STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 28365**

(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
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 12/17/25 through 12/18/25. Event ID# 1DE949-H1. The following intakes were investigated 2693550, 2684216, and 2687265. 3 of the 6 complaint allegations resulted in deficiency.	F0000		01/20/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Pharmacy Consultant, Medical Director, and Corporate Medical Director interviews, the facility did not ensure a resident was free of a significant medication error when Resident #1 received 60 milligrams (mg) of oxycodone (a short-acting opioid which is a class of drug used to reduce moderate to severe pain). Oxycodone 60 mg was not prescribed to Resident #1. On 11/28/25 Resident #1 was given oxycodone 60mg medication prescribed to another resident. This deficient practice affected 1 of 5 residents reviewed for significant medication error. Findings included: Resident #1 was admitted to the facility on 2/7/25 with diagnoses that included Parkinson's disease (a brain disorder that primarily affects movement) with dyskinesia (involuntary, erratic movements), dementia, and palliative (specialized medical support for people with serious illnesses) care. Resident #1's quarterly Minimum Data Set (MDS) dated 9/3/25 revealed she was cognitively impaired and did not receive opioid medications. Review of Resident #1's active and discontinued orders	F0760	"Past Noncompliance - no plan of correction required"	01/20/2026

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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F0760 SS = D	Continued from page 1 revealed she did not have an order to receive oxycodone. Review of a medication related incident report dated 11/28/25 indicated that Resident #1 was administered 60 mg of oxycodone that was intended for another resident. The incident report revealed Resident #1 was assessed, the Nurse Practitioner (NP) and Director of Nursing (DON) were notified, an intravenous (IV: within a vein) fluid bolus (a single, large amount of intravenous (IV) fluids administered quickly to a patient) and naloxone (a medication used to reverse opioid overdoses) were ordered, neurological checks (a quick, simple assessment of your nervous system (brain, spinal cord, nerves) by a healthcare provider, checking things like alertness, reflexes, balance, strength, and senses to spot problems like weakness, numbness, or confusion, often using questions, and lights) remained stable, and no distress was observed. Review of the facility's investigation report revealed on 11/28/25 during a medication pass, Nurse #1 administered 60 mg of oxycodone to Resident #1 that was intended for another resident. The DON and the Unit Manager were immediately notified and assessed Resident #1. The Nurse Practitioner was notified by the Unit Manager, and naloxone and 1 liter (L) of IV fluid were ordered. Resident #1 remained alert and her vital signs remained stable. Resident #1's resident representative was notified of the incident. Resident #1 was monitored after the administration of 60 mg of oxycodone per the facility's neurological (neuro) check protocol (every 15 minutes (min) x 2 hours, then every 30 min x 2 hours, then every 60 min x 4 hours, then every 8 hours until at least 72 hours had elapsed). Review of Resident #1's Neuro (neurological) Check Flow Sheet revealed her neuro checks and vital signs were performed per the facility's neuro check protocol and Resident #1 remained stable. Resident #1's medical orders were reviewed. She had an order dated 11/28/25 for naloxone HCL (hydrochloric acid) liquid 4 mg/0.1milliliters (ml) one (1) spray alternating nostrils every 2 minutes as needed for signs of opioid overdose; may be repeated every 2 to 3 minutes for unresponsiveness or difficulty breathing, until individual is breathing (respiratory rate greater than 10 per minute). Resident #1 also had an order dated 11/28/25 for sodium chloride solution 0.9 % (a sterile mixture of 0.9 grams of salt (sodium chloride) dissolved in 100 milliliters of water; a salt concentration like that of human blood and bodily fluids) one (1) liter intravenously one time only for	F0760		

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F0760 SS = D	Continued from page 2 hydration for a 1-day bolus. An interview was conducted on 12/18/25 at 11:29 AM with Nurse #1. Nurse #1 stated she was in training and Nurse #2 handed her medication (oxycodone) intended for Resident #1's roommate. Nurse #1 stated she thought they were for Resident #1 and gave the medication (oxycodone) accidentally to her. Nurse #1 stated she recalled she verified Resident #1's name. Nurse #2 informed her she gave the medication to the wrong resident. Nurse #1 stated she notified the Unit Manager, who called the NP, and received orders. She stated Resident #1 was closely monitored and a few hours after receiving the medication she became sleepy and received one dose of naloxone. Nurse #1 continued to monitor Resident #1, and she was acting like her normal self. Nurse #1 stated the incident was reported to the next oncoming shift. Review of Resident #1's medication administration record (MAR) revealed she received one dose of naloxone at 2:15 PM on 11/28/25. An interview was conducted on 12/17/25 at 6:15 PM with Nurse #2 who was training Nurse #1 on 11/28/25. Nurse #2 stated Nurse #1 asked if she could take the medications into the resident room. Nurse #2 stated she told Nurse #1 the medication was for Resident #1's roommate. Nurse #2 stated she was still at the medication cart preparing Resident #1's medications at that time. Nurse #2 stated she went into the room and saw Nurse #1 standing in front of Resident #1, and she immediately knew Nurse #1 gave Resident #1 the wrong medication. Nurse #2 stated she did not hear or see Nurse #1 confirm Resident #1's name. Nurse #2 stated she immediately walked out of the room and told Nurse #1 she gave the medication to the wrong resident, and they needed to report it. Nurse #2 stated they reported the incident to the Unit Manager, who reported it to the provider and family representative. Nurse #2 stated she and Nurse#1 assessed and monitored Resident #1. Nurse #2 stated when Resident #1 became sleepy she was administered naloxone and responded to it, and Resident #1 stated she felt fine. Nurse #2 stated Resident #1 also received IV fluid as ordered and Nurse #1 monitored her throughout the shift. Nurse #2 stated she checked on Resident #1 throughout the rest of the shift, and she remained at her baseline. Nurse #2 stated she notified the oncoming nursing staff of the incident. Nurse #2 further stated when administering narcotics the 5 rights of medication administration should be followed (the right patient, the right time and frequency of administration, the right dose, the right route, the right drug). Nurse #2 stated along	F0760		

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F0760 SS = D	Continued from page 3 with the 5 rights, a resident should be verified by name and their picture in their electronic medical record (EMR). An interview was conducted with the Unit Manager on 12/17/25 at 3:03 PM. She recalled a nurse had notified her Resident #1 received the wrong medication on 11/28/25 immediately after the error had occured. She stated she notified the NP and received orders for naloxone and an IV fluid bolus, and the facility's neuro check protocol was initiated. The Unit Manager stated Resident #1 kept telling the staff she was ok. The Unit Manager further stated when administering narcotics staff should identify the correct resident, verify the order, ensure you have the correct medication and the right resident. An interview with Director of Nursing (DON) was conducted on 12/18/25 at 1:34 PM. She stated Nurse #1 and Nurse #2 were passing medications together and Nurse #1 gave Resident #1 the wrong medication. Once Nurse #1 and Nurse #2 realized the error, the Unit Manager was notified and the Unit Manager notified me (DON). The provider was notified and orders were given. Nurse #1 and Nurse #2 were placed on administrative leave pending the investigation. The DON further stated staff were expected to use the 5 rights of medication administration and administer medications per the facility's policy. This included a minimum of 2 identifiers for residents including name, date of birth, and/or the resident photograph in their EMR. The DON stated should a medication administration error occur, the Unit Supervisor, DON, Provider, and resident representative were to be notified. An interview with Pharmacy Consultant was conducted on 12/17/25 at 3:12 PM. She stated she conducted a pharmacy review on 11/28/25 but was not aware an error had occurred. The Pharmacy Consultant stated she was not notified of the medication error. She stated the oxycodone Resident #1 received was an immediate release type (a conventional dosage form designed to release the entire dose of the active drug relatively quickly after administration, typically within minutes of ingestion) and could cause significant sedation if a resident was not used to that kind of a dose. She further stated during review of Resident #1's medications, the accidental oxycodone administration would not have had any interactions with the medications Resident #1 was prescribed. In an interview with the Nurse Practitioner (NP) she stated she was called by nursing staff on 11/28/25 and was informed Resident #1 received the wrong medication	F0760		

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F0760 SS = D	Continued from page 4 (oxycodone 60 mg). She stated she ordered naloxone, an IV fluid bolus, and frequent vital signs. The NP stated the Unit Manager informed her that after receiving the naloxone and the IV fluids Resident #1 was fine. An interview with the Medical Director was conducted on 12/17/25 at 3:52 PM. He stated oxycodone at 60 mg might cause side effects however he would not be able to tell how an individual would react because reactions could be different based on the person. An interview with the Administrator was conducted on 12/18/25 at 1:54 PM. The Administrator stated it was her expectation for nursing staff to follow the 5 rights of medication administration when giving medications. Staff were expected to confirm a resident's identity by looking at their picture in their electronic medical record and asking their name and date of birth. If a resident cannot answer or the nursing staff was unfamiliar with the resident, they should always check their picture in the EMR and ask for confirmation from a familiar staff member. The Administrator indicated in the event of a medication error the DON, herself (Administrator), the Provider, and resident representative should be notified. The facility provided the following corrective action plan. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 11/28/25 at approximately 12:30 PM during medication pass, a medication error occurred when Resident #1 was accidentally administered oxycodone 60mg that was intended for her roommate, by Nurse #1. The Director of Nursing (DON) and the Unit Manager were immediately notified, and Resident #1 was assessed by the licensed nurse. The assessment included obtaining vital signs, neurological status, respiratory status, and sedation level. During the assessment Resident #1 was alert and oriented, unlabored breathing, pulse rate normal, respirations normal, and O2 saturation normal. The Nurse Practitioner was notified of the medication error by the Unit Manager, and the following orders were obtained: naloxone HCL liquid 4 milligrams (mg)/0.1 milliliter (mL)-1 spray, alternating nostrils every 2 minutes as needed (PRN), and 1liter (L) normal saline (a mixture of sodium chloride and water) IV (within a vein) bolus (a single, large amount of intravenous (IV) fluids administered quickly to a patient). The naloxone and the 1 L of normal saline IV	F0760		

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F0760 SS = D	Continued from page 5 bolus were administered. Resident #1 was administered 1 dose of naloxone, remained alert, and her vital signs remained stable. Resident #1 was assessed by the licensed nurse and the Unit Manager following the administration of naloxone. Her vitals were stable, she was alert and oriented, no signs, symptoms or indication of being in distress. Resident #1's representative (grandson) was notified and informed of the medication error and interventions on Friday, 11/28/25 at 1:30 PM. On 11/29/25 Resident #1 continued to be evaluated every shift for signs and symptoms of any adverse reaction to the medication (erroneously) administered. She was alert and communicated to the staff at her baseline. She offered no complaints of shortness of breath or difficulty breathing and denied pain. On Monday, 12/1/25, Resident #1 was assessed by the Nurse Practitioner. It was noted that the resident was in no acute distress, lungs were clear, and she displayed appropriate mood/affect. She was clinically stable and exhibited no on-going adverse effects from the medication error. Resident #1 continued to be closely monitored for 72 hours through the neurological (neuro) check protocol (every 15 minutes (min) x 2 hours, then every 30 min x 2 hours, then every 60 min x 4 hours, then every 8 hours until at least 72 hours had elapsed). Nursing documentation was completed every shift. She continued to remain alert and oriented, and her vital signs were within normal limits throughout the monitoring period. Nurse #1 was hired on 11/25/25. She completed her on-line education on 11/28/25. Her completed education included medication administration. Nurse #1's first day of orientation on the floor was 11/28/25 with Nurse #2 assigned to orient Nurse #1. Nurse #1 was the nurse that administered Resident #1, the oxycodone 60mg that was intended to be administered to her roommate. Nurse #2 pulled the medication for Resident #1's roommate and instructed Nurse #1 to administer the medication. Nurse #2 entered the room and identified Nurse #1 standing at the bedside of the wrong patient (Resident #1) for which she administered the medication. The Nurse Practice Educator (NPE) educated both nurses and medication assistants on medication administration, adhering to the 5 rights of medication administration to include the right patient, the right medication, the right dose, the right route, the right time. On 11/28/25 the nurses and medication assistants also were	F0760		

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F0760 SS = D	Continued from page 6 educated on the safe handling of controlled substances. Staff must verify all residents using two identifiers, such as: resident's full name, date of birth, photograph in the electronic medical record (Point Click Care or PCC and medication administration record or eMAR). When able, the residents should be asked to state their full name and date of birth. Staff compare the residents' identifiers with the eMAR in PCC, the medication label, and the resident photograph. The residents' room number and bed assignment should be verified as supporting information only. A resident's room number should never be used alone as an identifier. If the resident is disoriented, non-verbal, or cognitively impaired staff verify their identity using the photo identification in PCC and confirm the resident's identity with another licensed staff member. Staff should confirm the medication label matches the resident's name, as well as confirm the medication name, the dose, the route, and the time was correct. Nurses and Medication Aides should verify the resident's name, room number, photograph in electronic medical record and MAR prior to medication administration to ensure the correct resident was administered medications as prescribed per their physician's orders. On 12/1/25, a Root Cause Analysis was completed by the Administrator and the Director of Nursing regarding the medication error. It was determined that Nurse #2 failed to follow the facility's medication administration policy, including the required 5 Rights verification (right resident, right medication, right dose, right route, right time) when she asked Nurse #1 to administer medication that she pulled from the medication cart during Nurse #1's orientation. Nurse #1 failed to verify the resident identifiers prior to administering the controlled medication. In addition, the Root Cause Analysis identified that Nurse #1 and Nurse #2 had not completed the new hire orientation process to include medication administration skills checklist and education. Upon further review of facility systems and practices, it was determined that the cause of the errors was as follows: failure to enforce medication administration policies, including the required 5 Rights and resident identification process, incomplete orientation and competency validation for licensed nursing staff prior to medication administration, inadequate supervision during orientation allowing medication administration outside approved training protocols, a breakdown in accountability and communication resulting in reliance	F0760		

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F0760 SS = D	Continued from page 7 on another nurse's preparation and identification rather than independent verification. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the medication administration error. Residents with a brief interview for mental status (BIMS) score of 11 or less were assessed by the DON on 12/4/25 to ensure that they did not have any signs or symptoms of having the wrong medication administered. No concerns were identified. Assessments included a neurological assessment including level of consciousness, orientation to person/place/time as able, speech clarity, and presence of confusion or behavioral changes; vital sign monitoring which included blood pressure, heart rate, respiratory rate, temperature, and oxygen saturation; a cardiovascular assessment which included heart rate and rhythm, presence of chest discomfort, dizziness, or palpitations (feelings of having a fast-beating, fluttering or pounding heart); a respiratory assessment including respiratory effort, breath sounds, shortness of breath, or changes in oxygen needs; a gastrointestinal assessment including nausea, vomiting, abdominal discomfort, or changes in appetite; a pain assessment including new or worsening pain or discomfort; a medication-specific side effect monitoring based on each resident's current medication profile which included observation for signs of over-sedation, adverse drug reactions, or allergic responses; a review of medication administration records (MAR) for accuracy and timeliness; and staff interviews and resident observations for any reported changes from baseline. Residents were monitored for any deviation from baseline status. No adverse signs or symptoms were identified, and no further medical intervention was required. Residents with a BIMS of 12 or greater were interviewed to ensure that they were administered the correct medication by the Director of Nursing on 12/5/25. No concerns were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. By 12/5/25, Licensed Nurses and Certified Medication Assistants were educated on adhering to the resident rights of medication administration by the Nurse	F0760		

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F0760 SS = D	Continued from page 8 Practice Educator, the Director of Nursing, and/or the Nurse Manager. Any nurse who was not educated will be educated prior to their next shift. All newly hired Licensed Nurses and Certified Medication Assistants will be educated during their orientation regarding the resident rights of medication administration by the Nurse Practice Educator or by a Nurse Manager. The overall responsibility for ensuring completion, compliance, and ongoing education will be overseen by the Director of Nursing (DON). The Director of Nursing, Nurse Practice Educator (NPE), and Unit Managers were formally notified of their roles and responsibilities by the Regional Consultant Nurse on 12/5/25, at which time implementation of the education plan was initiated. The Regional Consultant Nurse implemented the corrective action on 12/5/25 which included assigning education responsibilities to the NPE and Unit Managers, directing oversight responsibilities to the DON, and requiring documentation of completed education and follow-up for any staff not present. The Nurse Practice Educator conducted an audit of current licensed nurses and Certified Medication Assistants. The Nurse Practice Educator reviewed their personnel files for completed education and skill competencies checklist; this was completed by 12/4/25. Any identified concerns were addressed. The Nurse Practice Educator educated both nurses on medication administration, adhering to the 5 rights of medication administration and safe handling of controlled substances on 11/28/25. On 12/5/25 The Resource Operator educated the scheduler on the new hire orientation onboarding process to include validating completion of mandatory training prior to new staff being assigned on the schedule. On 12/5/25 The Regional Nurse Consultant educated the Director of Nursing and Nurse Practice Educator regarding ensuring licensed nurses and medication aides completed education and the skills competency checklist on medication administration prior to being scheduled on the floor. The Nurse Practice Educator and/or the Director of Nursing will conduct an audit of licensed nurses and medication aides' personnel files to ensure 5 rights of medication administration education and medication administration skill competencies have been completed upon hire. The Nursing Home Administrator (NHA) will conduct	F0760		

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F0760 SS = D	Continued from page 9 biweekly audits of new hire files to ensure education/competencies are completed for 12 weeks. 4. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? Auditing was initiated on 12/5/25 to evaluate compliance with the facility's medication administration policy, including adherence to the 5 Rights of medication administration and resident identification procedures. The DON and Nurse Managers will complete random audits of medication administration passes as follows: no less than 2 patients per medication cart every shift for 7 days a week for 2 weeks; no less than 2 patients per medication cart every shift for 5 days a week for 2 weeks; no less than 2 patients per medication cart every shift for 3 days a week for 2 weeks; no less than 2 patients per medication cart every shift for 2 days a week for 6 weeks. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, Minimum Data Assessment Nurse, and at least one direct care staff. The facility will audit to ensure compliance with the deficient practice through audits and education. Date of Compliance 12/8/25. The facility's corrective action plan was validated by the following: On 12/18/25 the facility's plan of correction was validated upon review of the sign-in sheets for in-service education provided to all licensed nurses and medication aides on the 5 rights of medication administration per medication policy and procedures. Review of the monitoring audits revealed they were completed as stated in the corrective action plan with no concerns identified. Interviews conducted with licensed nurses and medication aides revealed they had received education on medication administration. Medication Administration was observed as part of the complaint investigation survey and no errors were noted. The compliance date of 12/8/25 for the	F0760		

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F0760 SS = D	Continued from page 10 corrective action plan was validated.	F0760		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to	F0842	Nurse #3 was educated on by the Nurse Practice Educator on January 6th, 2026 ensuring that all narcotics signed out on the declining count sheet are also signed for on the Medication Administration Record. Nurse #4 no longer works in the facility. An audit was conducted by January 11th, by the Director of Nursing and/or Nurse Managers comparing all narcotic declining count sheets to the MAR's for the last 30 days on current residents to identify residents that had narcotics signed out on the narcotic record and signed out on the Medication Administration Record. Any discrepancies were reviewed by the Medical Director. By January 19th, 2026, the Director of Nursing and/or the Nurse Practice Educator will educate all of the licensed nurses and the medication administration assistants on the importance of signing out narcotics on both the declining count record when a narcotic is removed from the narcotic box and to document the administration of the narcotic on the Medication Administration Record after administering the narcotic to the resident. Any licensed nurses or certified medication assistants who are not available by January 14th, 2026, will have this education prior to their next scheduled shift. The Director of Nursing and/or the Nurse Practice Educator will provide this same education to all newly hired licensed nurses and medication administration assistants during their orientation period. Additionally, this same education will be provided to agency licensed nurses prior to them working on the floor. The Director of Nursing or Nurse Managers will conduce quality improvement monitoring 3 times per week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure that all narcotics signed out on the declining count sheet are also signed for on the Medication Administration Record after the nurse has administered the medication to the resident. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services	01/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 28365**

(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
F0842 SS = D	Continued from page 11 health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility did not maintain accurate records related to documentation of medication administration for 1 of 7 residents reviewed for accurate medical records (Resident #2). The findings included: Resident #2 was admitted to the facility on 12/9/25 with diagnoses which included chronic pain syndrome and fibromyalgia (a chronic condition causing widespread body pain, fatigue, sleep problems, and cognitive difficulties).	F0842	Continued from page 11 Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. COMPLIANCE DATE: January 20th, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

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F0842 SS = D	Continued from page 12 A review of Resident #2's physician orders revealed an order dated 12/12/25 for oxycodone-acetaminophen 5-325 milligrams (mg) give one (1) tablet by mouth every 6 hours as needed for pain. Resident #2's individual narcotic record sheet for oxycodone-acetaminophen 5-325 mg was reviewed. The narcotic record revealed Resident #2 received one (1) oxycodone-acetaminophen 5-325 mg tablet on 12/12/25 at 4:30 PM and at 10:00 PM. A review of Resident #2's December 2025 Medication Administration Record (MAR) indicated oxycodone-acetaminophen 5-325 mg was not documented as administered on 12/12/25 at 4:30 PM or at 10:00 PM. During a phone interview with Nurse #3 on 12/18/25 at 11:03 AM she confirmed she signed Resident #2's individual narcotic record sheet for oxycodone-acetaminophen 5-325 mg on 12/12/25 at 4:30 PM. Nurse #3 stated she thought she had signed the oxycodone-acetaminophen 5-325 mg tablet off in Resident #2's MAR, and if her initials were not there it was an error on her part. She stated when administering narcotics to any resident she would typically "hit" (highlight) the medication on the MAR as soon as she pulled the narcotic from the locked box, sign the medication out in the narcotic count book, administer the medication to the resident, and return to the MAR and sign the MAR record. Attempts to reach Nurse #4 who signed Resident #2's individual narcotic record sheet for oxycodone-acetaminophen 5-325 mg on 12/12/25 at 10:00 PM were unsuccessful. Nurse #4 was no longer employed at the facility. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 1:34 PM. She stated medications were supposed to be documented on both the MAR and narcotic sheet when they were administered to a resident. During an interview with the Administrator on 12/18/25 at 1:54 PM she stated narcotics should be documented on both the narcotic sheet and the MAR.	F0842		