:19 PM with the Director of Rehabilitation (Rehab). The Director of Rehab said OTA #1 had notified the NA at the time that she had taken Resident #11 to the bathroom and instructed Resident #11 to use the call bell. She did not remember who the NA was. The Director of Rehab stated Resident #11 had balance deficits, but the NA was outside of the room and said there was intended to be an immediate transference of care and observation for Resident #11. An interview was conducted with NA #9 on 9/18/25 at 3:26 PM. NA #9 said she was the assigned NA for Resident #11 on 7/24/25 when she fell. NA #9 explained she recalled the fall because she had been upset about what had happened. NA #9 reported a therapist had left Resident #11 on the toilet unattended without notifying her or any NA that she was on the toilet. She could not remember the therapist's name. NA #9 said the fall happened between 11:00 AM and 12:00 PM. NA #9 said she had been on a different hallway helping residents get up for lunch. NA #9 remembered Resident #11's roommate was yelling for help. She said when she went to the room, she found Resident #11 on the bathroom floor. She recalled Resident #11 was sitting on the bathroom floor with her leg bent under her and she was sitting on her ankle. She thought it had been her right ankle but was not sure. NA #9 stated she did not move Resident #11 but had asked her if she was in pain and Resident #11 said she had hurt her ankle. NA #9 stated she notified Nurse #14 and she came first to assess Resident #11. NA #9 stated three staff members assisted Resident #11 back into her wheelchair after the fall. She said Resident #11 wanted to stay up in her wheelchair so she could go smoke. NA #9 reported Resident #11 was not okay to be left in the bathroom alone. She reported Resident #11 needed supervision because she was shaky when she stood and did not always ring the call bell. She said Resident #11 did not ring the call bell on	F0689		

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F0689 SS = G	Continued from page 68 7/24/25, she stated when she went to Resident #11's room the call light had not been on. An interview was conducted on 9/19/25 at 11:13 AM with Nurse #14. She recalled Resident #11's fall on 7/24/25. Nurse #14 stated that it was the fall where the OTA had put her on the toilet and then told her to ring the call when she was done. Nurse #14 said someone came and told her Resident #11 had fallen, she could not remember who had told her. Nurse #14 stated Nurse #2 came to the room and they had assessed Resident #11 together. Nurse #14 said Resident #11 had not acted like she was in pain at all. She recalled Resident #11 was sitting on the bathroom floor and one of her ankles was under her. She said it looked odd how she was positioned on her leg on floor. Nurse #14 said after they assessed her and got her back into her wheelchair they had asked if her ankle was hurting and Resident #11 had said "no". Nurse #14 stated Resident #11 had not remembered what happened when they asked her. Nurse #14 was unsure if Resident #11 should be left alone in bathroom and said that she did not usually take care of her. Nurse #14 said staff did not usually leave residents in the bathroom alone if they could not be left unsupervised and that was a question that day. She remembered the NA was upset that day because the OTA had left Resident #11 in the bathroom and had not told her. She stated the NA had said she did not know Resident #11 was in the bathroom. Nurse #14 did not remember the NAs name. An interview was conducted on 9/18/25 at 12:01 PM with Nurse #2. She was the assigned nurse for Resident #11 on the 7/24/25 day shift (7:00 am to 3:00 pm). Nurse #2 recalled Resident #11's fall on 7/24/25 she stated therapy had assisted her to the toilet that day, she did not remember the exact time or if she had gone to Resident #11's room first or if Nurse #14 had. She said Resident #11 had not called for assistance, had tried to transfer herself, and fell. Nurse #2 stated cognitively Resident #11 was able to use the call light at the time of the fall. She reported she had asked Resident #11 why she did not ring the call bell for assistance and Resident #11 had told her she "thought she could do it herself". Nurse #2 said she asked Resident #11 about pain when she assessed her after the fall and she said Resident #11 had said her ankle hurt. Nurse #2 stated Resident #11 had swelling to her left ankle and that was why she had gotten the x-ray ordered. Nurse #2 said she did not remember if the x-ray results came back on her shift or if she had called the physician about the results. Nurse #2 reported after the fall Resident #11 had stayed up in her wheelchair and had not wanted to lay down in bed.	F0689		

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F0689 SS = G	Continued from page 69 She stated Resident #11 had propelled herself in her wheelchair and continued to go out to smoke. Nurse #2 said she remembered Resident #11 had other falls before the fall on 7/24/25 and she stated most of Resident #11's were related to her not calling for assistance and trying to transfer herself. An order dated 7/24/25 was entered at 11:00 AM by the DON that read, left ankle X-ray. The order indicated it had been ordered by the Medical Director. An X-Ray report dated 7/24/25 of Resident #11's left ankle read, "acute nondisplaced fracture at distal fibula, proximal to the lateral malleolus." An additional progress note dated 7/24/25 entered at 5:17 PM by the DON read, "new order per [Medical Director] refer to [local orthopedic office] ortho for left ankle fracture. Daughter made aware of fracture." An order dated 7/24/25 was entered at 5:30 PM by the DON that read, refer to [local orthopedic office] orthopedic for left ankle fracture. An interview was conducted on 9/18/25 at 3:56 PM with Nurse #9. Nurse #9 was the 3:00 PM to 11:00 PM nurse on 7/24/25 for Resident #11. Nurse #9 reported Resident #11 had been up in her wheelchair when she arrived at work on 7/24/25. Nurse #9 stated the x-ray results had already been called to the Physician from her earlier fall before she arrived at work. Nurse #9 said Resident #11 had a lot of falls and was a high fall risk. She reported she did not know what fall interventions had been put in place for Resident #11. She said staff tried to keep an eye on her when she was in bed and tried to encourage her to use the call bell. An orthopedic progress note dated 7/25/25 indicated Resident #11 had been seen for a closed displaced fracture of the lateral malleolus of left fibula. The note indicated a repeat X-Ray was completed at the office visit with results showing she had a "minimally displaced oblique (angle) lateral (side) malleolus (ankle bone) fracture that extends to the level of the tibial plafond (bottom of the shin bone). She had no widening of the ankle mortise (were the leg bones and ankle bones come together at the joint) or medial (middle) malleolus fracture". The note indicated the treatment plan included a short leg walking boot. The note reported a "cam boot (short walking boot) was prescribed" and said the boot could be removed for bathing and sleeping and that she may wear the boot as tolerated. Acetaminophen was recommended for pain. The note said to recheck in 6 weeks for repeat ankle x-rays	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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F0689 SS = G	Continued from page 70 or sooner if symptoms worsen. A combined interview was conducted with the Administrator and Director of Nursing (DON) on 9/19/25 at 6:00 PM. The Administrator and Director of Nursing stated Resident #11 should not have been left unassisted and unsupervised in the bathroom alone. 2. Resident #10 was admitted to the facility on 9/26/24. Her active diagnoses included Alzheimer's dementia. The quarterly MDS dated 11/10/24 indicated Resident #10 had not exhibited any wandering behavior. Resident #10's care plan with the focus revised on 9/13/24 revealed a risk for elopement related to dementia. Interventions included frequent checks on whereabouts and make sure hallway doors were alarmed at all times. a. Review of the facility incident log revealed there was no incident event for Resident #10 dated 2/02/25. Review of Resident #10's nursing progress note dated 2/02/25 at 3:58 PM entered by Nurse #3 read that the resident was noted outside of the building walking past the 200-hall door. Resident redirected and brought back in the building. An interview on 9/17/25 at 12:51 PM with the Nurse Practitioner (NP) revealed he had been notified of Resident #10's elopement and she was assessed to have no injuries. An interview on 9/18/25 at 10:53 AM with Receptionist #2 revealed she had been on duty at the front desk on 2/02/25 when Resident #10 eloped. She believed that Resident #10 exited the building when she opened the front door for a group of visitors to exit. She stated she did not know the resident had gotten out until Nurse #3 came and told her that Resident #10 had gotten outside. She did not know what time this incident occurred. An interview on 9/18/25 at 2:14 PM with the Business	F0689		

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F0689 SS = G	Continued from page 71 Office Manager revealed Receptionist #1 trained Receptionist #2. She stated she was informed that Receptionist #2 accidentally let Resident #10 out when she opened the door for a group of visitors to leave. She stated there was a book at the receptionist's desk with pictures of the residents. An observation on 9/18/25 at 2:30 PM with the Business Office Manager of the resident book at the receptionist's desk revealed the book contained a printed face sheet for all the facility residents. The face sheet contained a picture of each resident with their name. There was no indication of who was an elopement risk in the book. The Business Office Manager stated the elopement risk residents were verbally communicated to the receptionists and she did not know how the weekend receptionist (Receptionist #2) would become aware of elopement seeking residents. An interview on 9/18/25 at 4:09 PM with Nurse #3 revealed she was walking down the 200-hall when she observed through the glass hall exit door that Resident #10 was walking independently outside the facility. She stated she went out the 200-hall door and escorted Resident #10 back into the facility. She stated that Resident #10 was fully dressed and wearing shoes. She assessed the resident who appeared clean, dry and without injury. Nurse #3 stated she talked to the receptionist, and it appeared the receptionist had let Resident #10 out accidentally when she let a group of visitors out. She stated she did not remember notifying any administrative or supervisory staff. Nurse #3 was unaware Resident #10 had gotten outside until she saw her through the door. She was unable to say the last time she had seen the resident. Resident #10 was known to pace the facility and ask staff how to get out of the facility. An interview on 9/19/25 at 8:51 AM with Receptionist #1 revealed she had trained Receptionist #2 who worked weekends at the facility. She stated she had told Receptionist #2 who the elopement risk residents were but did not remember if she had shown her what the resident looked like or if Resident #10 was specifically included in the conversation. An observation and interview on 9/19/25 at 9:01 AM with the Director of Nursing (DON) revealed from the facility front door around the outside of the facility to the 200-hall door was between 105 to 123 steps	F0689		

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F0689 SS = G	Continued from page 72 depending on if you walked in the grass (105 steps) or the parking lot (123 steps). An interview on 9/19/25 at 10:14 AM with the Director of Nursing (DON) revealed she was unable to say when she became aware of Resident #10's elopement on 2/02/25 and did not have any incident or investigation paperwork. An unsuccessful interview was attempted on 9/19/25 at 1:04 PM with the NA #6 who was on duty on 2/02/25. An interview on 9/19/25 at 2:39 PM with the Administrator revealed Resident #10 had gotten out of the building on 2/02/25. She stated she reviewed the security camera footage, and the resident was outside for 'minutes'. She stated there was a facility investigation, but she was unable to locate the documentation. She stated that Receptionist #2 was educated on the elopement risk residents. Per wunderground.com reported the weather that day at 3:54 PM was 51 degrees with no rain. b. Review of the facility incident log revealed an elopement incident event dated 3/11/25 at 00:00 for Resident #10. The elopement incident report revealed an incident description that read Resident #10 was observed out front of building by receptionist, assisted back inside by receptionist and business office staff. No injuries were observed at the time of the incident. Resident #10's family member was notified on 3/11/25 at 3:47 PM and the physician was notified on 3/11/25 at 3:44 PM. Review of Resident #10's nursing progress note dated 3/11/25 at 3:53 PM entered by Nurse #6 read that resident was observed out front of building by receptionist, assisted back inside by receptionist and business office staff without incident. No fall; no apparent injury. Sister informed and note to MD. An interview on 9/19/25 at 1:14 PM with Nurse #6 revealed she was on duty and assigned to Resident #10 on 3/11/25. She stated she remembered Receptionist #1 bringing Resident #10 to the nurses' station around 3:45 PM and informing her she found the resident	F0689		

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F0689 SS = G	Continued from page 73 outside the front door. Nurse #6 assessed the resident with no injuries noted. She did not recall if she notified Administration or a Supervisor or if they had already been notified. She stated she completed the incident report but had not entered the correct time of the incident which should have been documented as around 3:45 PM. She was unaware the resident had gotten outside and unable to say the last time she had observed the resident on the unit. An interview on 9/19/25 at 9:38 AM with Receptionist #1 revealed she was on duty at the facility front door on 3/11/25. She stated she observed Resident #10 outside the front door on 3/11/25 around 3:45 PM and went outside and escorted her back into the building and to a nurse at the 200-hall nurses' station. She also stated that Resident #10 was fully dressed and wearing shoes with no visible distress. Receptionist #1 stated no one from the business office assisted her with getting Resident #10 back into the facility. An interview on 9/17/25 at 12:51 PM with the Nurse Practitioner (NP) revealed he had been notified of Resident #10's elopement and she was assessed to have no injuries. An interview on 9/19/25 at 1:29 PM with Nursing Assistant #2 revealed she worked with Resident #10 frequently and was assigned to her hall on 3/11/25. She stated on 3/11/25 before her elopement, Resident #10 was behaving as usual which included pacing inside the facility, exit seeking, and checking doors. She was unable to say the last time she had observed Resident #10 on the unit. An interview on 9/19/25 at 10:14 AM with the Director of Nursing (DON) revealed she was unable to say when she became aware of Resident #10's elopement on 3/11/25. She stated that maintenance monitors the hallway door alarms. An interview on 9/19/25 at 11:15 AM with the Maintenance Director revealed he checked the hall doorway alarms monthly and as needed. An interview on 9/19/25 at 2:39 PM with the Administrator revealed Resident #10 had gotten out of the building on 3/11/25 around 3:45 PM. She stated that	F0689		

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F0689 SS = G	Continued from page 74 the facility power had been off and, in the restoration process around 3:45 PM, the hall door became unlocked. She stated that Resident #10 had not eloped since this incident, and she felt the interventions were effective. Per wunderground.com reported the weather that day at 3:54 PM was 71 degrees with no rain.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff, and Medical Director interviews, the facility failed to act on the Registered Dietitian's (RD) recommendation of 8/31/25 to reweigh a resident (Resident #29) after a monthly weight triggered a significant weight change. The diet order was revised to add more calories, and the volume of the nutritional supplement was increased as recommended by the RD. The facility failed to reweigh Resident #29 until 9/3/25 and then staff did not document the weight or report it to nursing management until 9/18/25. The reweight confirmed a significant weight loss. During meal observation on 9/19/25, Resident #29 did not consume any food on her	F0692	Nursing staff should timely follow up on any recommendations made by the Medical Director, Nurse Practitioner, Wound Care PA, and dietician. Resident #29 was seen by the RD on 9/20/25. No recommendations were made. Note states weight fluctuation expected with diuretic use. Other residents had the potential to be affecting by a recommendation not being followed up on. The facilities Medical Director and Nurse Practitioner were given current and historical weights, which includes any significant changes, for all residents on 10/3/25. This documentation was also given to the dietician on 10/6/25. The dietician did not order any recommendations based on these weights. There have been no dietician recommendations since. The ADON is responsible for notifying the RD and the provider for significant weight changes. A significant weight loss is defined as having a 5% loss in 30 days or a 10% loss in 180 days, and a weight gain is defined as 5% gain in 30 days or 10% gain in 180. Audit of resident's weights completed by the DON and Administrator on 10/17/25, indicated 3 residents that had experienced weight loss. These could be explained by recent hospital admission for 1 of the residents, GI issues 1 resident, and medication use for the other. The provider was notified of these weights on 10/3/25 and the dietician on 10/6/25. ADON has provided education to the unit clerk who is responsible for obtaining residents weights, about the importance of obtaining repeat weights on residents timely per recommendations in order for the provider to make timely decisions on treatment plans. This education was completed on 10/16/25. Routine monthly weights are to be completed by the 10th of every month. If the unit clerk is unable to obtain weights, the shower team CNA's or the other CNA's on the floor will assist with getting them completed. ADON will now routinely send the Medical Director, the Nurse Practitioner, and Dietician a spreadsheet of all monthly weights with color coding for significant	10/17/2025

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F0692 SS = D	Continued from page 75 own and staff did not provide any cues or encouragement to eat. The interdisciplinary team did not discuss Resident #29's weight loss or lack of eating in the clinical meeting, nor was it reported to the physician. This deficient practice occurred for 1 of 2 residents reviewed for nutritional care. Findings included: Resident #29 was admitted to the facility on 2/21/24. Her diagnoses included dementia, hypothyroidism, nutritional deficiency, and protein-calorie malnutrition. Resident #29's active physician orders revealed an order dated 6/5/24 for Remeron 7.5 milligrams (mg), give one tablet by mouth at bedtime related to primary insomnia. Remeron is an antidepressant medication that can be used to stimulate appetite. A care plan revised on 3/17/25 was in place for impaired nutrition related to malnutrition, hypothyroidism, and nutritional deficiencies. The care plan interventions included using remeron (antidepressant medication) to stimulate appetite, monitor weights as indicated, obtain and monitor lab work as ordered, provide and serve diet as ordered, provide and serve supplements as ordered, Registered Dietician (RD) to evaluate and make diet change recommendations. Resident #29's medical record indicated a thyroid stimulating hormone (TSH) level was checked on 4/23/25 with normal results. The medical record indicated a complete blood count (CBC) (lab test that counts the type/ type/ number of cells in your blood and is an indicator of health) was also checked in April 2025. Resident #29 last had a complete metabolic panel (CMP) (lab that shows glucose, electrolytes, protein, and indicators for kidney and liver function) completed in February 2025. The Medical Record revealed she had not had any additional lab work completed since April. On 6/25/25, the electronic record documented Resident #29's weight was 134.4 pounds (lbs.) On 7/29/25, the electronic record documented Resident #29's weight as 132.1 lbs. A quarterly Minimum Data Set (MDS) assessment dated 8/7/25 indicated Resident #29 had severe cognitive impairment. She was not documented for behaviors or rejection of care. The MDS documented she needed setup/ clean up assistance with eating The MDS did not	F0692	Continued from page 75 weight changes. The ADON was trained on her responsibility to notify the provider and RD with significant weight changes when taking on the ADON role in October of 2024. DON has provided education to the ADON on the expectation of reporting significant weight changes to the provider and RD. This education given by the DON was completed on 10/3/25. Director of Nursing will monitor the compliance Dietician recommendations being followed up on, as well as completion and reporting of weight gains/losses to RD and provider, 3x/week x 12 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the Director of Nursing where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion date 10/17/25.	

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F0692 SS = D	Continued from page 76 document she had weight loss or difficulty swallowing. The MDS documented she received a mechanically altered diet. The MDS documented her weight was 132 lbs. A quarterly mini nutritional assessment dated 8/19/25 indicated Resident #29's most recent weight was 132.1 lbs. on 7/29/25. The assessment documented she had no decrease in her food intake and had weight loss between 2.2 and 6.6 lbs. The assessment documented that she had normal nutritional status. A revised diet order on 8/21/25 read, regular diet mechanical soft texture, regular thin liquid consistency, extra gravy with dry meats, mighty shake (supplement) with meals. On 8/26/25, the electronic record documented Resident #29's weight as 114.4 lbs. A progress note dated 8/31/25 by Registered Dietitian (RD) #1 indicated Resident #29 was reviewed. The note indicated she had a significant weight loss of 13.6% in a month. The note indicated Resident #29 received a regular diet with mechanical soft texture and her intakes ranged from 0-50% of most meals. The note indicated she was receiving Med Pass (nutritional supplement) 60 milliliters (ml) twice daily and a mighty shake (nutritional supplement) three times daily. The note indicated the RD recommended obtaining a reweight for weight loss verification and increasing her Med Pass to 90 ml twice daily to promote weight stability. A medical nutrition therapy recommendation log by RD #1 dated 8/31/25 included Resident #29. The recommendations stated "reweigh resident for verification of weight loss. Increase Med Pass to 90 ML twice daily to promote weight stability" RD #1 was not available for interview. A reweight was not located in Resident #29's electronic medical record. A physician's order revised on 9/1/25 by the Assistant Director of Nursing (ADON) read, "Med Pass 90 ml two times a day related to protein calorie malnutrition." An interview was conducted with ADON on 9/18/25 at 11:01 AM. The ADON reported she was responsible for keeping up with residents' weights and ensuring they were completed. The ADON explained that the Unit Clerk was responsible for obtaining resident weights. She further explained only a couple of residents, including	F0692		

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F0692 SS = D	Continued from page 77 Resident #29 had weights obtained for the month of August because the former Unit Clerk had not obtained them before her last day of work at the end of August. The ADON stated Unit Clerk #1 started on 9/1/25. She said Unit Clerk #1 was working on obtaining the weights for September but had not yet obtained all of them. The ADON said the RD pulled a weight report and looked for weight loss and would see those residents. The ADON explained the RD sent the facility her recommendations by email after reviewing the residents. The ADON stated she and the DON received the RD recommendations by email. The ADON reported the DON had asked her to ensure a reweight was completed for Resident #29. The ADON explained she had asked Unit Clerk #1 to get the reweight at the beginning of September. The ADON said she followed up with Unit Clerk #1 today about the reweight but had not followed up with her previously. She reported Unit Clerk #1 had obtained Resident #29's weight on 9/3/25 and it was 110 lbs. She explained Unit Clerk #1 had not entered the weight into the electronic computer system or reported the weight to her. The ADON stated she had not notified the physician of Resident #29's significant weight loss. She said the Physician should be notified if a resident had significant weight loss so they could check the resident medically to see if there was a reason for the weight loss. The ADON stated Resident #29's reweight not being reported or entered until 9/18/25 by Unit Clerk #1 was a little late. The ADON said she noticed Resident #29's weight loss at the end of August but was waiting on the reweight before she notified the Physician. The ADON explained that a reweight should be obtained within a couple of days and that she should have followed up with Unit Clerk #1 in a couple of days if the reweight was not done. The ADON said she should have checked but had gotten busy. An interview was conducted with Unit Clerk #1 on 9/18/25 at 2:41 PM. Unit Clerk #1 said she started in the role of Unit Clerk #1 on 9/1/25. Unit Clerk #1 stated the ADON asked her to get a reweight on Resident #29 at the very beginning of the month. Unit Clerk #1 reported she did the reweight but had forgotten to enter it into Resident #29's medical record. Unit Clerk #1 stated the ADON had asked her about the weight earlier today but had not asked her about it prior to today. Unit Clerk #1 said the ADON had not asked her to notify her of the results. Unit Clerk #1 said she was told monthly weights needed to be done by the 15th day of the month, but she stated weights were taking longer to complete this month. On 9/19/25, a weight of 110 lbs. was entered into Resident #29's electronic record by Unit Clerk #1.	F0692		

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F0692 SS = D	Continued from page 78 An interview was conducted on 9/19/25 at 10:45 AM with RD #2. RD #2 explained she was the interim RD and had started at the end of August. RD #2 said she had been conducting reviews remotely. She stated she had just reviewed Resident #29 because she was not gaining weight. RD #2 said she thought last month in August Resident #29's weight was maybe not accurate because her weight had been down 18 lbs. from her prior weight in July. RD #2 reported a reweight was requested at the end of August. RD #2 said staff should get a reweight as fast as they can, she said within 2-3 days would be reasonable but ideally immediately. RD #2 explained she could not find where the facility reweighed Resident #29 in August. RD #2 said she was unaware a weight of 110 lbs. was obtained on 9/3/25 and entered for Resident #29 on 9/18/25. RD #2 reported that the Physician should also be notified if a resident had significant weight loss. RD #2 said she was not aware of who was responsible for notifying the physician. RD #2 stated she was not told by anyone at the facility the RD was the person who notified the Physician. RD #2 reported it was important to notify the Physician of significant weight loss so they could review the resident from a medical standpoint. RD #2 explained if she had been aware of Resident #29's reweigh weight of 110 lbs. on 9/3/25 she would have made recommendations to further address her weight loss. She explained she would have recommended staff seeing if she needed further assistance with her meals, suggested to check labs such as a thyroid stimulating hormone (TSH) level, she said she would consider increasing or trying a different supplement, she reported she would suggest occupational therapy or speech therapy to screen her for swallowing and self-feeding ability. RD #2 reported monthly weight should be obtained by the 10th day of the month. She explained monthly weights were important to make sure residents were getting what they needed, to identify significant weight loss, and provide intervention quickly if weight loss was seen. RD #2 said she was not seeing monthly weights completed at this facility for more than half of the residents for September and in August only 5 residents had weights documented. RD #2 reported she was not sure why weights had not been obtained by the facility but said she was putting in her recommendations for all residents to have weights obtained and entered in their records if they did not have them yet. She explained that weights should be entered when they were obtained so they could be reviewed in real time and interventions implemented if needed. A meal observation was completed on 9/19/25 at 12:40 PM of Resident #29. She was observed in her room. NA #1	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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F0692 SS = D	Continued from page 79 delivered her meal tray and provided meal tray setup. Her meal ticket indicated a mechanical soft diet. The meal being served included tater-tots, fish sandwich, slaw, and peaches. Her meal was mechanically soft. A mighty shake and tea were present on the meal tray. Resident #29 was observed sitting up on the side of her bed with her bedside table in front of her with her meal tray sitting on it. She sat up for a couple of minutes, she was not observed to eat anything from her meal tray. Resident #29 then proceeded to lay back down on the bed. An interview was conducted on 9/19/25 at 12:45 PM with NA #1. She stated Resident #29 did not eat breakfast today either. She reported Resident #29 typically only ate about 25% of her meals and said, “for the last couple of months she has not been a big eater”. NA #1 said Resident #29 typically drank her mighty shake. NA #1 explained Resident #29 could feed herself but that she sometimes needed cueing. NA #1 stated Resident #29 either ate in her room or at the nursing desk. NA #1 explained she went by Resident #29’s room during meals to check on her, cue her, and encourage her to eat. An interview was conducted with the Medical Director on 9/18/25 at 9:53 AM. He stated he was aware Resident #29 had some prior weight loss in the past but had not been notified in the last month about her having significant weight loss. He said if a resident had significant weight loss it would trigger for him to review and see them. The Medical Director said if he had been notified of Resident #29’s significant weight loss he may have done labs and checked a TSH level because Resident #29 took Synthroid (thyroid medication). The Medical Director said the facility should have followed the RD recommendations and obtained a reweight to confirm her weight loss and ensure the weight was reported. An interview was conducted with the Director of Nursing (DON) on 9/18/20 at 10:20 AM. The DON explained that RD #1 emailed recommendations to her on 8/31/25 and Resident #29 was the only resident listed on the recommendation log. The DON stated after she reviewed the RD recommendation, she gave it to the ADON to follow up on and ensure a reweight was obtained. The DON stated she expected a reweight to be obtained immediately when someone had significant weight loss to confirm the weight loss. The Director of Nursing stated weights and weight loss was discussed in the daily clinical meetings. She explained they discussed if someone was not eating well and “would say they needed to keep an eye on that”. The DON said she did not remember Resident #29’s weight or her not eating well being discussed or brought up in the meetings. The DON	F0692		

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F0692 SS = D	Continued from page 80 reported resident weights were monitored monthly unless ordered otherwise or unless they were a new admission then they were monitored weekly x 4 weeks. An interview was conducted with the Administrator on 9/18/25 at 5:11 PM. The Administrator stated the ADON had notified her about Resident #29's weights today. The Administrator said the monthly weights should be completed by the 10th day of the month. The Administrator said she would expect a reweight to be obtained within a day of receiving the recommendation and results to be entered into the resident's medical record.	F0692		
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 record review, observations and staff interviews, the facility failed to clean oxygen concentrator filters (Resident #1 and Resident #2) and provide oxygen in use signage on resident room entrances (Resident #1, Resident #2, and Resident #9) for 3 of 3 residents reviewed for respiratory care (Resident #1 and Resident #2, Resident #9). In addition, the facility failed to secure an oxygen tank stored upright in a resident's room (Resident #1) and failed to secure an oxygen tank while being transported for 1 of 1 staff member observed carrying an oxygen tank (Nurse Aide #2). Findings Included: 1a. Resident #1 was admitted on 4/22/25 with diagnoses that included chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). Resident #1 had active physician order dated 8/7/25 for oxygen via nasal cannula at 2 liters per minute every shift. Resident #1 was care planned for impaired breathing	F0695	All oxygen concentrator filters should be clean and oxygen tanks should be transported using a secured oxygen transportation cart. The facility has multiple signs throughout the facility indicating oxygen in use. Signs are available to place outside of the residents' rooms indicating oxygen in use and should be in place. Oxygen cylinders should not be left unsecured an any part of the facility. All residents requiring oxygen have the risk to be affected. All residents requiring the use of oxygen were checked to make sure they had signage in place outside of their rooms and that their concentrator filters were clean. All areas were checked throughout the facility to ensure there were no oxygen cylinders that were left unsecured. In-service training is being conducted by the DON, ADON, SDC, and the RN Weekend supervisor reviewing the proper way to transport oxygen tanks, making sure concentrator filters are clean, and that the proper oxygen signage is outside the resident's door. This training will be complete by 10/21/25. The facility DON, ADON, or designee will monitor O2 filter cleanliness, signage on the outside of rooms, oxygen tank transportation, and ensuring there are no free-standing oxygen cylinders left unsecured 3x/week x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the DON/ADON where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion Date 10/21/25	10/21/2025

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F0695 SS = D	Continued from page 81 patterns related to COPD (8/22/24). Interventions included oxygen as ordered (8/22/24). Resident #1's quarterly Minimum Data Set (MDS) dated 8/21/25 coded her cognitively intact and for oxygen use. On 9/16/25 at 11:20 AM an observation of Resident #1's room found her oxygen concentrator filter contained debris build-up that was fluffy in appearance and crumbled when touched. Furthermore, Resident #1's room door was missing oxygen in use signage. Resident #1's in room observation found an oxygen tank that was not empty sitting vertically on the floor near the corner of Resident #1's room. The oxygen tank was not in a secure oxygen tank holder. Resident #1 stated during the observation a staff member removed the oxygen tank earlier that day from her wheelchair, and placed it over by the corner, she could not remember who the staff was. The oxygen tank pressure gauge revealed the tank to be 50% full. The Wound Nurse who was working as a floor nurse was interviewed on 9/19/25 at 11:21AM. The Wound Nurse stated Nurse Aide (NA) #10 was responsible for cleaning the concentrator filters weekly. On 9/16/25 at 11:34 AM Nurse #3 was notified the oxygen tank was stored in Resident #1's room and then observed the stored oxygen tank in the room. Nurse #3 stated on 9/16/25 at 11:36 AM she did not know who had stored the tank in the room and that the oxygen tank needed to be stored in a secure stand. Nurse #3 then placed the oxygen tank in a secure oxygen tank holder. 1b. Resident #2 was admitted on 2/9/18 with diagnoses including vascular dementia, Chronic Obstructive Pulmonary Disease (COPD), and respiratory failure. Resident #2 was care planned for impaired breathing patterns related to COPD and respiratory failure dated 7/4/24. Interventions included administering oxygen as ordered, monitor signs of respiratory distress, and monitor vitals and oxygen saturations as indicated (7/4/24). Resident #2's quarterly Minimum Data Set (MDS) dated 9/2/25 revealed she was severely cognitively impaired and coded for oxygen use. On 9/16/2025 at 11:27 AM an in-room observation of Resident #2's room found her oxygen concentrator	F0695		

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F0695 SS = D	Continued from page 82 contained a light brown colored substance uniformly covering the top of the concentrator. The debris was easy to remove when touched. The concentrator's filter was found to contain a thick and fluffy debris that was crumbly to touch. There was no signage for oxygen in use observed. 1c. Resident #9 was admitted to the facility on 3/20/19 with diagnoses that included acute respiratory failure and hypoxemia. Resident #9 had a physician's order dated 8/7/25 for oxygen via nasal cannula at 2 liters per minute as needed (PRN). Resident #9's annual MDS assessment dated 9/3/25 coded her with moderate cognitive impairment and oxygen use. On 9/16/25 at 11:44 AM an observation of Resident #9's room found an oxygen concentrator and no oxygen in use signage. On 9/17/2025 at 2:57 PM Resident #9's room entrance was observed to not contain an oxygen in use sign. 1d. An observation on 9/16/25 at 11:50 AM found NA #2 carrying an oxygen tank cradled in both arms against her torso and switched to carrying it with one hand on the handle of the tank used for grabbing and protection. NA #2 was walking from the oxygen storage room down a hallway and into the main dining room. NA #2 stated on 9/16/25 at 11:51AM she was taking the full oxygen tank to replace an empty tank on a wheelchair. NA #2 stated she was being careful carrying the oxygen tank when transporting it. NA #2 said she thought there was a small cart to transport the oxygen tank but was unsure where it was located. Furthermore, NA #2 said if the tank was dropped or hitting something hard, it could possibly blow-up or fly into a resident or staff. A follow-up interview with NA #2 was conducted on 9/16/25 at 2:26 PM. NA #2 stated she had spoken with the Administrator, and the facility did have a cart to use for oxygen transportation. Na #2 said the cart should be used when transporting a full oxygen tank long distance. NA #10 was interviewed on 9/19/25 at 11:30 AM. NA #10 stated she was responsible for changing oxygen tubing every week on Wednesday. She stated she also cleaned oxygen concentrators including filters, and nebulizers. NA #10 stated she documented a progress note every time	F0695		

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F0695 SS = D	Continued from page 83 the oxygen tubing was changed for each resident. NA #10 stated she took oxygen tubing into resident rooms in a plastic bag that was dated for 7 days. NA # 10 stated she did not label the actual oxygen tubing, but only the plastic bag they were in and if the bag was removed, it was not possible to know when the oxygen tubing was placed on the concentrator or nebulizer and when it should be changed. Additionally, NA #10 stated she cleaned the oxygen concentrator filters weekly when the tubing was changed, and she was not aware the filters needed to be cleaned daily. NA #10 was informed the oxygen concentrator filters were found to be dirty with build-up of debris and she stated the oxygen concentrators would quickly get dirty in resident rooms. NA #10 went on to say she did not know who was responsible for placing the oxygen in use signage on the outside of residents' doors, and she had not placed any signage on the doors. The Director of Nursing (DON) was interviewed on 9/19/25 at 4:04 PM. She stated oxygen tubing needed to be labeled and changed weekly, and the unit clerk was responsible for changing tubing. The DON stated the oxygen filters needed to be cleaned daily by nursing. Additionally, the DON stated every resident room that had oxygen needed to have oxygen signage at the entrance to the room. She stated the signage should be placed on or near the resident door by the nurse who initially received an order for oxygen use. The DON further stated oxygen tanks should be transported in a secure oxygen holder, when transporting long distances and that oxygen tanks should be stored in a secure holder.	F0695		
F0725 SS = G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff.	F0725	The facility should have enough staff to provide ADL care for dependent residents, to obtain treatment orders for residents with pressure ulcers when they are first identified, to routinely assess a resident for being at risk of a pressure ulcer, to implement measures to prevent a pressure ulcer, provide an ongoing assessment, and to complete accurate head to toe assessments. Resident's that are listed in the statement of deficiency have received correction including ADL care (showers), current and appropriate treatment orders for residents with pressure ulcers, complete assessments of current pressure ulcers or at risk for pressure ulcers, and accurate head to toe assessments. The facility had experienced a loss in a key position that was responsible for hiring of staff as well as managing staffing the building. That position has now been filled. There have also been several new hires and	10/17/2025

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F0725 SS = G	Continued from page 84 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to maintain sufficient staff to provide activities of daily living (ADL) care for dependent residents, to obtain treatment orders for residents with pressure ulcers when the pressure ulcers were first identified, to routinely assess a resident for being at risk of a pressure ulcer, to implement measures to prevent a resident from developing a pressure ulcer and then failed to provide an ongoing assessment, treatment, and necessary medical care for a resident's diabetic and pressure ulcer. Additionally, the facility failed to complete accurate head to toe assessments to identify new or existing pressure ulcers. This was for 5 of 9 residents reviewed for sufficient staffing (Resident #2, Resident #8, Resident #11, Resident #6 and Resident #28). The findings included: This tag was cross referred to: F 677 Based on observation, record review, staff, and resident interviews, the facility failed to provide activity of daily living (ADL) care for dependent residents when Resident #28 and Resident #11 did not receive showers. This deficient practice affected 2 of 4 residents reviewed for ADL care (Residents #28 and #11). F 684 Based on record review, observations, staff wound provider, and physician interviews, the facility failed to provide skin assessments, failed to identify a new wound on the heel at the onset, and failed to ensure necessary medical treatment when positive culture and sensitivity results were available Resident #2. This	F0725	Continued from page 84 staff have returned to work from personal leaves. This has improved the facility staffing. However, other residents could be at risk for being affected by staffing issues that result in deficient practice of providing ADL care, proper care and assessment of wounds, and decreased timeliness of assessments. Record review has been completed on all residents in the facility. Record review for ADL care (showers) was completed on 10/7/25 to observe 2 weeks of scheduled showers. All residents were offered and given showers other than a few that refused. DON and ADON are completing and documenting head to toe skin assessments on all residents in the facility. This will be completed by 10/17/25. Any resident that has a wound have continued to be followed by the wound care PA weekly which has provided the facility with weekly updates and progress notes. The Administrator has in-serviced the Director of Nursing and Assistant Director of Nursing on the facilities staffing policies and procedures. This education was provided on 9/22/25. To ensure there is sufficient nursing staff to provide nursing care to all residents, the Administrator will monitor resident care areas including ADL care (showers), assessments, treatment orders, timeliness of care, as well as overseeing the monitoring being done of nursing services in the other statements of deficiency. This monitoring will be 3x/week until compliance is maintained for one month or longer if the QAPI committee recommends. Documentation of the monitoring will be maintained and presented by the Administrator at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Completion Date 10/17/25	

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F0725 SS = G	Continued from page 85 delayed the treatment for an infected wound. This was for 1 of 2 residents reviewed for quality of care. F 686 Based on observations, record reviews, interviews with the Wound Care Nurse Practitioner, Medical Director (MD) and staff, the facility failed to obtain treatment orders for two (2) pressures ulcers (Resident #8 and Resident #16) when first identified resulting in numerous days that the pressure ulcers went without treatment and worsening to unstageable for Resident #8 and a stage 2 for Resident #16. Resident #8's pressure ulcer was first identified on 08/22/25 as a red open area but an assessment or treatment was not documented. The pressure ulcer was later identified on 09/04/25 and treatment was initiated but no assessment was documented. The pressure ulcer was assessed and documented on 09/09/25 as unstageable wound to the right heel with black eschar (dry, black, or brown crust that forms on the surface of wounds) with foul odor and measuring 3.5 centimeters (cm) by 3.5 cm. The facility failed to routinely assess Resident #16 for being at risk of pressure ulcer, failed to implement measures to prevent Resident #16 from developing a pressure ulcer and then failed to provide ongoing assessment and treatment for Resident #16's pressure ulcer. Resident #16 was identified on 8/31/25 to have a stage 2 pressure wound to the back of his right thigh, there were no wound measurements completed until 9/3/25. After 9/3/25 there was no assessment or measurement documented for the wound. Resident #16 had an initial treatment order entered on 8/31/25 for his stage 2 pressure ulcer that was for 7 days and stopped on 9/7/25. After 9/7/25 there were no additional treatment orders for the wound. The facility failed to complete accurate head to toe skin assessments to identify new or existing pressure ulcers that include the location, type of wound, length, width, depth, and stage of pressure ulcers. This deficient practice occurred for 2 of 3 residents reviewed for pressure ulcers (Resident #8 and Resident #16). During an interview with the Wound Nurse on 09/16/25 at 2:39 PM the Wound Nurse explained that she was pulled to the hall to work as the hall nurse about every day and she could not stay caught up with her wound care responsibilities. She stated that the facility tried to give her half a day a week to catch up on all the documentation that pertained to the wounds in the facility but that was not enough time to keep caught up on the documentation. She continued to explain that when the Wound Care Nurse Practitioner made rounds at the facility which was usually one day a week and if she happened to be on the hall that day, one of the administrative nurses would cover her hall while she	F0725		

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F0725 SS = G	Continued from page 86 made rounds with the Wound Care Nurse Practitioner. The Wound Nurse reported it was hard to monitor the wounds in the facility because she was often pulled to the hall to work as the nurse, and she was unable to be consistent in providing the wound care. The Wound Nurse stated that it was not unusual for her not to see a wound for two weeks or longer because of having to be pulled to the hall to work. On 9/18/25 at 5:11 PM during an interview, the shower sheets were reviewed with the Administrator, DON and ADON for the month of September. There were 8 days residents were supposed to receive showers from 9/1/25 through 9/12/25 and 4 out of 8 of the days no showers were given. - The DON reviewed the shower sheet dated 9/1/25 and stated not all residents received showers because one of the shower team NAs (NA #1) was pulled to work on the floor. - There was no shower sheet dated 9/2/25, the DON, ADON, and Administrator explained if there was not a shower sheet then there would be no showers given on that day. - The DON and Administrator reviewed the shower sheet dated 9/5/25 and both stated there was only one shower team member giving showers from 7:00 AM to 2:00 PM and then she was pulled to work the floor. They stated not all residents received showers on that day. - The DON, ADON, and Administrator reviewed stated no showers were given on 9/8/25 due to staffing shortages. - The DON, ADON, and Administrator stated no showers were given on 9/9/25 due to staffing shortages. - The DON, ADON, and Administrator reviewed the shower sheet dated 9/11/25 and all stated only 8 showers were given to residents because the shower team was pulled and then had to leave early that day. - The DON and Administrator stated no showers were given on 9/12/25 due to staffing shortages. An interview was conducted with the Administrator and the Director of Nursing (DON) on 09/19/25 at 6:00 PM who explained that the staffing coordinator was on leave and the administrative nurses were helping out with the scheduling. The Administrator explained that facility was experiencing a difficult and challenging time regarding staffing in that they had staff to go out on leave, go back to school and drop the number of	F0725		

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F0725 SS = G	Continued from page 87 hours they could work as well as other reasons to make staffing challenging. The DON stated the administrative nurses as well as the Administrator had to work on the medication cart recently to help with staffing. The Administrator continued to explain that they were “backing up and regrouping” and the facility had posted on job sites to draw more staff to the facility. The Administrator stated she knew that duties were not getting done like the showers, wound treatments and assessments but she did not realize to the extent that they were not getting done.	F0725		
F0728 SS = D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(e)(1)-(3) §483.35(e) Requirement for facility hiring and use of nurse aides- §483.35(e)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(e)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(1)(i) and (ii) of this section. §483.35(e)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program;	F0728	The facility should document staff competency prior to staff member providing direct care to residents. Employee #17 has previously completed a CNA program in North Carolina and received certification. That certification has expired and does not meet the requirement for her to take a refresher course to have certification reinstated because of the timeline since certification expired. Because employee does not meet the state requirements for certification renewal and was unable to complete the hybrid program to go through the full training again, her daily assignment has been moved from the skilled part of the building to the assisted living hall. Other residents could be at risk if staff providing care do not have the competencies required to provide appropriate care. DON has reviewed all records of nursing staff that provide direct resident care to ensure they meet competency requirements. Audit included ensuring up to date license, certification, or is a full-time employee in a State-approved training and competency evaluation program. This was completed on 9/23/25. Administrator and staffing coordinator completed an audit on 10/22/25 of all direct care staff to ensure an up-to-date skills list was in their personal records. Audit reviled some outdated skills competency lists. Administrator, DON, and ADON are working to complete updated skills competency checklists. These will be completed upon these identified employee's next working shift. Completion date to have these check lists completed by is 10/27/25. The Administrator has in-serviced the Director of Nursing and Assistant Director of Nursing on the facilities hiring policies and procedures. Which includes obtaining records that indicate an applicant has the appropriate credentials to provide competent and appropriate resident care. This education was provided on 9/22/25. The facility staffing coordinator	10/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fleshers Fairview Health Care	**3016 Cane Creek Road , Fairview, North Carolina, 28730**

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F0728 SS = D	Continued from page 88 (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to provide staff that met minimum competency requirements when they employed a staff member to work in the capacity of a nurse aide (NA) and were assigned NA tasks who had not completed a state-approved nurse aide training program, certification exam, or competency evaluation prior to providing direct care to residents. This deficient practice occurred for 1 of 8 staff reviewed for minimum competency requirements (Staff #17). Findings included: The North Carolina (NC) Department of Health and Human Services (DHHS) Health Care Personnel Education and Credentialing Section's website indicated under the section of Nurse Aide I, last updated 1/29/25, that in accordance with federal law, a facility may employ a nurse aide (NA) for a period of up to 4 months under the following conditions: -During the 4-month grace period, an individual must be deemed competent to provide nursing or nursing-related services by a Registered Nurse and work toward meeting the training and testing requirements by participating in a state-approved Nurse Aide I training and competency evaluation program or a state-approved competency evaluation program. The website clarified that the individual must be "actively participating" in a state-approved Nurse Aide I training and competency evaluation program during the 4-month grace period. It further indicated the NC Nurse Aide I Registry was a registry of all people who met the state and federal training and testing requirements to perform Nurse Aide I tasks. Staff #17's employee file stated her date of hire was 5/12/25. She was hired to work full time in the capacity of a nurse aide but had not completed a state approved training program or passed a certification exam. In addition, Staff #17 had not completed a skills	F0728	Continued from page 88 that was responsible for ensuring new hire, and yearly paperwork that included the skills competency list, was completed and returned to be filled in the employees personal file, unexpectantly left her position. Paperwork was found incomplete, which included skills competency lists, after she left this position. The Administrator has been in the process of correcting and completing paperwork. This position has been filled as of 10/13/25 and she is currently receiving all training for the position. Part of this training includes how to use the new hire checklist which includes ensuring skills lists are completed and returned to the employee's personal file timely. New hire checklists should be completed and returned upon the employees last day of orientation. Training has also included the completion of the yearly paperwork which includes the skills competency checklist. The yearly paperwork process, which includes the competency checklist, is initiated by the Administrator. Administrator provides the list of every employee due for yearly paperwork based on their hire date and gives to each department head including the staffing coordinator. The department head is to then fill out the skills competency checklist. Competency skills lists for anyone in the nursing department (nurses, nurse aides, shower aides, unit clerk) is completed by the DON or ADON and is completed by return demonstrations and observations. The DON, ADON, or department head will review the checklist with the employee. It is then the staffing coordinators responsibility to ensure the department head returns the checklist to her timely, so it can be filed in the employee's personal file. A process change will be the Administrator checking the flow of this process every month to ensure competencies are completed and are returned promptly. The Administrator will monitor all facility new hires to ensure applicant has up to date license, certification, or is a full-time employee in a State-approved training and competency evaluation program prior to providing direct care to residents. This monitoring will be 3x/week x 8 weeks until compliance is maintained for one month or longer if the QAPI committee recommends. The Administrator will document her monitoring of skills competency checklists being completed and returned to be filled in the employee's personal record. This monitoring will be 3x/week x 8 weeks until compliance is maintained for one month or longer if the QAPI committee recommends. Documentation all the monitoring will be maintained and presented by the Administrator at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed.	

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F0728 SS = D	Continued from page 89 competency check list. On 9/18/25 at 4:00 PM the DON reported Staff #17 was not currently enrolled in a state approved training program. The DON stated Staff #17 had been enrolled in a hybrid online program a week ago but was told by the program instructor she needed an in-person program and to return in December. Review of nursing schedules from 9/1/25 through 9/19/25 revealed Staff #17 was scheduled to work and was assigned NA tasks on 9/2/25, 9/4/25, 9/5/25, 9/6/25, 9/7/25, 9/11/25, 9/18/25. A telephone interview was attempted on 9/22/25 at 11:55 AM and Staff #17 was unavailable for interview. A joint interview was conducted on 9/18/25 at 5:11 PM with the Administrator and DON. The Administrator stated the facility hired “Staff in to eventually become a Nurse Aide”. The Administrator stated the facility did not have an in-house state approved nurse aide training program. She explained that Staff were basically hired as an NA without certification and they were able to do direct patient care. The Administrator said Staff were not enrolled in a state approved training program when hired. She explained Staff were hired and then the facility tried to get them enrolled in a program during their first four months. The Administrator stated the facility paid for the Staff to go to NA school and that the Staff had to complete the NA program and pass NA certification exam within four months. The Administrator reported during the four-month period Staff could work anywhere in the building taking care of residents and doing everything a certified NA could do. The Administrator explained after four months if the Staff had not completed an NA program and became certified, then they could only work on the hallway with uncertified rest home beds and take care of those residents. The Administrator stated they had started hiring Staff during the pandemic as part of a waiver that allowed the use of “Temporary Nurse Aides”. The Administrator explained the waiver allowed staff to take an online class, receive on the job NA training, and then be checked off on skills through return demonstration by the facility. She reported that during the waiver Staff could challenge the NA certification exam (take the NA certification exam without completing a state approved training program). The Administrator explained when the waiver went away when the pandemic ended, she thought Staff could still work for the 4 months and the only part that had changed was that staff could not challenge the certification exam anymore. The Administrator stated	F0728	Continued from page 89 Completion Date 10/27/25	

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F0728 SS = D	Continued from page 90 that the waiver had expired and the facility had switched to the model they were currently using. She explained that the current model was hiring Staff and then having them enroll in an NA program and the facility paying for the program, she said it was a scholarship program. The Administrator stated she had not been aware that for staff working in the capacity of an NA for less than 4 months the regulation said Staff needed to actively be participating in a state approved NA program or have completed a state approved NA program and be waiting to take the competency exam.	F0728		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §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.	F0732	The nurse staffing hours were posted on the receptionist desk facing outwards to where they could easily be seen by any residents, visitors, and staff. They have been posted in this same location for many years. The receptionist is responsible for adding the census number at the top of this sheet. She was unaware that the assisted living census number was not to be included in the total census number. No residents were directly affected. The receptionist immediately corrected the census on the nurse staffing sheets listed in the statement of deficiency and has corrected all historical sheets which was completed on 9/26/25. This receptionist as since retired from the facility. The new receptionist that started work on 10/6/25, has been educated on only including the skilled census on the nurse staffing sheets. The nurse staffing sheets have also been moved to signage that is beside the kiosk where visitors check into the facility. The facility Administrator, DON, or designee will monitor the compliance of the nurse staffing sheet location, and the accuracy of the census on the sheet, 3x/week x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the DON/ADON where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion Date 10/6/25.	10/06/2025

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F0732 SS = C	Continued from page 91 §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 observations, record reviews and interviews, the facility failed to ensure the Nurse Staffing Information was posted in a prominent place that was readily accessible to residents, staff and visitors. The facility also failed to ensure the posted Nurse Staffing Information accurately reflected the facility census and staffing for 4 of 4 days (09/16/25, 09/17/25, 09/18/25 and 09/19/25). The findings included: A. A review of the Nurse Staffing Information sheets for 09/16/25 at 9:45 AM, 09/17/25 at 9:26 AM, 09/18/25 at 4:56 PM and 09/19/25 at 11:42 AM revealed the staffing sheets were observed posted on counter of the receptionist desk in the front lobby which was approximately two and a half feet tall. The staffing sheets were posted flat on the counter, and the observer had to stand over the desk and look down to view the staffing sheets. On 09/19/25 at 2:10 PM an interview was conducted with the Receptionist who explained that she was given the Nurse Staffing Information sheets by the Scheduler either the day before or the morning of the day she posted them. She explained that lately the Scheduler had been out, so the Director of Nursing gave them to her to post. An interview was conducted with the Administrator on 09/19/25 at 6:00 PM with the Director of Nursing present. The Administrator explained that the facility had been posting the Nurse Staffing Information sheets in the lobby for a long time, and no one had made her aware that it was not readily accessible. B. A review of the Nurse Staffing Information sheet for 09/16/25 at 9:45 AM revealed the resident census section was left blank.	F0732		

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F0732 SS = C	Continued from page 92 A review of the Nurse Staffing Information sheet for 09/17/25 at 9:26 AM revealed the census total included both the skilled residents and assisted living residents. The posted census was 61 when the actual resident census for the skilled residents was 55. A review of the Nurse Staffing Information sheet for 09/18/25 at 4:56 PM revealed the census total included both the skilled residents and assisted living residents. The posted census was 61 when the actual resident census for the skilled residents was 55. A review of the Nurse Staffing Information sheet for 09/19/25 at 11:42 AM revealed the census total included both the skilled residents and assisted living residents. The posted census was 60 when the actual resident census for the skilled residents was 54. An interview was conducted with the Administrator on 09/19/25 at 6:00 PM with the Director of Nursing present. The Administrator explained that the facility had included the census of the whole facility for as long as she could remember and no one had ever told her anything different. The Administrator stated she had reviewed the regulations and now understood that the census for the assisted living part of the facility should not be included in the census of the skilled residents. C. A review of the nursing assignment sheet dated 09/16/25 for first shift (7:00 AM – 3:00 PM) had 2 Registered Nurses (RNs) for 16 hours and 6 Nurse Aides (NAs) for 43 hours scheduled to work. The Nurse Staffing Information sheet indicated there were 4 RNs for 32 hours and 8 NAs for 69 hours. There were 2 Temporary Nurse Aides (TNA) for 16 hours scheduled to work on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. A review of the nursing assignment sheet dated 09/16/25 for second shift (3:00 PM – 11:00 PM) had 1 RN for 4 hours and 7 NAs for 46 hours scheduled to work. The Nurse Staffing Information sheet dated 09/16/25 indicated there were no RNs and 7 NAs for 40 hours. There were 3 TNAs for 24 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet dated 09/16/25 for third shift (11:00 PM – 7:00 AM) had 4 NAs for 24 hours scheduled to work and the Nurse Staffing Information sheet had 4 NAs for 32 hours. A review of the nursing assignment sheet dated 09/17/25 for first shift had 3 RNs for 24 hours and 6 NAs for 41	F0732		

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F0732 SS = C	Continued from page 93 hours scheduled to work. The 9/17/25 Nurse Staffing Information sheet indicated there were 4 RNs for 32 hours and 9 NAs for 61 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet dated 09/17/25 for second shift had 2 RNs for 16 hours, 1 LPN for 8 hours and 4 NAs for 24 hours scheduled to work. The Nurse Staffing Information sheet indicated there was 1 RN for 8 hours, 2 LPNs for 16 hours and 5 NAs for 32 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet dated 09/17/25 for third shift had 2 NAs for 16 hours scheduled to work and the Nurse Staffing Information sheet had 3 NAs for 24 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. A review of the nursing assignment sheet dated 09/18/25 for first shift had 2 RNs for 12 hours, 1 LPN for 8 hours and 7 NAs for 61 hours scheduled to work. The Nurse Staffing Information sheet dated 9/18/25 indicated there were 3 RNs for 32 hours, 1 LPN for 4 hours and 8 NAs for 69 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet for second shift had 3 NAs for 20 hours scheduled to work and the Nurse Staffing Information sheet had 5 NAs for 32 hours. There were 2 TNAs for 12 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet for third shift had 2 NAs for 16 hours scheduled to work and the Nurse Staffing Information sheet had 5 NAs for 40 hours. There were 2 TNAs for 16 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. A review of the nursing assignment sheet dated 09/19/25 for first shift had 1 RN for 8 hours scheduled to work and the 9/19/25 Nurse Staffing Information sheet had 2 RNs for 16 hours. There were 3 TNAs for 24 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet. The nursing assignment sheet for second shift had 1 RN for 4 hours scheduled for work. The Nurse Staffing Information sheets had 0 RN and 0 hours. The nursing assignment sheet for third shift had 2 NAs for 16 hours scheduled to work and the Nurse Staffing Information sheet had 4 NAs for 32 hours. There was 1 TNA for 8 hours scheduled on the assignment sheet and no TNAs were listed on the Nurse Staffing Information sheet.	F0732		

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F0732 SS = C	Continued from page 94 An interview was conducted with the Administrator on 09/19/25 at 6:00 PM with the Director of Nursing present. The Administrator explained that she did not realize the Nurse Staffing Information sheets had to reflect the absences related to illness or call outs but after reading the regulations she became aware of it and will make adjustments to the Nurse Staffing Information sheets.	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 manufacturer guidelines, observations and staff interviews, the facility failed to remove loose and unsecured pills of various shapes, sizes and colors from 1 of 3 medication carts (200 Hall) and failed to label and store inhalation breathing solutions (Budesonide, Albuterol Sulfate, DuoNeb) according to manufacturers' guidelines for 2 of 3 medication carts (200 and 500 hall) reviewed for medication storage. The findings included:	F0761	Unsecured, loose pills should not be at the bottom of the medication cart drawers and foil pouches should be dated when they are opened. Other residents could have the potential to be affected by this. Upon discovery of the loose pills, and the nebulizer medication being opened outside the foil packets, the Director of Nursing immediately checked other medication carts to ensure the carts were not affected by this deficient practice. The DON also reached out to the facilities consultant pharmacist who provided written materials that explained the nebulizer medication only had to be used within one week if the vial of medication had been removed from the foil package. The DON is providing this education to the nursing staff. This education will be complete on 10/21/25. The importance of keeping the medication carts clean, no loose pills being in medication carts, as well as labeling open medications with the date it was opened, is included in this training with completion date 10/21/25, and is being added to new hire and annual training for nurses. The nurse assigned to each medication cart for each shift is responsible for ensuring the cart is clean, items in the cart are labeled when opened, and insuring there are no lose pills in the cart. DON or designee will monitor the medication carts for compliance of loose pills, cleanliness of medication carts, and the proper labeling of medication. This monitoring will be 2x/week until compliance is maintained for one month or longer if the QAPI committee recommends. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Observation of the medication carts for cleanliness, labeling, and loose medications is also being added to the Admin Nurses routine monthly monitoring, past this listed monitoring for plan of correction.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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F0761 SS = D	Continued from page 95 a. Review of manufacturers' guidelines for budesonide solution revealed after opening the foil pouch the vials are only good for 2 weeks. Review of the manufacturers' guidelines for DuoNeb solution revealed that after opening the foil pouch the individual vials of DuoNeb solution should be used within 7 days. An observation was made of the 200-hall medication cart on 09/19/25 at 11:50 AM accompanied by Nurse #1. The cart yielded 13 loose pills of various shapes, colors and sizes from the bottom of the medication cart drawers. Further review of the 200-hall medication cart revealed an open and undated box of budesonide solutions that contained multiple vials of budesonide solutions available for use in the medication cart drawer. The medication cart also yielded 2 open and undated boxes of DuoNeb solutions that were available for use in the medication cart drawer. An interview was conducted with Nurse #1 at 11:50 AM on 09/19/25. The Nurse explained that it was each nurse's responsibility to keep the medication carts clean and orderly. She stated that she had not cleaned the medication cart yet, but she doubted that the 13 loose pills had happened since the beginning of her shift at 7:00 AM. She stated that she had not used the budesonide nebulizing solution yet that shift. The Nurse indicated that she did not know how long the budesonide or DuoNeb solution could be used after the foil pouch was opened. b. Review of the manufacturers' guidelines for DuoNeb solution revealed that after opening the foil pouch the individual vials of DuoNeb solution should be used within 7 days. Review of the manufacturers' guidelines for albuterol sulfate solution revealed the solution should be stored in the foil pouch to protect them from light. On 09/19/25 at 12:38 AM an observation was made of the 500-hall medication cart accompanied by Nurse #2. The medication cart yielded 4 loose albuterol sulfate solutions vials laying in the bottom of the medication cart drawer. The medication cart also yielded 1 open and undated box of DuoNeb solutions that was in the medication cart drawer and available for use. An interview was conducted with Nurse #2 at 12:38 AM on 09/19/25. The Nurse explained that it was each nurse's responsibility to keep the medication carts clean and orderly. She indicated that she had not cleaned the	F0761	Continued from page 95 Completion Date 10/21/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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(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
F0761 SS = D	Continued from page 96 medication cart yet and that she had not used the albuterol sulfate nebulizing solution. The Nurse indicated that she did not know how long the DuoNeb solution could be used after opening the foil pouch. During an interview with the Director of Nursing (DON) on 09/19/25 at 6:00 PM the DON explained that it was each nurse's responsibility to keep the medication carts clean, but it was the weekend supervisor's responsibility to clean and organize the medication carts which included removing loose pills and ensuring that nebulizing solutions were stored and labeled appropriately.	F0761		
F0773 SS = D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Wound Provider, Nurse Practitioner, and Medical Director interviews, the facility failed to notify the Wound Provider of a positive wound culture and sensitivity lab result when the results were received. This resulted in a delay of antibiotic treatment for 1 of 1 resident reviewed for notifying a physician of laboratory results (Resident #2). Findings Included: Resident #2 was admitted on 2/9/18 with diagnoses of vascular dementia and hemiparesis (weakness of a limb) and hemiplegia (side of body paralyzed) of left side following a stroke. A progress note written by the Wound Nurse dated 9/10/25 at 2:05 PM read she found an open area on Resident #2's left heel. The note read the open area was unstageable and measured 2 centimeters (cm) x 1.5	F0773	Residents' providers should be notified promptly of any abnormal lab results including cultures and sensitivities per the facilities policy so that there is no delay in treatment. Antibiotics were started on 9/17/25 for Resident #2. Other residents have the potential to be affected if they have lab work ordered that fall outside of the clinical reference range. DON and ADON have completed record reviews to ensure the Medical Director has been notified of all abnormal lab results. This was completed on 10/10/25. DON, ADON, SDC, and Weekend Supervisor are completing in-service training to all nurses on the importance of notifying providers of abnormal lab results timely, including cultures and sensitivities. DON has also educated the unit clerk on emailing all lab results, even if they have not been completed, to the Medical Director daily. In-service education will be completed by 10/21/25. DON or designee will monitor to ensure the Medical Director has been notified of all abnormal labs timely, and that the Medical Director has addressed the abnormal labs. This monitoring will be 3x/week until compliance is maintained for one month or longer if the QAPI committee recommends. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Completion Date 10/21/25	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

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F0773 SS = D	Continued from page 97	F0773		

(cm).

On 9/11/25 the Wound Provider evaluated the left heel dorsal wound. The Wound Provider treatment note read; given the dorsal location of this wound, it was consistent with a diabetic etiology. The wound was deep and full of necrotic slough (dead tissue) and suspected the wound had been present for some time. The recommendations included: wound culture and sensitivity.

On 9/11/25 at 12:48 PM the Unit Clerk wrote a progress note. The note read: Resident # 2's wound culture of left heel was collected by the Wound Provider and awaiting pick up.

A laboratory report dated 09/11/25 and a final report dated 09/14/25 read in part: Wound culture left heel-moderate proteus mirabilis (bacteria) and scant staphylococcus aureus (bacteria).

The Wound Provider was interviewed via phone on 9/18/25 at 1:30 PM and stated Resident #2 was evaluated by her on 9/11/25 for the first time. Resident #2 was evaluated for 3 wounds with one being the left heel diabetic wound. The Wound Provider stated the left heel wound had yellow necrotic slough and it was difficult to measure the depth but suspected it was to the bone. Furthermore, the Wound Provider stated she had ordered and obtained a culture and sensitivity for the left heel wound for suspected wound infection on 9/11/25.

On 9/15/25 the Wound Provider documented the Wound Nurse reported the wound culture obtained last Thursday (9/11/25) was negative. The Wound Provider noted a subsequent culture was obtained today because she had a high suspicion that the previous culture result was inaccurate.

On 9/15/25 at 12:09 PM the Wound Nurse wrote a progress note for order to repeat the wound culture and sensitivity (left heel wound).

Resident #2's Nurse Practitioner (NP) was interviewed on 9/17/25 at 11:00 AM. The NP stated he was aware that Resident #2 had wounds on her back and sacrum area but did not know she had a wound on her left heel. The NP stated he was not notified of any laboratory results ordered by the Wound Provider on 9/11/25 and was not aware of her treatment orders. Additionally, the NP stated normally the Wound Provider should have been notified with results of any labs or diagnostics first because she had ordered them and then results would be placed in his folder to review or would have been

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F0773 SS = D	Continued from page 98 called in to him. A follow-up interview was conducted with the NP 9/17/25 at 2:30 PM. He stated Resident #2's culture and sensitivity laboratory results from 09/11/25 had been reviewed by him today (09/17/25). The NP stated the culture and sensitivity for the wound on Resident #2's left heel was positive for moderate proteus mirabilis and scant staphylococcus aureus on the results dated 9/14/25. He then added orders for 2 antibiotics (Bactrim 400/80 milligrams by mouth twice daily for 14 days, Ceflin 250 milligrams by mouth one time daily for 14 days) for the infected heel wound, based on the culture and sensitivity results obtained on 09/11/25. The Medical Director was interviewed on 9/18/25 at 11:25 AM. The Medical Director stated the culture and sensitivity laboratory report was verified on 9/14/25 and the facility should have notified the Wound Provider or the NP on 9/15/25 of the results. The Medical Director said Resident #2's labs had indicated an infection of the left heel, and Resident #2 had missed 1 day of antibiotic treatment due to the Wound Provider not receiving the wound culture and sensitivity results promptly. A follow up interview with the Wound provider was conducted on 9/18/25 at 1:30 PM. The Wound Provider stated on 9/15/25, she evaluated and treated Resident #2 and was told by the Wound Nurse that the culture and sensitivity from 09/11/25 had come back negative. The Wound Provider stated she had not seen the results of the culture and sensitivity, nor had they been called or communicated to her prior to the Wound Nurse's report that they were negative. The Wound Provider went on to state she had suspected an infection of the left heel wound and was surprised the culture and sensitivity results were negative (as stated by the Wound Nurse). She ordered another culture and sensitivity to be sent to the lab for confirmation. The Wound Provider said she was only able to see laboratory results if they were uploaded to the resident's electronic chart or handed to her in person. The surveyor informed the Wound Provider the wound culture and sensitivity was completed on 9/14/25 and had been sent to the facility. Resident #2's NP had seen the results on 9/17/25 and had ordered antibiotics for the infected heel wound. The Wound Provider responded, Resident #2 had missed at least 1 day of antibiotic treatment because she had been provided with incorrect information for the culture and was not provided with the results on 9/15/25. The Wound Provider said the wound culture and labs should have been made available for her to review.	F0773		

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F0773 SS = D	Continued from page 99 An interview was conducted with the Wound Nurse on 9/18/25 at 1:15 PM. She did not know why she communicated to the Wound Provider that the left heel wound culture was negative on 9/15/25. The Wound Nurse said she had not seen the results of the culture and sensitivity that was ordered on 9/11/25. The Director of Nursing (DON) was interviewed on 9/18/25 at 12:45 PM. She stated labs or culture results were not given to the providers until all the results had been completed and returned to the facility from the laboratory. The DON stated Resident #2's lab results were not completed fully until 9/16/25 and the resident's NP would not have seen the results until that day. The DON stated the culture and sensitivity results had been completed by the lab on 9/14/25 but was not sure at what time on 9/14/25 the results were faxed to the facility. Additionally, the DON stated the Wound Provider should have been shown the results of the culture and sensitivity results upon her visit on 9/15/25, because it was a positive result for infection. The DON stated she was not aware the Wound Nurse had told the Wound Provider the results of the wound culture were negative on 9/15/25.	F0773		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	Infection prevention and control standards should be maintained for all staff and residents based on the facility policy and procedures as well and federal and local guidelines. Resident #2 and Resident #8 were both placed on EBP Precautions. Other residents/staff have the potential to be affected if other residents met the criteria of being on EBP and were not on the precautions. The ADON who is the facilities infection preventionist audited every resident to ensure if they met the precautions of EBP they had the appropriate signage on their room and ensured required PPE was available. This was completed on 9/22/25. Education was provided to the DON and ADON by the Administrator on EBP precautions, what the criteria of EBP is, as well as making sure needed precautions are current and appropriate. Education was also provided to the wound care nurse by the DON on the proper use of PPE, as well as correct step by step procedures of a dressing change. This education was done on 9/22/25. DON or designee will observe 3 dressing changes a week x4 weeks to ensure proper infection control procedures	09/25/2025

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F0880 SS = D	Continued from page 100 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 100 are followed, and dressing changes are completed properly. This monitoring will be 3x/week until compliance is maintained for one month or longer if the QAPI committee recommends. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Completion Date 9/23/25	

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F0880 SS = D	Continued from page 101 Based on observations, record reviews and staff interviews, the facility failed to follow their Hand Hygiene and Enhanced Barrier Precautions (EBP) policy and procedures when the Wound Nurse did not don a gown, doff her gloves, perform hand hygiene and don clean gloves after removing the soiled dressing and after cleansing the wound and before applying the new dressing during wound care to Resident #8. The Wound Nurse also did not don a gown, use hand hygiene after doffing gloves after removing soiled dressing and before donning clean gloves, and did not doff gloves and use hand hygiene after cleansing the wound and before applying the new dressing during wound care to Resident #2 for 1 of 7 staff observed for infection control practices (Wound Nurse). The findings included: Review of the facility's undated policy for Enhanced Barrier Precautions (EBP) revealed: EBP are used to prevent the transmission of multidrug resistant organisms. EBP will be used when contact precautions do not apply. EBP will be used for high contact resident care involving wounds or any medical indwelling devices including central line, urinary catheter, feeding tube, tracheostomy/ventilator. High contact care including dressing, bathing, transferring, changing linens, providing hygiene, incontinent care, device care and wound care. Policy: Gloves and Hand Hygiene 1) Hand hygiene should be complete prior to donning gloves 2) Gloves should be worn when entering the room and while providing care for a resident 3) Gloves should be changed after having contact with infective material like fecal matter and wound drainage 4) Gloves should be removed before leaving the residents' room and hand hygiene should be performed immediately 5) After removing the gloves and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items. Gowns: 1) A gown should be worn when providing high contact resident care 2) If a gown is worn it should be removed before leaving the resident's room 3) After removing the gown, clothing should not contact potentially contaminated environmental surfaces. Review of the facility's undated policy for Hand Hygiene read in part: Handwashing is the single most important thing you can do to prevent the spread of infection. Thorough handwashing removes pathogens from the skin. In order to perform hand hygiene appropriately, soap, water, alcohol-based hand rub, and a sink should be readily accessible. Staff must perform hand hygiene even if gloves are used: before and after	F0880		

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F0880 SS = D	Continued from page 102 contact with the residents, before performing an aseptic task, after contact with blood, body fluids, visible contaminated surfaces or after contact with objects in the residents' room, after removing personal protective equipment (gloves, gown and mask). 1a. On 09/16/25 at 2:49 PM an observation was conducted of the Wound Nurse performing a wound treatment on an unstageable right heel of Resident #8. The Wound Nurse gathered the supplies and went to the Resident's room (there was no EBP signage on the door) where she prepared the supplies on the over bed table. The Wound Nurse did not don a gown for the treatment and proceeded to wash her hands and don gloves before she removed the soiled dressing from the unstageable right heel pressure ulcer. Then without changing her gloves and sanitizing her hands the Wound Nurse then cleansed the pressure ulcer and again without changing her gloves and sanitizing her hands she applied the ordered medication and border dressing. The Wound Nurse then removed her gloves and washed her hands. An interview was conducted with the Wound Nurse on 09/18/25 at 2:20 PM. The Wound Nurse explained that she knew she had "messed up" while doing wound care on Resident #8 because she did not change her gloves and wash her hands when she should have which was after she removed the old dressing and after she cleansed the wound and applied the new dressing. The Wound Nurse stated she just forgot. The Wound Nurse also explained that she did not wear a gown because she questioned the Assistant Director of Nursing (ADON) about if Resident #8 should be on Enhanced Barrier Precautions (EBP) because she had a chronic wound and she was told Resident #8 did not require EBP. 1b. An observation was made on 09/18/25 at 2:12 PM of the Wound Nurse performing a wound treatment on Resident #2 who had a diabetic foot ulcer on her left heel. The Wound Nurse gathered her supplies and went to the Resident's room (there was no EBP signage on the door) where she placed the supplies on the bedside table. The Wound Nurse washed her hands and donned gloves but did not don a gown for the procedure. The Wound Nurse removed the soiled dressing from the Resident's heel and doffed her gloves and without sanitizing her hands she applied a new pair of gloves. She then cleansed the wound and without removing her gloves and using hand sanitizer she picked up the gauze soaked with a liquid used to kill bacteria and packed the wound with the gauze before she applied a border dressing to the wound. The Wound Nurse then doffed her gloves and washed her hands.	F0880		

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F0880 SS = D	Continued from page 103 On 09/18/2025 at 2:20 PM an interview was conducted with the Wound Nurse who explained that she knew she had “messed up” when she performed the treatment on Resident #2 because she did not change her gloves and wash her hands after she cleansed the wound before she applied the ordered treatment. She stated she just forgot. The Wound Nurse did not realize that she did not sanitize her hands after she removed her gloves and donned new gloves before she cleansed the wound. The Wound Nurse also explained that she did not wear a gown for the procedure because she had questioned the ADON about Resident #2 being on EBP because of her chronic diabetic ulcer and the ADON informed her that the Resident’s wound was not considered to be chronic. An interview was conducted with the Infection Preventionist (IP) on 09/16/25 at 1:16 PM and 09/19/25 at 5:43 PM. The IP was informed that the Wound Nurse did not don a gown when she performed the wound treatment on Resident #2 or Resident #8. The IP explained that she did not put Resident #2 or Resident #8 on Enhanced Barrier Precautions because she thought according to the CDC (Centers for Disease Control) guidelines the wound had to be present six months or longer. The IP was informed that EBP does not have to be for wounds that will heal in a short time such as skin tears that could be covered with a band aide but open draining wounds no matter what stage should have EBP. The IP indicated the Wound Nurse should have changed her gloves and used hand sanitizer after she removed the old dressing, and after she cleansed the wound before applying the new dressing. An interview was conducted with the Director of Nursing (DON) on 09/19/25 at 6:00 PM. The DON explained that she and the IP had a conversation about Resident #8 being on EBP and she thought that her pressure ulcer did not meet the CDC guidelines of six months or longer. The DON was informed that EBP does not have to be for wounds that will heal in a short time such as skin tears that could be covered with a band aide but open draining wounds no matter what stage should have EBP. The DON indicated the wounds would be reevaluated for EBP. The DON also reported that she had reviewed the Wound Nurse’s technique with the wound treatments and had cautioned her to change her gloves and sanitize her hands during the procedure. The DON indicated that the Wound Nurse would need more education.	F0880		
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and	F0908	The dryers that are used in the laundry building are leased from Highland Equipment. The operations manual for these dryers state to clean the filter daily. The blower from the dryer that blows the lint out is designed to blow the lint down to the ground under the	10/10/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F0908 SS = D	Continued from page 104 patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to keep essential equipment clean and in safe operating order for 2 of 2 dryers (dryer #1 and dryer #2) observed for safe operating conditions. The findings included: On 09/18/25 at 4:00 PM an observation was made of the laundry room which was in a building separate from the facility accompanied by the Environmental Services Supervisor. Laundry Aide #1 was asked to open the dryer doors to be able to observe the dryer lint traps. The observation yielded dryer #1 and dryer #2 with copious amount of dark colored dust balls in the bottom of the dryers and both lint traps of the dryers had a sheet of lint that fell from the traps when touched that appeared to be approximately ¼ inch thick. An interview was conducted with Laundry Aide #1 on 09/18/25 at 4:05 PM who explained that he worked on first shift and that he cleaned the dryer vents and filters every shift. The Laundry Aide could not explain the buildup lint and dust in the dryers. During the interview with the Environmental Services Supervisor on 09/18/25 at 4:05 PM the Supervisor explained that the dryer vents and lint traps should be cleaned every day, but she indicated if cleaning them every day had a buildup of lint and dust remaining like what was found then the cleaning would need to be changed to a more frequent occurrence.	F0908	Continued from page 104 dryer so that minimal lint is ever on the lint trap. The laundry building is not connected to the facility. No residents were directly affected. Education was provided to the laundry aide on 10/9/25 regarding the proper use of the dryer equipment per the operations manual, the daily cleaning of the lint trap, and cleaning the lint under the dryer. The importance of keeping the laundry building clean, as well as following the operations manual for use of dryer equipment including the lint traps, has been added to the new hire and annual training for laundry staff. The facility Administrator, Environmental Services Director, or designee will monitor the cleanliness of the lint traps of both dryers, 3x/week x 4 weeks or until compliance is met. Documentation of the monitoring will be maintained and presented at the QAPI meetings by the Administrator/Environmental Services Director where corrective action will be evaluated for effectiveness and changes made to the corrective action as need. Completion Date 10/10/25	