STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Rehabilitation & Health Center	**2700 Roal Commons Lane , Matthews, North Carolina, 28105**

(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 12/1/25-12/5/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DCA28-H1.	E0000		12/16/2025
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 12/1/25 through 12/5/25. Event ID# 1DCA28-H1. The following intakes were investigated: 2666607, 2662609, 2648224, 2647365, 2644306, 2623338, 2621410, 2601122, 2588816, 2571651, 843643, 843640, 843639, 843638, 843636, 843635, 843634, 843632, 843631,843644, 843626, 843625, 843613, 843624, and 843623. 9 of the 74 complaint allegations resulted in deficiency.	F0000		12/16/2025
F0641 SS = B	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.	F0641	F641 Accuracy of Assessments For resident #163 a corrective action was obtained on 12/9/2025 by modifying and correcting MDS assessment for assessment reference date of 9/21/2025. Coding of question A2105 (Discharge) was corrected to accurately reflect that resident discharged to hospital the specified lookback timeframe. Correction was completed by MDS Coordinator 12/8/2025, re-submitted and accepted into state database on 12/09/2022 with submission identification 34946838. For resident #7 a corrective action was obtained on 12/05/2025 by the MDS Coordinator by modifying and correcting the MDS assessment with assessment reference date of 09/24/2025. The assessment was modified and coding for question J1400 was corrected in order to accurately reflect that resident is receiving Hospice services. Correction was completed by MDS Coordinator on 12/04/2025, re-submitted and accepted into state database on 12/05/2025 with submission identification 34929054. Corrective action for residents with the potential to	12/16/2025

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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F0641 SS = B	Continued from page 1 §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 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) assessment in the areas of discharge (Resident #163) and Hospice (Resident #7) for 2 of 29 residents reviewed for accuracy of assessments. The findings included: 1. Resident #163 was admitted to the facility on 9/16/25. Review of the discharge MDS assessment dated 9/21/25 indicated Resident #163 was discharged to home. Review of a nursing progress note dated 9/21/25 indicated Resident #163 was sent to the hospital for evaluation following an episode of sudden confusion and shaking. An interview with the MDS Nurse on 12/4/25 at 1:43 PM was conducted. She stated the discharge MDS for Resident #163 dated 9/21/25 was coded for a discharge to home because Resident #163's Responsible Party (RP) informed the facility that he was sent home from the hospital and would not return to the facility. She stated since Resident #163 ultimately went home, she coded the MDS to reflect his discharge home. An interview with the Director of Nursing (DON) on	F0641	Continued from page 1 be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/14/2025, an audit of all current residents who have had a Minimum Data Set assessment completed during the past thirty days was completed to determine accuracy of coding in Section A2105 and accuracy of coding Section J1400. This audit was conducted by the Regional MDS Consultant and completed on 12/15/2025 Audit Results: · 48 Residents audited for accuracy of coding in Section A2105. · 0 Residents were noted to be coded incorrectly to home "01" in Section A2105 that were discharged to Acute Care hospital "04" Audit Results: Section J1400 – 18 current Hospice Residents reviewed for accuracy of coding Section J1400 · 15 current Residents audited for accuracy of coding Section J1400 · 1 Residents was noted to be coded incorrectly at Section J1400 · Assessment modified 12/15/2025 Systemic Changes On 12/15/2025, the Administrator provided an in-service training for the facility Minimum Data Set Coordinators that included the importance of thoroughly reviewing the medical record during the assessment process and before coding the MDS assessment. Special emphasis was highlighted on: · Section A2105: location to which the resident is being discharged at the time of discharge, which is crucial for discharge planning. · Codes: · 01: Home/Community (e.g., private home, assisted	

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F0641 SS = B	Continued from page 2 12/4/25 at 2:52 PM revealed residents' discharge MDS should accurately reflect their discharge location from the facility. During an interview with the Administrator on 12/4/25 at 3:40 PM she indicated the MDS should be completed accurately. The findings included: 2. Resident #7 was admitted to the facility on 7/14/2021 with diagnoses that included Alzheimer's dementia and rheumatoid arthritis. A Hospice Comprehensive Plan of Care dated 9/11/2025 indicated that Resident #7 was admitted under the care and services of Hospice for end of life on 6/19/2025. Further review of the Hospice Comprehensive Plan of Care for Resident #7 indicated that a recertification of Resident #7's prognosis of 6 months or less was received on 9/11/2025 from the physician. A quarterly Minimum Data Set (MDS) assessment dated 9/24/2025 indicated Resident #7 was severely cognitively impaired and received Hospice services. Resident #7's prognosis of 6 months or less was coded no. An interview on 12/4/2025 at 1:30 PM with the MDS Coordinator revealed she had completed the quarterly MDS dated 9/24/2025 for Resident #7 and coded it incorrectly for the prognosis of 6 months or less which should have been coded yes. The MDS Coordinator stated the incorrect coding was a mistake and the MDS should have been coded correctly. An interview on 12/4/2025 at 3:56 PM with the Administrator indicated that the MDS assessments should be accurate.	F0641	Continued from page 2 living facility). · 03: Skilled Nursing Facility (SNF). · 04: Short-Term General Hospital (acute hospital). · 05: Long-Term Care Hospital (LTCH). · 06: Inpatient Rehabilitation Facility (IRF). · 07: Inpatient Psychiatric Facility (psychiatric hospital). · These codes help identify the setting of discharge, which informs care planning and discharge planning. · Question J1400: codes prognosis of residents with conditions that may result in a life expectancy of less than six months. · It requires documentation from a physician indicating that the resident's condition is terminal or that they are receiving hospice services. · The coding for J1400 is based on the physician's judgment and must be substantiated by documentation in the medical record. · Changes to the MDS Item Sets, including updates to Section J1400, will take effect on October 1, 2025. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Beginning the week of 12/22/2025, the Director of Nursing or designee will begin monitor the coding of MDS items: Section A2105 and J1400 for accuracy. This will be completed by reviewing 5 assessments weekly x 4 and monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. Date of Compliance: 12/16/2025	
F0690 SS = G	Bowel/Bladder Incontinence, Catheter, UTI	F0690	F690 Bowel/Bladder Incontinence, Catheter, UTI	12/16/2025

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F0690 SS = G	Continued from page 3 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on record review and Medical Director, Hospital Urologist, Nurse Practitioner (NP), Resident Representative (RR) and staff interviews, the facility failed to follow hospital discharge orders for a urinary catheter to remain in place for 1 of 5 residents reviewed for urinary catheters (Resident #161). Resident #161 was admitted to the facility from the hospital on 9/18/25 with a urinary catheter due to a diagnosis of hydronephrosis (swelling of the kidneys due to urinary retention). Resident #161's urinary catheter was removed at the facility on 9/19/25 at 6:27 AM and subsequently reinserted at 11:09 PM after the Medical Director reviewed the hospital records which	F0690	Continued from page 3 Corrective action for resident(s) affected by the alleged deficient practice: On 9/20/2025 Medical Director was notified of change of condition by nurse#9 for resident #161 and order given to send resident to hospital for evaluation and treatment. Corrective Action for Potentially Affected Residents. All residents admitted to the facility with an indwelling catheter have the potential to be affected by the alleged deficient practice. Beginning on 12/10/2025, the Director of Nursing completed an audit for the past thirty days for all residents with current orders for indwelling catheters to identify any issues with orders. No other issues with Indwelling catheter orders were noted. This was completed by 12/10/2025. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/10/2025, the Director of Nursing began in servicing in person and via phone with written education to all full time, part time, and as needed (PRN) nurses including agency staff on the following topics: · Insertion and Removal of an indwelling catheter · Admission Process and orders verification with medical director The Director of Nursing will ensure that any Nurse who has not received this training by 12/15/2025 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance-	

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F0690 SS = G	Continued from page 4 indicated the urinary catheter was to remain in place until follow up with urology. On 9/20/25 Resident #161 was complaining of lower abdominal pain, blood was observed in the catheter tubing, and he was transferred to the emergency department (ED) for further evaluation. The Hospital Urologist noted Resident #161's urinary catheter was not advanced properly, the balloon of the urinary catheter was inflated in the prostate, and during a cystoscopy (insertion of a scope to assist with visual guidance) to insert a 3-way catheter he observed a false passage (tear in the urethral wall). Resident #161 was hospitalized 9/20/25 through 9/26/25 for CBI (constant bladder irrigation) and antibiotics were administered as a preventative measure. The RR revealed Resident #161 was discharged home on 9/26/25 and was still "traumatized" by the experience. The findings included: The hospital discharge summary dated 9/18/25 at 7:45 PM scanned into the electronic medical record (EMR) revealed Resident #161 was hospitalized 9/14/25 through 9/18/25 due to a sacral fracture severe bilateral hydronephrosis (swelling of the kidneys due to retention of urine) and was noted to have a history of prostate and bladder cancer, removal of the right lower ureter (tube from the bladder to the kidney) and was tentatively scheduled for surgery to remove a bladder tumor on 10/22/25. The hospital discharge summary further noted that Resident #161's urinary catheter was to remain in place and to schedule a follow up appointment with urology in two weeks. Resident #161 was admitted to the facility on 9/18/25 and discharged to hospital on 9/20/25. His admitting diagnoses included fracture of the sacrum and malignant neoplasm (cancer) of the prostate and bladder. The nursing admission assessment dated 9/18/25 completed by Nurse #8 indicated Resident #161 was cognitively intact and had a urinary catheter in place draining clear amber colored urine. Resident #161's physician orders revealed the following orders: 9/18/25 remove urinary catheter 9/19/25 for a voiding trial. 9/19/25 place a urinary catheter for hydronephrosis. Resident #161's treatment administration record (TAR) indicated the following:	F0690	Continued from page 4 Beginning the week of 12/22/2025, the Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for F690 to ensure Indwelling catheter orders are completed per discharge summary and verified with facility Physician or Nurse Practitioner per facility policy. The monitoring will include reviewing 5 newly admitting residents to identify if indwelling catheter is ordered and in place per discharge orders at time of admission and that orders are being followed. This will be completed weekly for 4 weeks then monthly x 2 months or until resolved to ensure medications are administered without delay. Reports will be given to the Monthly Quality of Life-QA committee and corrective action initiated as appropriate. The Quality-of-Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, and Maintenance Director. Date of compliance: 12/16/2025	

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F0690 SS = G	Continued from page 5 9/19/25 removal of the urinary catheter for a voiding trial was documented as completed by Nurse #8 at 6:27 AM. 9/19/25 urinary catheter placement was documented as completed by Nurse #8 at 11:09 PM. A nurse's note dated 9/19/25 at 2:32 AM written by Nurse #8 indicated Resident #161 was admitted to the facility for short term rehabilitation due to a sacral fracture and had a history of bladder cancer. Resident #161's urinary catheter was patent and draining clear amber colored urine and per physician's orders a voiding trial was to begin on 9/19/25 at 6:00 AM. A physician's note dated 9/19/25 at 3:32 PM indicated Resident #161 was admitted to the facility following hospitalization due to a sacral fracture and incidentally developed urinary retention which resolved after placement of a urinary catheter. Resident #161's urinary catheter was removed at the facility the morning of 9/19/25, however a review of the hospital records indicated the urinary catheter was to remain in place until a follow up with urology. Nursing staff were notified of new order to reinsert the urinary catheter on 9/19/25. A nurse's note dated 9/19/25 at 5:36 PM written by Nursing Supervisor #1 revealed the Medical Director evaluated Resident #161 and reviewed the hospital records which noted a diagnosis of hydronephrosis and for the urinary catheter to remain in place until a follow up with urology. Resident #161 was informed of new order from the Medical Director to reinsert the urinary catheter to prevent recurrence of hydronephrosis and kidney injury. Resident #161 voiced disappointment due to voiding three times since the catheter was removed this morning but verbalized understanding and agreeable to reinsertion of the urinary catheter. Resident #161 indicated he would notify his RR to schedule a follow up appointment with his urologist. A nurse's note dated 9/20/25 at 7:16 AM written by Nurse #8 revealed Resident #161 tolerated urinary catheter placement with flash of 30 cubic centimeters (ccs) of urine upon insertion, catheter draining clear amber colored urine with total output of 200 ccs by end of shift. A nurse's note dated 9/20/25 at 12:00 PM written by Nurse #9 revealed Resident #161 was observed to have string like blood clots in urinary catheter with	F0690		

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F0690 SS = G	Continued from page 6 complaints of burning and pain. Resident #161 was administered pain medication, the on-call provider was notified, and new orders were received to reposition the urinary catheter and to obtain a urinalysis. When attempting to reposition the urinary catheter blood was observed coming from Resident #161's urethral meatus (external opening at the tip of the urethra) onto the bed sheets as well as in the catheter tubing. Resident #161 expressed pain and was visibly wincing. The on-call provider was again notified and gave an order to transfer Resident #161 to the Emergency Department (ED) for further evaluation. Resident #161's hospital records dated 9/20/25 through 9/26/25 indicated Resident #161 was transferred to the ED from the facility due to lower abdominal pain and blood in his urine. Resident #161's urinary catheter was noted to have been removed and then reinserted at the facility for unknown reasons however hospital records from 9/14/25 through 9/18/25 indicated the catheter was to remain in place until follow up with urology. The Hospital Urologist noted Resident #161's urinary catheter was not advanced properly, and the balloon of the urinary catheter was inflated in the prostate. The Hospital Urologist performed a cystoscopy to insert a 3-way catheter and noted a false passage (tear in the urethral wall) was observed during the procedure. Resident #161 was admitted to the hospital for further monitoring, CBI as initiated and antibiotics were administered as a preventative measure. Resident #161's bleeding and pain related to the urinary catheter resolved and he was discharged home on 9/26/25. A phone interview was conducted with Resident #161's RR on 12/04/25 at 12:29 PM. The RR stated she was present when Resident #161 was admitted to the facility on 9/18/25. The RR indicated she did not recall her name but the nurse on duty reviewed the medication and treatment orders that were received from the hospital including an order to remove the urinary catheter. The RR stated she and Resident #161 voiced concern about removing the urinary catheter due to complications that occurred in the hospital and Resident #161's history of prostate and bladder cancer. The RR indicated the nurse informed them the order to remove the urinary catheter was from the hospital, so they proceeded with removing the catheter the next morning. The RR revealed that within hours of the catheter being removed the facility determined it was supposed to remain in place and reinserted the urinary catheter. The RR stated on 9/20/25 Resident #161 was experiencing severe pain and bleeding from the catheter and was transferred to the hospital for further evaluation. The RR indicated the	F0690		

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F0690 SS = G	Continued from page 7 urinary catheter was not positioned properly and the Hospital Urologist had to use a scope to reinsert the catheter. The RR revealed that Resident #161 was hospitalized for approximately a week and was still “traumatized” by the experience. The RR revealed Resident #161 was able to have surgery to remove a bladder tumor on 10/22/25 and no longer required the urinary catheter. A phone interview conducted with Nursing Supervisor #1 on 12/5/25 at 8:47 AM revealed she received Resident #161’s hospital discharge summary from the Assistant Admission Director on 9/18/25 at approximately 2:30 PM and called NP #2 to review the discharge summary and verify the medication and treatment orders. She revealed NP #2 verified the discharge summary orders including removal of the urinary catheter for a voiding trial and then she entered the orders into the EMR. Nursing Supervisor #1 stated she was not at the facility when Resident #161 arrived, she did not review the paperwork sent with him from the hospital, however the discharge summary scanned into the EMR was not the one she reviewed with NP #2. Nursing Supervisor #1 indicated Nurse #8 activated and followed the orders she entered in the EMR and removed Resident #161’s urinary catheter on the morning of 9/19/25. She stated the afternoon of 9/19/25 the Medical Director evaluated Resident #161 and informed her that he reviewed the hospital records which indicated the urinary catheter was to remain in place and gave an order to reinsert the catheter. She stated she informed Resident #161 of the order to reinsert the urinary catheter and that he was disappointed because he had been voiding with no issue, but voiced understanding as to why the catheter had to be reinserted. A phone interview with the Assistant Admissions Coordinator on 12/05/25 at 10:14 AM revealed when a new resident was admitted to the facility, she would access the hospital EMR system and print records as needed but did not recall printing Resident #161’s discharge summary on 9/18/25 and giving it to Nursing Supervisor #1. During a phone interview with Nurse #8 on 12/04/25 at 7:30 AM she revealed she was the assigned nurse to Resident #161 on 9/18/25 from 7:00 PM to 7:00 AM on 9/19/25. She stated Resident #161 was a new admission and arrived at the facility on 9/18/25 around 9:00 PM or 10:00 PM. She indicated Resident #161’s medication and treatment orders had been confirmed and entered into the electronic medical record (EMR) by Nursing Supervisor #1 earlier in the day. Nurse #8 indicated a packet of information was sent with Resident #161 from	F0690		

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F0690 SS = G	Continued from page 8 the hospital and she reviewed the discharge summary in the packet however she did not compare the orders on the discharge summary to the orders in the EMR nor did she notice instructions for the urinary catheter to remain in place. She stated Nursing Supervisor #1 had already verified the orders and she had no indication the orders were changed and her responsibility was just to activate the orders in EMR when Resident #161 arrived at the facility. She stated she reviewed the orders in the EMR with Resident #161 and the RR including the order to remove the urinary catheter for a voiding trial. She stated Resident #161 and the RR were concerned about removing the catheter due to complications with bleeding that occurred in the hospital, but when she explained the orders were verified by the facility's provider, they agreed with the removal. Nurse #8 indicated she removed Resident #161's urinary catheter 9/19/25 at approximately 6:00 AM without incident. She stated when she returned to work on 9/19/25 at 7:00 PM, Resident #161 had an order to reinsert the urinary catheter which she completed that night without incident. She stated when she placed the catheter Resident #161 exhibited no signs or symptoms of pain or discomfort and the catheter was draining clear amber colored urine. A phone interview conducted with Nurse #9 on 12/5/25 at 3:57 PM indicated she was assigned to Resident #161 on day shift (7AM to 7 PM) on 9/20/25. She stated Nurse #8 reported at shift change Resident #161's urinary catheter was reinserted without incident and draining urine. Nurse #9 revealed she checked on Resident #161 throughout the morning and there were no concerns related to the catheter until approximately 11:00 AM when he reported pain in his lower abdomen. She indicated Resident #161's lower abdomen was visibly distended, and she observed string like blood clots in the catheter tube. Nurse #9 revealed she administered pain medication to Resident #161 and then notified the on-call provider and received orders to obtain a urinalysis and reposition the urinary catheter. Nurse #9 stated she was going to attempt repositioning the catheter, but when she moved the catheter tubing from the side of Resident #161's leg he winced in pain and a large amount of blood started draining through the catheter tube. Nurse #9 revealed she notified the on-call provider of what occurred and received an order to transfer Resident #161 to the ED for further evaluation. A phone interview was conducted with NP #2 on 12/04/25 at 3:28 PM. NP #2 stated Nursing Supervisor #1 reviewed Resident #161's hospital discharge summary with her by phone to verify the orders. NP #2 revealed she was not	F0690		

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F0690 SS = G	Continued from page 9 aware Resident #161 had a diagnosis of hydronephrosis in the hospital but that would have made her hesitant to approve an order to remove the urinary catheter before a follow up with urology. During a phone interview with the Medical Director on 12/04/25 at 3:03 PM he indicated when evaluating a newly admitted resident he either reviews the hospital records scanned into the facility's EMR or directly through the hospital EMR system, but he did not recall in which system he reviewed Resident #161's records. The Medical Director revealed as stated in his progress note dated 9/19/25, Resident #161 had the urinary catheter removed prior to his visit, however after reviewing the hospital records he noted the catheter was to remain in place and gave an order for the catheter to be reinserted. The Medical Director revealed if changes were made to Resident #161's discharge summary orders provided to the facility prior to Resident #161 arriving then the hospital was responsible for notifying the facility of the changes. The Medical Director indicated the complications Resident #161 encountered related to the urinary catheter and his subsequent hospitalization would have been avoided if the catheter had remained in place. A phone interview was conducted with the Hospital Urologist on 12/05/25 at 9:41 AM. He stated he evaluated Resident #161 on 9/20/25 when he was transferred to the ED from the facility and he presented with significant pain and bleeding related to the urinary catheter. The Hospital Urologist indicated upon assessment of the catheter it was not advanced properly, and the catheter balloon was inflated at the prostate. The Hospital Urologist stated Resident #161 had trauma to his urethra and prostate due to the incorrect placement of the catheter and a false passage was observed. He revealed attempts to reposition the catheter in the ED were unsuccessful and a cystoscopy was performed to insert a 3-way catheter. The Hospital Urologist stated CBI was initiated due to the bleeding and passage of clots, and antibiotics were administered as a preventative measure. He indicated Resident #161 was hospitalized from 9/20/25 through 9/26/25 and then discharged home. The Hospital Urologist indicated Resident #161's hospital records from 9/14/25 through 9/18/25 clearly ordered the urinary catheter to remain in place and it should not have been removed at the facility. He further stated that Resident #161's significant history of bladder and prostate cancer made him difficult to catheterize, and the facility should have transferred him to the hospital to have the urinary catheter reinserted.	F0690		

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F0690 SS = G	Continued from page 10 An interview with the Director of Nursing (DON) on 12/4/25 at 3:53 PM revealed Nursing Supervisor #1 received Resident #161's hospital discharge summary from the facility's admission department and followed the proper procedure for reviewing and verifying the orders with NP #2. The DON stated the facility had no indication the hospital discharge orders had changed prior to Resident #161 arriving at the facility and Nurse #8 followed the orders that were verified and entered into the EMR. During an interview with the Administrator on 12/04/25 at 4:40 PM she stated the hospital discharge summary orders that were sent with Resident #161 should have been reconciled with the orders that were already entered into the EMR to ensure the orders were correct and no changes had been made.	F0690		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to store a syringe used for enteral feedings (also known as tube feeding, is a method of delivering nutrition directly into the gastrointestinal tract) dry and with the plunger separated from the syringe and free from moisture for 1	F0693	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-tag 693 Tube Feeding management Corrective action for resident(s) affected by the alleged deficient practice: Resident #73 tubing feeding syringe was replaced on 12/2/2025 by the Director of Nursing and properly separated. Nurse# 10 was provided 1:1 education on 12/2/2025 by the Director of Nursing regarding storage of tubing feeding syringe that included separating the plunger and syringe and washing and allowing to air dry after use prior to placing in storage bag. Corrective action for residents with the potential to be affected by the deficient practice: All resident with Gastric tubes have potential to be affected by the alleged deficient practice. On 12/10/2025, the Director of Nursing /designee completed an audit of all current residents requiring enteral feeding management to ensure that feeding syringes and plungers are separated and washed and are properly stored after use. The audit completed on 12/10/2025. The results of the audit revealed no other residents affected by alleged deficient practice. Measures /Systemic changes to prevent reoccurrence of	12/16/2025

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F0693 SS = D	Continued from page 11 of 3 residents reviewed for enteral feeding management (Resident #73). This practice had the potential for bacterial growth and contamination. Findngs included: Resident #73 was admitted to the facility on 11/29/23 with diagnoses of diabetes, stroke, hypertension, hemiplegia, malnutrition, difficulty swallowing, esophageal web, gastrostomy status (indicates the presence of a gastrostomy tube, which is surgically placed to provide direct access to the stomach for nutrition and hydration when oral intake is insufficient or unsafe), dysphagia, and oropharyngeal. Review of Resident #73 order dated 03/16/24 revealed the resident was ordered to receive 250 milliliters of Glucerna (tube feeding formula) 1.5 through bolus every 6 hours and to receive water flush of 100 milliliters before and after each bolus feeding. Bolus feeding is a way to give enteral nutrition (tube feeding). Bolus feedings give large doses of formula several times a day. The formula is poured slowly into a syringe attached to a feeding tube. A significant change Minimum Data Set assessment dated 11/07/25 indicated Resident #73 received 51% of more of her total calories from enteral feedings and 501 milliliters of fluids per day by enteral feedings. Review of the Resident #73's Medication Administration Record (MAR) revealed Nurse #10 had signed off Resident #73's morning medications on 12/02/2025. During an observation on 12/02/2025 at 10:00 AM Resident #73's syringe used for enteral feedings and medication administration was observed with the plunger inside the syringe which was wet with condensation and stored in a plastic bag on the bedside table. During an observation and interview on 12/02/25 at 12:00 PM, Nurse #10 administered the enteral bolus feeding to Resident #73, followed by the water flush. After the feeding was completed Nurse #10 did not separate the plunger from the syringe and wash it. The Nurse placed the syringe in the bag with the residual feeding formula still in it. Nurse #10 stated she normally did not wash Resident #73's syringe after the resident's feeding due to their not being residue on the syringe after the last flush. Nurse #10 stated she was not aware the syringe was required to be dried before placing the syringe back in the storage bag. Nurse #10 indicated she was aware the plastic syringe and plunger should be washed if residue is left in the	F0693	Continued from page 11 alleged deficient practice: On 12/10/2025, the Director of Nursing/designee began educating all full time, part time, and prn licensed nurses including agency staff on the following topics: Management and Caring for G-tubes including proper storage of tube feeding syringes, that includes separating the plunger and syringe and washing and allowing to air dry after use prior to placing in storage bag. The Director of Nursing will ensure that any licensed nurse who has not receive education by 12/15/2025 will not be allowed to work until training completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 12/22/2025, the Director of Nursing or designee will monitor compliance utilizing the Quality Assurance Tool for Tube Feeding Management Monitoring will include reviewing 5 residents with G-tubes to ensure proper storage of tube feeding syringe and plunger that includes washing and allowing plunger and syringe to dry after use prior to placing in storage bag. Monitoring will be completed weekly x 4 weeks then monthly x 2 months. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Manger, Wound nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager Date of Compliance: 12/16/2025	

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F0693 SS = D	Continued from page 12 syringe but was not aware the plunger should be left out to air dry to prevent any bacterial growth in the syringe. Nurse #10 confirmed she had given Resident #73 his medications through his feeding tube earlier this shift. An interview was conducted with the Director of Nursing on 12/04/25 at 1:40 PM and she stated after an enteral feeding the plastic syringe and plunger should be washed and the plunger left out of the syringe to allow it to air dry to prevent any bacterial growth in the syringe. The DON further revealed nurses had been educated on this protocol and all new hires had been educated during orientation. During an interview with the Administrator on 12/04/25 at 2:05 PM she stated Nurse #10 should have washed the plastic syringe and plunger separately to remove any residue and allowed them to dry completely to prevent any bacterial growth.	F0693		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation;	F0755	F755- Pharmacy Svcs/Procedures/Pharmacist/Records Corrective action for resident(s) affected by the alleged deficient practice: On 10/22/2024, resident #172 discharged from facility to home. On 10/21/2024, the Director of Nursing verbally reeducated nurses and medication aides related to utilizing emergency medication backup system for any medication unavailable on medication cart and notifying the medical director. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected. On 12/10/2025, the Director of Nursing audited 100% of resident medication administration records to identify any medications documented as not administered due to medication unavailable. The results of the audit were no medication noted not administered due to medication unavailable. Additionally, on 12/3/2025, the pharmacy audited the emergency medication backup system to ensure medications in stock. Any medication with low stock or not available was replenished on 12/3/2025. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/10/2025 the Director of Nursing began in servicing in person and via phone with written education to all full time, part time, and prn nurses, medication aides, and agency staff on the following topics: Medication Omission/Medication Error	12/16/2025

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F0755 SS = E	Continued from page 13 and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and facility staff, pharmacy staff and Nurse Practitioner (NP) interviews, and record reviews, the facility failed to have effective systems in place for obtaining medications and to ensure they were available to administer to a newly admitted resident in accordance with the physician's orders. This resulted in multiple doses of eleven (11) medications being omitted for 1 of 6 residents (Resident #172) who were reviewed for the availability of their medications. The findings included: Resident #172's resided in the community with a family member prior to her admission to the facility. A physician's "Orders Note" dated 10/9/24 revealed plans were made to admit Resident #172 to the facility for respite care from 10/18/24 to 10/23/24. Respite care is temporary care given to a person who is unable to care for himself or herself while providing short-term relief for primary caregivers. The Orders Note included a list of the resident's current medications and provider contact information. The resident was admitted to the facility for respite care on 10/18/24. Her diagnoses included end stage renal (kidney) disease with dependence on renal dialysis, glaucoma, gastro-esophageal reflux disease (GERD), and dementia. The resident's admission orders to the facility included the following medications scheduled for administration:--81 milligrams (mg) enteric coated (EC) aspirin to be given as one tablet by mouth one time a day for health maintenance (ordered on 10/18/24 and scheduled for 9:00 AM);--500 mg / 15 milliliters (ml) acetaminophen to be given as 30 ml by mouth two times a day for mild to moderate pain (Ordered on 10/18/24 and scheduled for 9:00 AM and 5:00 PM);--0.2 – 0.5 % brimonidine-timolol solution (an eye drop used to treat glaucoma) to be instilled as one drop in both eyes every 12 hours for glaucoma (Ordered on 10/18/24 and scheduled for 9:00 AM and 5:00 PM);--2% dorzolamide ophthalmic solution (an eye drop medication to treat glaucoma) to be given as one drop instilled in both eyes three times a day for glaucoma (Ordered on 10/18/24 and scheduled for 9:00 AM, 2:00 PM, and 9:00 PM);--0.02 – 0.005% netarsudil – latanoprost solution to be instilled as one drop in both eyes at bedtime for glaucoma (Ordered on 10/18/24	F0755	Continued from page 13 Prevention to assure that medications are provided to residents per medical order and steps to take if a medication is unavailable. The Director of Nursing will ensure any registered nurse, licensed practical nurse, or medication aide who has not completed training by 12/15/2025 will not be allowed to work until training is completed. Additionally, the assigned nurse will be responsible for requesting medications from regular or backup pharmacy. The Director of Nursing or Unit Manager will be responsible for following up on medication request to ensure medications have been obtained from regular or backup pharmacy. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning the week of 12/22/2025, The Director of Nursing or designee will monitor Compliance with the regulatory requirements utilizing QA Tool for Monitoring Medication Availability. Monitoring will include reviewing MAR and observing medications on cart for 5 newly admitted/readmitted residents to ensure meds are available to be administered as ordered. The audit is be completed weekly for 4 weeks, then monthly x 2 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 12/16/2025	

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F0755 SS = E	Continued from page 14 and scheduled for 9:00 PM);--5 mg donepezil (a medication used to treat dementia) to be given as one tablet by mouth at bedtime for dementia (Ordered on 10/18/24 and scheduled for 9:00 PM);--40 mg esomeprazole (a medication used to manage GERD) to be given as one capsule by mouth one time a day for GERD (Ordered on 10/18/24 and scheduled for 9:00 AM);--7.5 mg mirtazapine (an antidepressant) to be given as one tablet by mouth at bedtime (Ordered on 10/18/24 and scheduled for 9:00 PM);--8.6 – 50 mg sennosides – docusate tablet (a combination laxative containing a bowel stimulant and stool softener) to be given as 2 tablets by mouth two times a day for constipation; Hold for diarrhea (Ordered on 10/18/24 and scheduled for 9:00 AM and 5:00 PM);--0.8 grams (g) sevelamer packet (a phosphate binder) to be given as two packets by mouth with meals for chronic renal disease three times daily; mix with 1 – 2 ounces of water (Ordered on 10/18/24);--180 mg diltiazem extended release (ER) capsule (an antihypertensive medication) to be given as one capsule by mouth one time a day for hypertension. (Ordered 10/18/24 and scheduled for 9:00 AM). A Nursing Note dated 10/20/24 at 2:00 PM was authored by Nurse #4. The note reported Nurse #4 contacted a representative of Resident #172's managed care program and made her aware that the resident's medications had not yet been received. The representative reported that their pharmacy (different from the facility's contracted pharmacy) was closed on this date (Sunday) and she would make the pharmacy aware of the situation on Monday morning. Attempts made to contact the managed care program's representative for a telephone interview were unsuccessful. An interview was conducted on 12/3/25 at 2:00 PM with Nurse #4. During the interview, Nurse #4 (a weekend nurse supervisor) stated she did not recall Resident #172. When asked how medications would typically be obtained for a resident admitted for respite care (including participants of the managed care program), the nurse reported that sometimes the resident brought in his/her medications for use at the facility. On 10/21/24 at 4:37 PM, a Nursing Note authored by Nurse #3 indicated both the pharmacy and Nurse Practitioner were notified about the "resident's medication status." The note reported that Resident #172 was alert, responsive, and able to make her needs known. Nurse #3 also reported the resident's vital signs were stable and that she denied having pain. Multiple unsuccessful attempts were made to contact Nurse #3 for a telephone interview. A review of Resident #172's Nursing Notes revealed from 10/18/24 to 10/21/24, the resident's vital signs included blood pressure results ranging from 99/71 to 102/76; pulse rate ranging from 72 to 78 beats per minute; respiration rate ranging from 16 to 18 respirations per	F0755		

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F0755 SS = E	Continued from page 15 minute; and, her oxygen saturation rate ranging from 96 – 97% on room air. A Nursing Note dated 10/22/24 at 5:02 PM reported the resident was discharged from the facility and returned home with her family. Resident #172's October 2024 Medication Administration Record (MAR) revealed the following medication doses were not documented as given in accordance with her physician orders. On 10/18/24, the medication doses that were not documented as given included:--1 dose of 0.2-0.5% brimonidine-timolol ophthalmic solution left blank on the MAR;--1 dose of 2% dorzolamide ophthalmic solution held and 1 dose left blank on the MAR;--1 dose of 0.02 – 0.005% netarsudil – latanoprost ophthalmic solution left blank on the MAR;--1 dose of 5 mg donepezil left blank on the MAR;--1 dose of 7.5 mg mirtazapine left blank on the MAR;--1 dose of 0.8 g sevelamer noted as held on the MAR. On 10/19/24, the medication doses that were not documented as given included:--1 dose of 81 mg EC aspirin was left blank on the MAR;--1 dose of 500 mg / 15 ml acetaminophen suspension was left blank and one dose was noted as held on the MAR;--1 dose of 0.2-0.5% brimonidine-timolol ophthalmic solution was left blank and one dose was noted as held on the MAR;--2 doses of 2% dorzolamide ophthalmic solution were left blank and one dose was noted as held on the MAR;--1 dose of 0.02 – 0.005% netarsudil – latanoprost ophthalmic solution was noted as held on the MAR;--1 dose of 40 mg esomeprazole was left blank on the MAR;--1 dose of 8.6-50 mg sennosides – docusate was left blank on the MAR;--2 doses of 0.8 g sevelamer were left blank and one dose was noted as held on the MAR;--1 dose of 180 mg diltiazem ER capsule was left blank on the MAR. On 10/20/24, the medication doses that were not documented as given included:--1 dose of 81 mg EC aspirin was left blank on the MAR;--1 dose of 500 mg / 15 ml acetaminophen suspension was left blank and one dose was noted as "other" on the MAR;--1 dose of 0.2-0.5% brimonidine-timolol ophthalmic solution was left blank and one dose was noted as "other" on the MAR;--1 dose of 2% dorzolamide ophthalmic solution was left blank and two doses were noted as "other" on the MAR;--1 dose of 0.02 – 0.005% netarsudil – latanoprost ophthalmic solution on dose was noted as "other" on the MAR;--1 dose of 40 mg esomeprazole was left blank on the MAR;--1 dose of 8.6-50 mg sennosides – docusate was noted as "other" on the MAR;--1 dose of 0.8 g sevelamer was left blank and two doses were noted as "other" on the MAR;--1 dose of 180 mg diltiazem ER capsules was left blank on the MAR. On 10/21/24, the medication doses that were not documented as given included:--1 dose of 81 mg EC aspirin was noted as refused on the MAR;--1 dose of 500 mg / 15 ml acetaminophen suspension was noted as refused on the MAR;--1 dose of 0.2-0.5% brimonidine-timolol ophthalmic solution was noted as	F0755		

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F0755 SS = E	Continued from page 16 held on the MAR;--2 doses of 2% dorzolamide ophthalmic solution were noted as held on the MAR;--1 dose of 0.02 – 0.005% netarsudil – latanoprost ophthalmic solution; --1 dose of 40 mg esomeprazole was noted as held on the MAR;--3 doses of 0.8 g sevelamer were noted as held on the MAR;--1 dose of 180 mg diltiazem ER capsule was noted as held on the MAR. On 10/22/24 (the date of Resident #172's discharge), no medications were documented as given to Resident #172. An interview was conducted on 12/3/25 at 2:05 PM with Nurse Supervisor #1. During the interview, the supervisor was asked how medications would be obtained for a resident admitted for respite care (including participants in the managed care program). She stated that, "generally speaking," his/her medications would be dispensed by the facility's contracted pharmacy. An interview was conducted on 12/3/25 at 2:12 PM with the facility's DON. At that time, the DON reported a resident admitted for respite care (and on a managed care program) would be "typically looked at on a case by case basis." The DON indicated that since she started her position in April 2025 (after Resident #172's October 2024 stay at the facility), she would need to review Resident #172's electronic medical record (EMR) to become familiar with the resident's respite admission. A telephone interview was conducted on 12/4/25 at 10:50 AM with a representative of the dispensing pharmacy for Resident #172's managed care program. The representative reported that this pharmacy did not provide medications for its participants admitted to a facility for respite care. A telephone interview was conducted on 12/4/25 at 10:58 AM with the facility's contracted pharmacy. During the interview, the pharmacist reviewed Resident #172's dispensing records. He reported the pharmacy received several medication orders dated 10/18/24 but the medications were marked to be profiled, noting profiled medications were put into the resident's record to be filled later upon request. He stated that none of Resident #172's medications were requested to be filled until 10/21/25. A 2-day supply of the following medications were requested, dispensed, and delivered to the facility for Resident #172 on 10/21/25. These medications included: 0.2-0.5% brimonidine-timolol ophthalmic solution, 2% dorzolamide ophthalmic solution, 0.02 – 0.005% netarsudil – latanoprost ophthalmic solution, 5 mg donepezil, 7.5 mg mirtazapine, 0.8 g sevelamer, and 180 mg diltiazem ER capsules. Upon inquiry, the pharmacist reported that while the facility may have been able to obtain Resident #172's oral medications from their on-site, automated medication dispensing system, the eye drops would not have been available in-house. A telephone interview was conducted on 12/4/25 at 11:28 AM with NP #1. NP #1 was identified as one of Resident #172's	F0755		

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F0755 SS = E	Continued from page 17 managed care program providers. During the interview, the NP was asked how medications would be obtained for the managed care program's participant receiving respite care. She stated the facility's nursing staff was expected to put medication orders into the resident's EMR and request the medications be dispensed and delivered from the facility's contracted pharmacy. When noting that Resident #172's vital signs were reported as stable throughout her respite stay, the NP did not identify any harm caused by missing doses of her medications. A telephone interview was conducted on 12/4/25 at 2:15 PM with the facility's former DON. While the former DON did not recall Resident #172, she did remember running into a problem with obtaining medications for a managed care program's participant who was receiving respite care at the facility. The DON stated this was the first time she had dealt with respite care, and she was not sure of the process that was supposed to be implemented to obtain the resident's medications. The former DON acknowledged that due to the problems encountered with obtaining the resident's medications, there was a "delay in care for the resident." A follow-up interview was conducted on 12/4/25 at 12:33 PM with the facility's current DON. At that time, concerns related to the failure of the facility to obtain medications for Resident #172 for 3 days after her admission to the facility were shared. The DON reported that all respite care residents were treated like regular admissions and their medications would be ordered, dispensed, and delivered by the facility's contracted pharmacy. She added that if there was a situation where a resident's medication was not on the medication cart when it was scheduled for administration, the nurses knew to go to the onsite automated dispensing system to obtain it. If that medication was not available on-site, then they needed to call the pharmacy and get that medication from the backup pharmacy or contact the provider for an alternative medication, if needed. When asked if the facility had developed and implemented a plan of correction related to the situation encountered with Resident #172, the DON reported she would need to check. On 12/4/25 at 3:15 PM, the facility provided a plan of correction (POC) for review. The POC indicated the facility's date of compliance was 10/25/24. A follow-up interview was conducted with the DON on 12/4/25 at 3:40 PM to discuss concerns about the facility's failure to continue compliance with their POC as evidenced by the interviews conducted on 12/3/25 with Nurse #4, Nurse Supervisor #1, and herself. At that time, each of the nurses expressed uncertainty as to how medications would be obtained for residents admitted to the facility for respite care. The DON stated the nurses' answers may not have been clear due	F0755		

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F0755 SS = E	Continued from page 18 to “nerves.” A second attempt to validate the facility’s POC began on 12/4/25 at 3:47 PM. When the nurses and medication aide(s) were asked how medications would be obtained for residents admitted to the facility for respite care (including managed care program residents), the responses included the residents bringing his/her own medications from home and/or obtaining them from the facility’s contracted pharmacy. Due to the varying responses obtained during the interviews conducted on 12/3/25 and 12/4/25, the facility’s POC could not be validated as past non-compliance.	F0755		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.5% for 3 of 5 residents (Resident #24, Resident #53, and Resident #168) observed during the medication administration observation. The findings included: 1. Resident #24 was admitted to the facility on 12/26/24. Her cumulative diagnoses included end stage renal disease requiring hemodialysis. On 12/3/25 at 4:50 PM, Nurse #2 was observed as she began to prepare medications for administration to Resident #24. The medications were administered at 5:05 PM and included two tablets of 800 milligrams (mg) sevelamer. Sevelamer is a phosphate binder used to control blood phosphorous levels for patients with chronic kidney disease on dialysis. A review of Resident #24’s December 2025 Physician Orders included a current order for 800 mg sevelamer to be given as two tablets by mouth with meals for end stage renal disease. The sevelamer was scheduled for administration at 9:00 AM, 1:00 PM, and 6:00 PM. The manufacturer’s prescribing information for sevelamer noted this medication should be taken with meals. The facility's schedule for the delivery of meal trays to	F0759	F759- Free of Medication Rate 5 % or More Corrective action for resident(s) affected by the alleged deficient practice: For resident # 24: On 12/3/2025 the Nurse Supervisor assessed resident, those findings were no harm noted. Additionally, the RP and MD were notified of medication error and gave no new orders. On 12/3/2025, the Director of Nursing verbally reeducated nurse# 2 related to the six rights of medication administration and completed medication error form. For resident #53: On 12/3/2025 the Nurse Supervisor assessed resident, those findings were no harm noted. Additionally, the RP and MD were notified of medication error and gave no new orders. On 12/3/2025, the Director of Nursing verbally reeducated nurse# 1 related to the six rights of medication administration and completed medication error form. For resident# 168: On 12/3/2025 the Nurse Supervisor assessed resident, those findings were no harm noted. Additionally, the RP and MD were notified of medication error and gave no new orders. On 12/3/2025, the Director of Nursing verbally reeducated medication aide#1 related to the six rights of medication administration and completed medication error form. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected. On 12/10/2025 the Director of Nursing began random medication pass observations on all halls to identify and medication pass errors. The results of the audit were no other issues identified. The medication pass observations were completed on 12/10/2025. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/10/2025, the Director of Nursing began in servicing in person and via phone	12/16/2025

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F0759 SS = D	Continued from page 19 each of the residents' hallways was reviewed. The schedule indicated the evening dinner meal trays for Resident #24's hall were scheduled to be delivered at 6:35 PM daily. An interview was conducted with Nurse #2 on 12/3/25 at 5:55 PM. As of the time of the interview, no evening meal trays had been delivered to Resident #24's hallway. Upon request, Nurse #2 reviewed Resident #24's medication order which included instructions to administer sevelamer "with meals." The nurse stated she thought those instructions just meant that sevelamer should be given with food and added that she had given Resident #24 juice and crackers approximately 10 minutes before the observation of her medication administration. However, Nurse #2 confirmed the resident would still be receiving her evening meal (not yet delivered). The nurse reported she was not aware the medication was intended to be given with meals. 2. Resident #53 was admitted to the facility on 12/23/23. On 12/3/25 at 7:50 AM, Nurse #1 was observed as she prepared eight (8) medications for administration to Resident #53. The medications included two tablets of a single ingredient medication with each tablet containing 8.6 milligrams (mg) sennosides (a stimulant laxative) taken from a stock medication bottle stored on the medication cart. The medication was administered to Resident #53. A review of Resident #53's current physician's orders revealed his medication orders included a combination medication containing 8.6 mg sennosides and 50 mg docusate (a stool softener) to be given as two tablets by mouth two times a day for bowel management. Resident #53 did not have a physician's order for the sennosides to be given as a single ingredient medication. An interview was conducted on 12/3/25 at 10:00 AM with Nurse #1. At that time, Nurse #1 reviewed Resident #53's December 2025 Medication Administration Record (MAR) and confirmed a physician order was written to administer a combination medication containing 8.6 mg sennosides and 50 mg docusate to the resident. The nurse pulled the stock bottle containing 8.6 mg sennosides used for the medication administration observation from the medication cart, reviewed its labeling, and acknowledged it contained sennosides but did not include the second ingredient (docusate). Upon further review of the stock medications available on the medication cart, Nurse #1 identified a bottle containing a combination of the two medications (8.6 mg sennosides and 50 mg docusate) as ordered by the physician. The nurse confirmed she should have administered the combination medication (including docusate) instead of a single ingredient medication containing only sennosides. Nurse #1 stated, "I've learned something." 3. Resident #168 was admitted to the facility on 11/26/25. On 12/3/25 at 8:55 AM,	F0759	Continued from page 19 with written education to all full time, part time, and prn nurses, medication aides, and agency staff on the following topics: Medication Administration Process to assure that medications are provided to residents per medical order. The Director of Nursing will ensure any licensed nurse or medication aide who does not receive the above education by 12/15/2025 will not be allowed to work until training completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning the week of 12/22/2025, The Director of Nurses or designee will monitor Compliance with the regulatory requirements utilizing F759 Med Pass QA monitoring tool. Monitoring will include completing medication pass observations for 4 nurses and 2 medication aides to include at least 3 medication opportunities for each observation for a total of 6 med pass observations to include day and night shifts and weekends to ensure staff are following the 6 rights of medication administration. The monitoring will be completed weekly x 4 weeks, then monthly x 2 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, Social Worker and the Dietary Manager. Date of Compliance: 12/16/2025	

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F0759 SS = D	Continued from page 20 Medication Aide (Med Aide) #1 was observed as she prepared eight (8) medications for administration to Resident #168. The medications included one tablet of a single ingredient medication with each tablet containing 8.6 milligrams (mg) sennosides (a stimulant laxative) taken from a stock medication bottle stored on the medication cart. The medication was administered to Resident #168. A review of Resident #168's current physician's orders revealed her medication orders included a combination medication containing 8.6 mg sennosides and 50 mg docusate (a stool softener) to be given as one tablet by mouth two times a day for constipation. Resident #168 did not have a physician's order for the sennosides to be given as a single ingredient medication. An interview was conducted on 12/3/25 at 10:43 AM with Med Aide #1. Upon request, the medication aide reviewed Resident #168's December 2025 Medication Administration Record (MAR) and confirmed her medication order was for a combination medication containing both sennosides and docusate. When she pulled the stock bottle used to provide the laxative for Resident #168, it was noted that the ingredient label indicated that medication bottle contained 8.6 mg sennosides only. Med Aide #1 then found a different stock bottle stored on the medication cart that contained the sennosides / docusate combination medication ordered for Resident #168. At that time, Med Aide #1 acknowledged she was not previously aware there was a difference between these two stock bottles of medication. She confirmed that she should have administered the combination medication containing 8.6 mg sennosides and 50 mg docusate instead of the single ingredient sennosides to Resident #168. An interview was conducted on 12/4/25 at 12:33 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she would expect nursing staff to look carefully at both the medication and the resident's medication order when passing medications. The DON added that the 6 medication administration rights should always be observed (right patient, right drug, right dose, right route, right time, and right documentation).	F0759		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F0804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	12/16/2025

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F0804 SS = E	Continued from page 21 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations, and resident and staff interviews, the facility failed to serve food at a palatable temperature, hot foods were served lukewarm or cold and a beverage was served partially frozen for 6 of 6 residents reviewed for food palatability (Resident #8, Resident # 37, Resident #54, Resident #14, Resident #110, and Resident #80). The findings Included: a. Resident 8 was admitted to the facility on 1/1/2024. Resident #8 had a physician's order dated 2/12/2025 for a cardiac diet with regular texture, a thin consistency, and double portions. A quarterly Minimum Data Set (MDS) assessment dated 10/13/2025 revealed Resident #8 was cognitively intact. An observation and interview of Resident #8 was conducted on 12/01/2025 at 2:14 PM during the lunch meal. Lunch trays arrived at the 200 Hall at 1:50 PM on 12/01/2025 and were delivered to all residents at the 200 Hall by 2:10 PM. Resident # 8 was observed removing the lid of the hot beverage on his lunch tray and no steam was visible. Resident #8 complained the lunch meal was also lukewarm and stated he would like his food and coffee served hot. Staff entered and offered to reheat the plated food and beverage. Resident #8 declined to have food reheated. Resident expressed frustration and stated he felt they intentionally always served hot food cold and was hesitant to eat it some days. b. Resident #37 was admitted to the facility on 10/06/2025. The admission MDS assessment dated on 10/13/2025 revealed Resident #37 was cognitively intact. Resident #37 had a physician's order dated 10/28/2025 for a regular diet with regular texture and consistency. Resident #37 was interviewed and observed on 12/2/2025	F0804	Continued from page 21 F804 Nutritive Value/Appear, Palatable/ Prefer Temp Corrective action for affected residents. For resident #8: On 12/3/2025, nurse aide #2 reheated resident's meal tray For resident #37: On 12/3/2025, nurse aide #2 reheated resident's meal tray For resident #54: On 12/3/2025, nurse aide #2 reheated resident's meal tray For resident #14: On 12/3/2025, nurse aide #2 reheated resident's meal tray For resident #110: On 12/3/2025, nurse aide provided resident with a cup of hot coffee. For resident #80: On 12/3/2025, nurse aide provided resident with a container of unfrozen juice. On 12/3/2025 the administrator followed up with Resident#8, #37, #54, #14, #110, and #80 to ensure the food and beverage items provided were at a palatable temperature. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. Beginning 12/10/2025, test tray audits were completed on 100 hall, 200 hall, 300 hall, 400 hall, 500 hall and 600 halls. Any concerns with meals were corrected immediately. Systemic changes On 12/10/2025 in-service education was provided to all full time, part time, and as needed dietary staff by the Dietary Manager. Topics included: Dietary Safe Food Temperatures. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all dietary staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above identified staff who does not receive training by 12/15/2025 will not be allowed to work until training is completed.	

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F0804 SS = E	Continued from page 22 at 9:12AM. Resident #37 stated his room was at the end of the hallway, so when his tray was served to him the hot foods were not warm when meal trays are served. Resident #37 stated staff needed to reheat at least 50% of the meals. Resident #37 was interviewed and observed on 12/2/2025 at 9:17 AM when staff brought in the breakfast tray and assisted in the set-up. Resident #37 stated to staff the scrambled eggs were lukewarm. Staff offered to reheat the eggs and Resident #37 declined. Resident #37 stated rewarming eggs dried them out and made them too difficult for Resident #37 to chew and swallow. Staff did not offer Resident #37 a replacement or alternative. c. Resident #54 was admitted to the facility on 4/15/2014. Resident #54 had a physician's order dated 9/11/2025 for a regular diet with pureed texture and a thin consistency ordered. The quarterly MDS assessment dated 10/28/2025 revealed Resident #54 was cognitively intact. When Resident #54 was interviewed on 12/1/2025 at 2:36 PM, Resident #54 complained the food was consistently cold when it arrived and staff repeatedly returned to reheat the meals throughout the day. On 12/2/2025 at 9:05 AM Resident #54 was interviewed and observed checking temperature of pureed scrambled eggs and cheese, pureed hot cereal, and pureed moistened biscuit using his index finger and complained the food was lukewarm. When the plate cover was removed there was no steam and the inside of the plate cover was visibly moist with condensation and did not feel warm to touch. At 9:17 AM, staff entered to deliver the roommate's tray and offered to reheat Resident #54's food. The resident agreed, and staff took the plate to reheat it. d. Resident #14 was admitted to the facility on 2/26/2025. A quarterly MDS assessment dated 9/23/2025 specified Resident #14 was cognitively intact. Resident #14 had a physician's order dated 2/26/2025 for a limited concentrated sweets diet with easy to	F0804	Continued from page 22 Quality Assurance monitoring procedure. Beginning the week of 12/22/2025, the Administrator or designee will complete a test tray 5 times weekly x 4 weeks and then monthly x 2 months using the Dietary QA Audit. Monitoring will include reviewing food and beverage items for temperature, appearance, and taste as well as visiting with residents when complaints are received. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance 12/16/2025	

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F0804 SS = E	Continued from page 23 chew texture and a thin consistency. Resident #14 was interviewed on 12/1/2025 at 11:31 AM and complained the food served was very poor in quality and the options weren't appropriate for a diabetic. Resident #14 stated there were not balanced diet options for diabetics, and the hot foods were cold and the cold foods warm. Resident #14 complained the sandwiches and bread were either soggy or dried out. Resident #14 reported raising her concerns repeatedly for the past 4–5 months to Resident Council and the Administrator without improvement. Resident #14 was interviewed and observed again on 12/3/2025 at 9:32 AM. Resident #14 attempted to eat a hardboiled egg from the tray. Resident #14 stated the items on the breakfast tray were not what she had ordered, tray items were not what was on the ticket, and the ham with gravy and bowl of grits were cold. The ticket listed scrambled eggs, ham, hot cereal, orange juice, hot coffee, and toast, but the tray instead contained chunked ham with gravy, grits, a boiled egg, and toast. NA #3 attempted to resolve the situation by offering another egg or reheating the grits. Resident #14 waved the tray away and became emotional, stating NAs tried to make up for ongoing problems with cold food. e. Resident #110 was admitted to the facility on 8/7/2023. Resident #110 had a physician's order dated 8/7/2023 for a regular diet with easy to chew texture and thin consistency ordered. A quarterly MDS assessment dated 10/29/2025 specified Resident #10 was moderately cognitively impaired. Resident #110 was interviewed and observed on 12/3/2025 at 8:48 AM seated in the 100-200 Unit Dining Hall at a table. Resident #110 drank from a cup of coffee that was set on the table when he arrived and stated it was cold and asked for some sugar packets for the cup of coffee. There was no lid on the cup, no condiments for the coffee, and no steam was observed coming from the cup. Resident #110 stated breakfast trays often arrived cold, residents waited an hour or more in the dining room for meals, and staff routinely reheated items in	F0804		

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F0804 SS = E	Continued from page 24 the microwave. Staff did not offer to reheat the coffee but brought packets of sugar to Resident #110. The Resident stated he reported cold meals to staff but did not bring concerns to Resident Council because he felt nothing changed when other residents raised food concerns. Resident #110 was again interviewed and observed on 12/4/2025 at 1:35PM at the 200 Unit dining room table while eating lunch. Resident #110 ate 75% of the lunch with no steam observed from the chicken or vegetables. The Resident reported his lunch and dinner on 12/3/2025 were not warm but stated the lunch he was eating was hotter than usual. f. Resident #80 was admitted to the facility 12/31/2024. Resident #80 had a physician's order dated 12/31/2024 for a regular diet with regular texture and thin consistency. The quarterly MDS assessment dated 9/11/2025 specified Resident #80 was cognitively intact. Resident #80 was interviewed on 12/3/2025 at 8:58 AM. Resident #80 stated meal trays were late twice a week, food temperatures were incorrect "9 times out of 10," and meal items often did not match the tray ticket. Resident #80 stated they bring the trays out to the table right when they get on the unit, but food was either too cold or not hot enough. Resident #80 was interviewed and observed on 12/3/2025 at 9:25 AM. Resident #80 complained about frozen juice. Resident #80 complained that the juice containers were frozen. Chunks were observed and slushing heard when Resident #80 used her utensils to break up and mix the partially frozen juice. On 12/4/2025 at 3:15 PM Nurse Aide (NA) #2 was interviewed and revealed each day more than half of the 20 resident dinner trays she delivered to the 200 Hall required reheating. NA #2 stated the nursing staff have made management aware over past several months that dinner trays arrived cold and that it takes extra time for staff to reheat them. A medical records staff member was interviewed and	F0804		

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F0804 SS = E	Continued from page 25 observed on 12/2/2025 at 9:21 AM as she passed out trays on the 200 Unit. The medical records staff member stated when they announced trays have arrived on a unit, she and other administrative staff members were assigned to pass out and set up meal trays on every unit. The medical records staff member revealed food was reheated 4 of 5 days each week for both breakfast and lunch trays for the 4 to 5 residents she delivered to and set-up for. On 12/4/2025 at 3:29 PM the Dietary Manager (DM) was interviewed about residents' concerns with cold food and beverages. The DM stated staff were to offer replacement trays if residents complained of cold food instead of offering to reheat food. The DM stated she worked with nurse management and requested the trays be delivered upon arrival to the unit to prevent a delay. The DM reported the kitchen conducted one test tray every day and found no issues with food palatability. The DM was unable to provide documented evidence of test tray records. On 12/01/2025 at 3:45 PM the Director of Nursing (DON) was interviewed. The DON stated all staff were trained, even administrative staff, to deliver trays and provide assistance with resident feeding. On a follow-up interview with the DON on 12/04/2025 at 4:10 PM it was revealed all staff were expected to report to the units when the announcement goes overhead that trays had arrived on a unit so they can deliver trays quickly. The DON stated that nursing leadership was aware that many staff repeatedly reheated trays upon arrival and delivery to the residents. The DON acknowledged an awareness of multiple residents across the facility had food complaints of unsatisfactory temperatures and stated it had been an issue for several months and stated the nursing staff were delivering the trays within a few minutes of arriving to the units. The DON stated this had been their practice for a few years at the facility. The DON stated they do not allow staff to schedule their breaks during mealtimes, so all staff are available to assist with tray delivery. On 12/4/2025 at 4:00 PM the Administrator was interviewed and reported awareness of food issues and palatability concerns raised at Resident Council meetings and reported to nurse leadership. The Administrator stated the facility was planning to terminate their current food service contract.	F0804		
F0806 SS = D	Resident Allergies, Preferences, Substitutes	F0806	The statements made on this plan of correction are not	12/16/2025

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F0806 SS = D	Continued from page 26 CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to honor a resident's food preferences for 1 of 3 residents reviewed for food preferences (Resident #136). Findings included: Resident #136 was admitted to the facility on 06/15/22. Review of Resident #136's quarterly Minimum Data Set (MDS) assessment dated 09/25/25 revealed the resident was cognitively intact. Review of Resident #136's undated preference sheet revealed that she disliked grits and hot cereal (oatmeal) for breakfast. An interview and observation with Resident #136 on 12/03/25 at 9:15 AM revealed she had received hot cereal for breakfast. Resident #136 stated she disliked hot cereal and had informed both dietary and nursing staff on multiple occasions, expressing a preference for yogurt instead. An interview and observation with Resident #136 on 12/04/25 at 9:00 AM revealed she had received grits for breakfast. Resident #136 reiterated that she disliked grits and had communicated this to dietary and nursing staff multiple times, again expressing a preference for yogurt. An interview with Nurse #1 on 12/04/25 at 10:45 AM revealed that Resident #136 had frequently expressed dissatisfaction with receiving food items she did not prefer. Nurse #1 stated she had communicated this to	F0806	Continued from page 26 an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F806 Res. Allergies, Preferences & Substitutes Corrective action Based on meal observations, record reviews, and interviews on 12/03/2025 and 12/4/2025, the facility failed to honor food preferences/likes/dislikes for 1 of 3 residents. On 12/8/2025, dietary manager visited resident #136, and food preferences were updated. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All current entries in Tray cards will be reviewed for accuracy and modified as needed by 12/15/2025. All residents will be interviewed to update food preferences by 12/15/2025 by the Dietary Manager. On 12/8/2025, the Administrator reviewed the facility's meal program software, and no issues were identified. Systemic changes In-service education was provided to all full time, part time, and as needed staff by the Administrator on 12/10/2025. Topics included: %ï Tray Accuracy Education %ï Diet Consistency and Accuracy Policies %ï Meal Procedures %ï Food Allergies %ï Food Preferences and Importance of Meals This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by	

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F0806 SS = D	Continued from page 27 dietary staff but could not recall to whom she had spoken. An interview with the Dietary Manager on 12/04/25 at 9:45 AM indicated ongoing issues with tracking residents' food preferences due to problems with the facility's meal program software. The Dietary Manager acknowledged that multiple residents had received food items they did not prefer and confirmed that Resident #136 had consistently received items she disliked. She stated that a better system was needed to ensure residents received food items they preferred. An interview with the Director of Nursing (DON) on 12/04/25 at 1:20 PM revealed she was unaware that Resident #136 or other residents had received food items they did not prefer. The DON stated she expected residents to receive food items that matched their preferences. An interview with the Administrator on 12/04/25 at 2:00 PM revealed that residents had not voiced concerns about food preferences to her. The Administrator stated she expected residents to receive food items they preferred.	F0806	Continued from page 27 the Quality Assurance process to verify that the change has been sustained. Any dietary staff who does not receive scheduled in-service training by 12/15/2025 will not be allowed to work until training has been completed. Quality Assurance monitoring procedure. Beginning the week of 12/22/2025, the Administrator or designee will monitor a total of 7 trays to include 3 different mealtimes for accuracy of completed trays served to residents per Dietary QA Audit Tool 3 times weekly x 4 weeks and then monthly x 2 months. The consultant dietitian will complete quarterly diet orders. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director and/or Dietitian. Compliance will be monitored by the Administrator or designee daily and reviewed at the weekly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director. Date of Compliance: 12/16/2025	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F812__ Food Procurement, Store, Prepare, Serve-Sanitary Corrective action for affected residents On 12/1/2025, Food opened and undated was discarded from refrigerators on 300/400 hall and 500/600 halls by Dietary Manager Corrective Action for Potentially Affected Residents. All current residents have the potential to be affected by the alleged deficient practice. On 12/2/2025, the Dietary Manager completed inspection of all nourishment room refrigerators, and all food items were properly stored. Any food items noted unlabeled or without a date were removed and discarded.	12/16/2025

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F0812 SS = E	Continued from page 28 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to label and date food items and discard expired items in 2 of 3 nourishment rooms (300/400 hall nourishment room and 500/600 hall nourishment room). These deficient practices had the potential to affect food served to residents. Findings included: 1. Observation and interview conducted with the Dietary Manager on 12/1/25 at 10:25 AM revealed Nourishment Room #1 (300/400 hall) had: an opened container of coffee creamer that was labeled with a name, but no date. a container with noodles labeled with a resident's name but no date. a gallon of iced tea not labeled with the product or resident name and had the best by date of 11/29/25. an opened bottle of prune juice that was not labeled with a resident's name. The Dietary Manager stated during the observation she expected all items to be labeled and expired items discarded. 2. Observation and interview conducted with the Dietary Manager on 12/1/25 at 10:50 AM revealed Nourishment Room #3 (500/600 hall) had: a container of leftover pudding that was not dated or labeled.The Dietary Manager stated during the observation she expected all items to be labeled. The Dietary Manager revealed kitchen staff checked the nourishments rooms twice a day. The Dietary Manager stated the Assistant Dietary Manager had checked the nourishment rooms on 11/30/25. An interview conducted with the Assistant Dietary Manager on 12/4/25 at 2:25 PM revealed she had worked on 11/30/25 but failed to check the nourishment rooms. It was further revealed she had worked as a dietary aide that day and forgot to check the nourishment rooms. The Assistant Dietary Manager stated she or the Dietary Manager normally checked the nourishment rooms daily. An interview conducted with the Director of Nursing (DON) on 12/4/25 at 1:40 PM revealed all nursing staff had been educated to label and date residents' items in the nourishment rooms. The DON indicated she expected nursing staff to follow those instructions. The DON stated all staff were educated during orientation.	F0812	Continued from page 28 Systemic Changes On 12/10/2025, the Administrator began In-service education to all full time, part time, and as needed staff on checking for and discarding all food items noted not labeled and not dated and all food must be stored, dated and discarded per NC State Regulations and Food Safety, Food Storage Policy reviewed. The Administrator will ensure that any of the above identified staff who does not receive scheduled in-service training by 12/15/2025 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance Beginning the week of 12/22/2025, the Administrator or designee will monitor food storage weekly x 4 weeks then monthly x 2 months using the Dietary Quality Assurance Audit Tool. Monitoring will include auditing nourishment room refrigerators in which food is stored to ensure all items are stored properly with label and date. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Performance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Maintenance Director, Environmental Services Director, and the Dietary Manager Date of Compliance: 12/16/2025	

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F0812 SS = E	Continued from page 29 An interview conducted with the Administrator on 12/4/25 at 2:00 PM revealed staff were educated to label residents' items when placed in the nourishment rooms. The Administrator further revealed when new staff were hired, they were taught that residents' items were to be labeled during orientation. The Administrator indicated dietary staff checked the nourishment rooms daily as well and were advised to look for items that were unlabeled.	F0812		