| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345359 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/18/2025 |
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| **Ahoskie Health and Rehabilitation Center** | **604 Stokes Street East , Ahoskie, North Carolina, 27910** |

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| E0000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 12/15/25 through 12/18/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DDCA1-H1. | E0000 | | 01/08/2026 |
| F0000 | INITIAL COMMENTS<br><br>A recertification and complaint survey was conducted from 12/15/25 through 12/18/25. Event ID# 1DDCA1-H1. The following intakes were investigated: 862121, 862122, 862123, 862124, 862129, 862130, 2612454, 2655664, 2682532, 2691918, and 2691546.<br><br>1 of the 28 complaint allegations resulted in deficiency. | F0000 | | 01/08/2026 |
| F0578<br>SS = D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br><br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br><br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br><br>(ii) This includes a written description of the facility's policies to implement advance directives and | F0578 | On 12/15/25 Advanced Directives for Resident #12 were reviewed by the Director of Nursing (DON). On 12/15/25 Physician's order for Full Code was provided for Resident #12. Care plan was updated on 12/15/25 by LPN Minimum Data Set (MDS) Nurse to reflect the resident representative wishes for Advanced Directives and corresponding physician order for Full Code status. On 12/15/25 the DON updated the communication icon bar in the electronic medical record.<br><br>Residents residing in the facility have Advanced Directives and the potential to be affected. The LPN Minimum Data Set (MDS) Nurse was interviewed by the Regional Vice President of Operations on 12/15/25. On 12/15/25 the LPN MDS Nurse stated to the Regional Vice President of Operations no other residents and only one other resident representative requested a code status change during the care plan meeting. That resident had the order, care plan, and the communication icon bar in the electronic medical record updated to reflect the code status change and the DNR Golden Rod Transport form was removed at the time of the request to change the Advanced Directives. The MDS Nurses completed a 100% audit review of the most recent care plan note in each resident's medical record on or before 1/13/26 to validate that no other residents were affected. There were no other residents who were noted to be affected. | 01/14/2026 |

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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| F0578 SS = D | Continued from page 1<br>applicable State law.<br><br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br><br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br><br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review and staff interviews, the facility failed to update the resident's code status information when Resident #12's Responsible Party requested a change from do not resuscitate to full code. This was for 1 of 4 residents reviewed for advanced directives (Resident #12).<br><br>The findings included:<br><br>Resident #12 was admitted to the facility on 9/25/19.<br><br>Resident #12's care plan revised 3/19/25 revealed he had a goal status of "do not resuscitate".<br><br>Resident #12's quarterly Minimum Data Set (MDS) assessment dated 9/24/25 revealed Resident #12 was assessed as being severely cognitively impaired.<br><br>Review of a care plan meeting note dated 11/25/25 written by the MDS Nurse indicated Resident #12's responsible party stated she would like to change Resident #12's code status from "do not resuscitate" to "full code".<br><br>An attempt to contact Resident #12's responsible party was not successful on 12/18/25 at 9:39 AM.<br><br>An observation of Resident #12's electronic medical record showed on the communication bar a code status icon that read do not resuscitate (DNR).<br><br>On 12/15/25 at 10:47 AM an interview was conducted with | F0578 | Continued from page 1<br><br>On 12/18/26 the Regional Vice President of Clinical Services provided one to one education with the LPN MDS Coordinator to include when a resident or resident representative desires a change of code status the MDS Nurse is to contact the provider to obtain the order, update the communication icon bar in the electronic medical record, update the care plan, and if needed update the Golden Rod Do Not Resuscitate (DNR) form.<br><br>On 1/12/26 the Nursing Home Administrator (NHA) provided education to the Social Worker, Minimum Data Set Nurses, Unit Manager and Director of Nursing (DON) on Advanced Directives to include ensuring Advanced Directives are reviewed and updated as needed on admission, re-admission, quarterly, with significant change of status, and as requested, and that Advanced Directives are honored.<br><br>Weekly for twelve weeks the Social Worker or MDS Nurse will review the most recent care plan notes for three random residents to validate their wishes correspond with their Advanced Directives to include Physician order, DNR golden rod transportable physician's order for DNR (if necessary), communication the icon bar in the electronic medical record and the care. Any discrepancy noted will be immediately reported to the DON who will immediately address any discrepancy by contacting the physician for a change of Advanced Directives order and update the care plan, communication icon bar in the electronic medical record, and DNR Golden Rod, if necessary. Monthly for three months the Social Worker will present the audit to the QAPI Committee. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing. | |

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| F0578<br>SS = D | Continued from page 2<br>the MDS Nurse who stated to locate a resident's code status she would check the medical record for the status. She reported Resident #12's code status was "do not resuscitate" after checking Resident #12's medical record during the interview.<br><br>A follow up interview was conducted with the MDS Nurse on 12/18/25 at 10:37 AM who stated she reported to the Social Worker and the former Director of Nursing that Resident #12's responsible party requested Resident #12's code status be changed from a DNR to a full code. The MDS Nurse was unable to recall the specific date she reported this information to the Social Worker and the former Director of Nursing. She reported she recalled the care plan meeting on 11/25/25 and wrote the care plan meeting note. The MDS Nurse reported the facility Social Worker was responsible for filling out the documents for the code status change.<br><br>An interview was conducted on 12/15/25 at 2:33 P.M with the facility Social Worker (SW). During the interview the SW stated when a resident's code status was updated after admission, she was responsible for changing and updating the code status on the communication bar and within the electronic medical record. She indicated she was not present when Resident 12's responsible party requested his code status be changed. The SW stated the MDS Nurse wrote the care plan meeting note but the code status was not changed. She did not recall the MDS Nurse telling her about the request for a code status change for Resident #12.<br><br>An interview was conducted on 12/18/25 at 11:00 A.M with the Administrator. She stated Resident #12's code status should have been changed when Resident #12's responsible party requested it be changed from "do not resuscitate" to "full code" and the SW should have ensured Resident #12's code status was changed. The Administrator reported this was an oversight. | F0578 | | |
| F0641<br>SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. | F0641 | Resident #22 Minimum Data Set (MDS) Assessment dated 8/23/25 was modified by the LPN MDS nurse on 12/18/25 to reflect Level II Pre-admission Record Review (PASRR).<br><br>Resident #25 MDS Assessment dated 9/18/25 was modified by the LPN MDS nurse on 12/18/25 to reflect Level II Pre-admission Record Review (PASRR).<br><br>Residents with Level II PASRRs have been identified as having the potential to be affected and had their Minimum Data Set (MDS) audited on 12/18/25 by the RN MDS Nurse to validate coding accuracy of the MDS per the Resident Assessment Instrument (RAI) Manual. Any | 01/14/2026 |

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| F0641 SS = D | Continued from page 3<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§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.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(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<br><br>(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.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set Assessments (MDS) for 2 of 32 residents whose MDS assessments were reviewed for accuracy (Resident #22, and Resident #25).<br><br>The findings included:<br><br>1. Resident #22 was admitted to the facility on 8/12/25 with diagnoses that included intellectual disabilities, schizophreniform disorder, depression, anxiety and dementia.<br><br>Review of Resident #22's electronic health record revealed a Preadmission Screening and Resident Review (PASRR, a federal requirement for Medicaid-certified nursing facilities to assess individuals for serious mental illness) was completed prior to his admission and indicated Resident #22 was screened as Level II determination (a comprehensive evaluation conducted to assess the needs of individuals identified as having serious mental illness or intellectual disabilities, ensuring they received appropriate care and services in the nursing home) with no end date. | F0641 | Continued from page 3<br>MDS that is identified as requiring a modification will be modified by the RN MDS Nurse and transmitted by 1/13/26.<br><br>MDS Coordinators were educated on 12/30/25 by the Regional Director of Case Management on coding of section A1500 per the RAI Manual.<br><br>Once a week for three months the RN MDS Nurse will audit the Minimum Data Set of any newly admitted resident with a Level II PASRR and any resident whose PASRR Level has changed to a Level II to validate coding per the RAI Manual for section A1500. Any areas of concern identified will be reviewed by the Regional Director of Case Management; modifications to the MDS will be performed and additional training will be provided for the MDS Nurses by the Regional Director of Case Management.<br><br>Results of the audits will be presented by the RN MDS Nurse in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing. | |

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| F0641 SS = D | Continued from page 4<br><br>A review of Resident #22's admission Minimum Data Set (MDS) assessment dated 8/23/25 revealed Resident #22 was not coded as having a Level II PASRR determination. The MDS documented diagnoses including dementia, depression, anxiety disorder and schizophrenia.<br><br>In an interview on 12/18/25 at 10:34 AM the MDS Nurse stated that Resident #22 should have been coded on the MDS for a Level II PASRR determination. She indicated it was an oversight.<br><br>2. Resident #25 was admitted to the facility on 12/21/20 with diagnoses that included depression, schizoaffective disorder, dementia and psychosis.<br><br>Review of Resident #25's electronic health record revealed a Preadmission Screening and Resident Review (PASRR, a federal requirement for Medicaid-certified nursing facilities to assess individuals for serious mental illness) was completed on 10/05/23 and indicated Resident #25 was screened as Level II determination (a comprehensive evaluation conducted to assess the needs of individuals identified as having serious mental illness or intellectual disabilities, ensuring they received appropriate care and services in the nursing home) with no end date.<br><br>A review of Resident #25's care plan dated 12/21/23 revealed a plan for Level II PASRR recommendations related to serious mental illness diagnoses of schizoaffective disorder, dementia and psychosis. The goal for the plan of care was that the Resident would receive recommended care and/or services as determined appropriate by Level II PASRR through next review. Interventions included continuing to adjust and meet activities of daily living (ADL) needs. Provide occupational therapy, physical therapy and restorative nursing to be provided as needed.<br><br>A review of Resident #25's annual Minimum Data Set (MDS) assessment dated 9/18/25 revealed Resident #25 was not coded as having a Level II PASRR determination. The MDS documented diagnoses including dementia, depression, psychotic disorder and schizophrenia.<br><br>In an interview on 12/17/25 at 10:11 AM the MDS Nurse stated that Resident #25 should have been coded on the MDS for a Level II PASRR determination. She indicated it was an oversight. | F0641 | | |
| F0656 SS = B | Develop/Implement Comprehensive Care Plan | F0656 | On 12/18/25 Resident #8 care plan was updated by LPN Minimum Data Set (MDS) Nurse to reflect the use of | 01/14/2026 |

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| F0656 SS = B | Continued from page 5<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed. | F0656 | Continued from page 5<br>antipsychotic medication.<br><br>On 12/18/25 Resident #109 care plan was updated by the Activities Director to reflect preferred activities.<br><br>On 1/12/26 RN MDS Nurse audited 100% of the residents with physician's orders for antipsychotics to validate antipsychotic care plans are in place. Any updates and or revisions needed were completed by MDSC #2 at that time.<br><br>On 1/12/26 the Activities Director audited 100% of the resident care plans to review and implement preferred activities are care planned. Any necessary updates and or revisions were completed by Activities Director at that time.<br><br>On 12/30/25 the Regional Director of Case Management educated LPN MDS Nurse, RN MDS Nurse, and the Activities Director on updating resident care plans as needed for use of antipsychotic medication and preferred activities.<br><br>Once a week for two months, the RN Minimum Data Set Coordinator will randomly audit three residents with physician's orders for antipsychotic medication, and three resident activities care plans for preferred activities to validate care plans are reflective of use of antipsychotic medication and preferred activities. RN MDS will update and revise the care plan if required. If it is noted that the care plan was not updated, the DON, Nursing Home Administrator, and Regional Director of Case Management will be immediately notified, an Ad Hoc QAPI meeting will be held. Re-education will be completed by the Nursing Home Administrator on an as needed basis.<br><br>RN Minimum Data Set Nurse will present the audits to the facility's Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audit and make recommendations to assure compliance is sustained ongoing.<br><br>Date of Compliance:<br><br>1/14/26 | |

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| F0656 SS = B | Continued from page 6<br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record reviews and staff interviews, the facility failed to develop a person-centered care plan in the areas of antipsychotic medication use (Resident #8), and preferred activities (Resident #109) for 2 of 32 residents whose care plans were reviewed.<br><br>The findings included:<br><br>1. Resident #8 was admitted to the facility on 07/01/25 with diagnoses that included vascular dementia with psychotic disturbance.<br><br>Review of Resident #8's December 2025 physician's orders revealed a medication order dated 07/22/25 for olanzapine (antipsychotic medication) 5 milligrams (mg) one (1) tablet every 12 hours for psychotic disorder.<br><br>Review of Resident #8's current comprehensive care plan last reviewed on 10/24/25 did not reveal a care plan focus area related to receiving an antipsychotic medication.<br><br>Resident #8's quarterly Minimum Data Set (MDS) assessment dated 11/14/25 revealed the Resident was severely cognitively impaired and was coded for antipsychotic medication use.<br><br>Review of Resident #8's December 2025 medication administration record for the period of 12/01/25 through 12/17/25 revealed Resident #8 received olanzapine 5mg one (1) tablet every 12 hours as prescribed.<br><br>An interview was completed with the MDS Nurse on 12/18/25 at 12:06 pm who revealed she was responsible for the development of resident care plans. The MDS Nurse stated Resident #8 should have had an antipsychotic medication care plan with interventions in place. The MDS Nurse stated the missing care plan was due to an oversight.<br><br>An interview was completed on 12/18/25 at 12:33 pm with the Director of Nursing (DON). The DON revealed the MDS Nurse was responsible for resident care plans. The DON stated resident care plans were reviewed during care plan meetings and Resident #8 should have had a care plan initiated for antipsychotic medication use when the medication was prescribed.<br><br>An interview was completed with the Administrator on 12/18/25 at 12:41 pm. The Administrator revealed the | F0656 | | |

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| F0656 SS = B | Continued from page 7<br>MDS Nurse was responsible for reviewing and developing residents' comprehensive care plans. The Administrator stated the MDS Nurse was responsible for developing Resident #8's care plan for antipsychotic medication use. The Administrator revealed the care plan was missed due to an oversight by the MDS Nurse.<br><br>2. Resident #109 was admitted to the facility on 10/10/25 with diagnoses that included vascular dementia.<br><br>Resident #109's admission Minimum Data Set (MDS) assessment dated 10/16/25 revealed the Resident was severely cognitively impaired. The assessment revealed it was very important for Resident #109 to listen to music, participate in groups, participate in favorite activities, and participate in religious services.<br><br>A progress note dated 10/26/25 revealed Resident #109 was taken from the dementia care unit to the main unit to attend a religious service.<br><br>Review of Resident #109's current comprehensive care plan last reviewed on 10/28/25 did not reveal a care plan focus area related to activities.<br><br>An interview was conducted with Nurse Aide #1 on 12/17/25 at 2:34 PM who stated Resident #109 frequently attended activities on the dementia care unit.<br><br>An interview was completed with the Activities Director on 12/18/25 at 9:58 AM who revealed she was responsible for the development of resident care plans related to activities and residents should have a focus related to activities on their care plan. She reported that sometimes the MDS Nurse ensured there was a focus related to activities on resident care plans. She stated it was an oversight that activities was not included in the comprehensive care plan.<br><br>During an interview with the MDS Nurse on 12/18/25 at 10:32 AM she stated sometimes she assisted the Activities Director and placed a focus related to activities on resident care plans, but it was the Activities Director's responsibility to ensure this was completed. She reported that if she noticed there was not a focus related to activities on the care plan, she would place one. She stated she was not aware that Resident #109 did not have a focus related to activities on her care plan.<br><br>An interview was completed with the Administrator on 12/18/25 at 11:00 AM. The Administrator revealed the Activities Director was responsible for developing | F0656 | | |

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| F0656 SS = B | Continued from page 8<br>residents' comprehensive care plans related to activities. The Administrator revealed the focus of activities on the care plan was missed due to an oversight by the Activities Director. | F0656 | | |
| F0690 SS = D | Bowel/Bladder Incontinence, Catheter, UTI<br><br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br><br>§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.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(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;<br><br>(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<br><br>(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.<br><br>§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.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review and staff interviews, the facility failed to secure the indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 1 resident reviewed for indwelling urinary catheter (Resident #11).<br><br>The findings included: | F0690 | On 12/18/25 Resident #11 had the indwelling urinary catheter secured with a securing device.<br><br>Residents with indwelling urinary catheters have been identified as having the potential to be affected. On 12/18/25 each resident with an indwelling urinary catheter had an observation audit conducted by the Director of Nursing to assure catheter securing devices were in place. All other residents with indwelling urinary catheters had a secure device in place.<br><br>On 12/18/25 the Director of Nursing initiated educational in-services with all nursing staff, including agency staff, on use of indwelling urinary catheter securing devices to prevent tugging or pulling on the indwelling urinary catheter. After 1/14/26 no licensed nurse, including agency nurses, will be permitted to work without first receiving the education by the Director of Nursing or Nursing Supervisor.<br><br>During their classroom orientation, newly hired licensed nurses will be educated on the importance of securing indwelling urinary catheter tubing.<br><br>Once a week for twelve weeks the Director of Nursing or Nursing Supervisor will audit each indwelling urinary catheter to validate use of securing device to prevent tugging or pulling. If a securing device is not in place, the assigned Licensed Nurse will be removed from resident care until one-to-one re-education is completed by the Director of Nursing or Nurse Manager.<br><br>The Director of Nursing will present the audits to the Quality Assurance and Performance Improvement Committee weekly for twelve weeks or as directed by the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations or revisions to the plan to assure compliance is sustained ongoing.<br><br>Date of Compliance:<br><br>1/14/26 | 01/14/2026 |

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| F0690<br>SS = D | Continued from page 9<br><br>Resident #11 was admitted to the facility on 7/11/25 with diagnoses that included bladder rupture and urinary retention.<br><br>The Admission Minimum Data Set (MDS) Assessment dated 7/25/25 revealed Resident #11 was cognitively intact. She was coded as having an indwelling urinary catheter.<br><br>A Physicians' Order dated 12/16/25 indicated Resident #11 had an indwelling urinary catheter for urinary retention.<br><br>An observation was conducted on 12/17/25 at 10:22 AM of Nurse Aide #2 performing catheter care for Resident #11. The indwelling catheter tubing had no securement device to prevent pulling of the catheter tubing. There was no tension on the catheter tubing during observation.<br><br>An interview was conducted with Nurse Aide #2 on 12/17/25 at 10:30 AM. NA #2 stated she was assigned to Resident #11 and had provided care for this resident. NA #2 stated the nurse caring for the resident was responsible for making sure the indwelling catheter tubing had a securement device.<br><br>An interview was conducted with Resident #11 on 12/17/25 at 11:22 AM. Resident #11 stated that staff did not consistently place a securement device on her indwelling urinary catheter.<br><br>During an interview with Nurse #1 on 12/18/25 at 10:44 AM, she stated that the nurse was responsible for making sure residents had a securement device on urinary catheter tubing. Nurse #1 stated the nurse aide usually informed the nurse if the securement device was missing or soiled.<br><br>An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 12:36 PM The DON stated the nurse aide, or nurse could apply the securement device for the urinary catheter. The DON stated that she expected that indwelling urinary catheter would have a securement device in place.<br><br>During an interview with the Administrator on 12/18/25 at 1:00 PM, the Administrator stated she expected that staff would have placed a urinary catheter securement device and checked for placement each shift. | F0690 | | |
| F0698<br>SS = D | Dialysis<br><br>CFR(s): 483.25(l) | F0698 | Resident #6 received an order for hemodialysis on 12/18/25. | 01/14/2026 |

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| F0698 SS = D | Continued from page 10<br><br>§483.25(l) Dialysis.<br><br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and staff interviews, the facility failed to ensure a resident receiving dialysis had a physician's order for dialysis for 1 of 2 sampled residents reviewed for dialysis (Resident #6).<br><br>The findings included:<br><br>Resident #6 was admitted to the facility on 3/24/23 with diagnoses including end-stage renal disease requiring dialysis.<br><br>The resident's care plan, last updated on 10/21/24, documented chronic renal failure and the potential for complications related to hemodialysis. Interventions included:<br><br>- Communicating with the dialysis center regarding medications, diet, and lab results.<br><br>- Coordinating care with the dialysis center.<br><br>- Monitoring the shunt site daily and as needed for signs of infection, pain, or bleeding.<br><br>- Notifying the physician of absence of thrill or bruit.<br><br>Review of a hospital note dated 11/18/25 revealed that Resident #6 was hospitalized on 11/13/25 for a critical procedure for patients requiring long-term dia lysis access. The resident continued receiving hemodialysis.<br><br>Upon readmission to the facility on 11/18/25, the physician's orders did not include dialysis services.<br><br>The Minimum Data Set dated 11/22/25 coded the resident as having end-stage renal disease and receiving dialysis services.<br><br>During an interview on 12/18/25 at 11:17 AM, the West Annex Unit Manager confirmed there was no dialysis order in the chart following the resident's return from | F0698 | Continued from page 10<br>Residents residing in the facility, who receive dialysis care, have the potential to be affected. Each of the residents who receive hemodialysis had a medical record review by the Director of Nursing (DON) to audit for hemodialysis physician orders. Each of the other residents who attend hemodialysis had physician orders to attend.<br><br>On 12/18/25, the Director of Nursing initiated education to the Licensed Nurses on validating physicians' orders for dialysis residents on admission or readmission. After 01/14/26 no Licensed Nurse will be permitted to work without first receiving the education from the Director of Nursing. The education will be incorporated into the facility orientation, including agency orientation for Licensed Nurses and taught by the DON.<br><br>Weekly for three months, the Director of Nursing will audit physician orders for dialysis residents on admission or readmission to the facility.<br><br>Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.<br><br>Date of Compliance: 1/14/2026 | |

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| F0698 SS = D | Continued from page 11<br>the hospital. She stated the order was not reinstated after readmission.<br><br>In an interview on 12/18/25 at 11:34 AM, the Director of Nursing reported she was unaware that the dialysis order was missing and acknowledged staff likely failed to re-enter the order upon readmission.<br><br>In an interview on 12/18/25 at 11:32 AM, the Administrator stated the dialysis order should have been immediately reinstated after the resident's return from the hospital. | F0698 | | |
| F0729 SS = D | Nurse Aide Registry Verification, Retraining<br><br>CFR(s): 483.35(e)(4)-(6)<br><br>§483.35(e)(4) Registry verification.<br><br>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless-<br><br>(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or<br><br>(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.<br><br>§483.35(e)(5) Multi-State registry verification.<br><br>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.<br><br>§483.35(e)(6) Required retraining.<br><br>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the | F0729 | On 12/2/25 NA #1 certification was renewed by the North Carolina Nurse Aid Registry. The facility is unable to correct the lapse in the certification from 8/31/25 – 12/2/25.<br><br>Residents residing in the facility have the potential to be affected by the deficient practice. On or before 1/13/26 the Human Resources Director validated each certification for the nursing assistants. No other nursing assistants had expired certifications.<br><br>Monthly for three months in the facility Quality Assurance Performance Improvement (QAPI) Meeting the Human Resources Director will report what certifications are due the following month and will report how many nursing assistants, if any, were removed from the schedule due to expired certification.<br><br>Date of Compliance: 1/14/26 | 01/14/2026 |

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| F0729 SS = D | Continued from page 12<br>individual must complete a new training and competency evaluation program or a new competency evaluation program.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, and staff interviews, the facility failed to monitor the North Carolina (NC) Nurse Aide (NA) Registry to ensure 1 of 6 nurse aides employed at the facility remained listed on the NC Nurse Aide Registry with an active Nurse Aide I certification (NA#1).<br><br>The findings included:<br><br>A review of Nurse Aide #1's employment record reported a hired date as 5/11/23. The Nurse Aide Registry Verification form revealed the facility requested verification of Nurse Aide #1's certification on 12/18/25 and the NA's certification was current.<br><br>During an interview with the Nurse Aide Registry Representative on 12/18/25 at 10:38 am, she stated NA #1's Nurse Aide I Registry expired on 8/31/25. She stated NA #1's Nurse Aide registry was submitted and processed on 12/2/25.<br><br>A review of NA #1's time sheet since 9/1/25 listed NA #1 worked the following dates:<br><br>On 9/2/25 at 06:59 am to 07:01 pm as a Nurse Aide<br><br>On 9/3/25 at 06:54 am to 07:01 pm as a Nurse Aide<br><br>On 9/5/25 at 07:14 am to 07:04 pm as a Nurse Aide<br><br>On 9/6/25 at 07:08 am to 07:00 pm as a Nurse Aide<br><br>On 9/7/25 at 07:09 am to 07:01 pm as a Nurse Aide<br><br>On 9/9/25 at 07:00 am to 07:02 pm as a Nurse Aide<br><br>On 9/10/25 at 07:00 am to 07:01 pm as a Nurse Aide<br><br>On 9/11/25 at 07:15 am to 07:01 pm as a Nurse Aide<br><br>On 9/12/25 at 06:56 am to 07:03 pm as a Nurse Aide<br><br>On 9/13/25 at 06:54 am to 07:04 pm as a Nurse Aide<br><br>On 9/14/25 at 06:54 am to 06:54 pm as a Nurse Aide<br><br>On 9/16/25 at 06:53 am to 06:56 pm as a Nurse Aide | F0729 | | |

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| F0729 SS = D | Continued from page 13<br>On 9/18/25 at 06:52 am to 01:28 pm as a Nurse Aide<br>On 9/20/25 at 06:55 am to 07:00 pm as a Nurse Aide<br>On 9/21/25 at 06:53 am to 06:55 pm as a Nurse Aide<br>On 9/30/25 at 06:55 am to 06:57 pm as a Nurse Aide<br>On 10/2/25 at 06:54 am to 07:03 pm as a Nurse Aide<br>On 10/3/25 at 06:53 am to 06:56 pm as a Nurse Aide<br>On 10/4/25 at 06:54 am to 07:06 pm as a Nurse Aide<br>On 10/5/25 at 06:55 am to 07:05 pm as a Nurse Aide<br>On 10/7/25 at 07:03 am to 07:07 pm as a Nurse Aide<br>On 10/8/25 at 06:56 am to 07:01 pm as a Nurse Aide<br>On 10/9/25 at 06:59 am to 07:01 pm as a Nurse Aide<br>On 10/10/25 at 06:54 am to 07:05 pm as a Nurse Aide<br>On 10/11/25 at 07:09 am to 07:00 pm as a Nurse Aide<br>On 10/12/25 at 06:53 am to 07:08 pm as a Nurse Aide<br>On 10/14/25 at 07:05 am to 07:06 pm as a Nurse Aide<br>On 10/16/25 at 06:54 am to 07:02 pm as a Nurse Aide<br>On 10/17/25 at 06:57 am to 06:59 pm as a Nurse Aide<br>On 10/21/25 at 06:52 am to 07:04 pm as a Nurse Aide<br>On 10/22/25 at 06:53 am to 06:59 pm as a Nurse Aide<br>On 10/23/25 at 06:55 am to 07:01 pm as a Nurse Aide<br>On 10/24/25 at 06:57 am to 06:59 pm as a Nurse Aide<br>On 10/25/25 at 07:09 am to 06:58 pm as a Nurse Aide<br>On 10/26/25 at 07:00 am to 07:01 pm as a Nurse Aide<br>On 10/28/25 at 07:05 am to 07:06 pm as a Nurse Aide<br>On 10/30/25 at 07:01 am to 07:00 pm as a Nurse Aide<br>On 10/31/25 at 07:03 am to 06:59 pm as a Nurse Aide<br>On 11/1/25 at 07:11 am to 07:05 pm as a Nurse Aide | F0729 | | |

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| F0729 SS = D | Continued from page 14<br>On 11/2/25 at 06:53 am to 06:58 pm as a Nurse Aide<br><br>On 11/4/25 at 06:54 am to 07:02 pm as a Nurse Aide<br><br>On 11/5/25 at 06:59 am to 07:00 pm as a Nurse Aide<br><br>On 11/6/25 at 07:00 am to 07:00 pm as a Nurse Aide<br><br>On 11/7/25 at 07:00 am to 07:00 pm as a Nurse Aide<br><br>On 11/8/25 at 07:00 am to 07:00 pm as a Nurse Aide<br><br>On 11/9/25 at 07:00 am to 07:00 pm as a Nurse Aide<br><br>On 11/11/25 at 06:59 am to 07:02 pm as a Nurse Aide<br><br>On 11/13/25 at 06:59 am to 07:00 pm as a Nurse Aide<br><br>On 11/15/25 at 06:50 am to 06:58 pm as a Nurse Aide<br><br>On 11/16/25 at 06:54 am to 06:58 pm as a Nurse Aide<br><br>On 11/18/25 at 06:53 am to 07:00 pm as a Nurse Aide<br><br>On 11/19/25 at 06:53 am to 07:01 pm as a Nurse Aide<br><br>On 11/20/25 at 06:55 am to 07:01 pm as a Nurse Aide<br><br>On 11/21/25 at 06:52 am to 07:09 pm as a Nurse Aide<br><br>On 11/22/25 at 06:58 am to 03:32 pm as a Nurse Aide<br><br>During an interview with Nurse Aide #1 on 12/18/25 at 10:32 AM, she stated that her Nurse Aide certification had expired at the end of August. NA #1 stated she was not aware that her certification had expired because she did not receive any notification via mail or email. NA #1 stated she had worked about a month when she found out that her Nurse Aide certification had expired. NA #1 stated that she completed the necessary online forms and got the nurse to sign off. NA #1 reported this was close to the end of September 2025.<br><br>An interview was conducted with Nurse Manager #1 on 12/18/25 at 11:04 PM. Nurse Manager #1 stated she had signed off electronically on NA #1's Nurse Aide Registry renewal form the end of September 2025.<br><br>A follow up phone call was made to the Nurse Aide Registry Representative on 12/18/25. She stated the process was for the Nurse Aide to complete their section of the electronic Nurse Aide Registry renewal form. The Nurse Aide Registry Representative stated once the Nurse Aide completed her section, she would | F0729 | | |

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| F0729<br>SS = D | Continued from page 15<br>then notify the Registered Nurse (RN) to go in and fill out her section on the renewal form. The Nurse Aide Registry Representative added that if the RN waited longer than 7 days to complete her section, the renewal form would reset, and the process would restart and the Nurse Aide had to resubmit her section. The Nurse Aide Registry Representative further stated that Nurse Aides were to check the system to see when the Nurse Aide Registry renewal was effective.<br><br>On 12/18/25 at 12:33 PM an interview was conducted with the Human Resources (HR) Director. The HR Director stated she was responsible for reviewing the Nurse Aide Registry verifications. The HR Director stated she reviewed all Nurse Aide Registry verifications every six months. She stated that it was human error that she had missed that NA #1's Nurse Aide certification had expired.<br><br>During an interview with the Administrator on 12/18/25 at 12:28 PM, she stated the HR Director was responsible for notifying staff that their Nurse Aide Registry renewal was due before the end of the month. She stated NA #1's certification expiration was an oversight. | F0729 | | |
| F0732<br>SS = C | Posted Nurse Staffing Information<br><br>CFR(s): 483.35(i)(1)-(4)<br><br>§483.35(i) Nurse Staffing Information.<br><br>§483.35(i)(1) Data requirements. The facility must post the following information on a daily basis:<br><br>(i) Facility name.<br><br>(ii) The current date.<br><br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br><br>(A) Registered nurses.<br><br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br><br>(C) Certified nurse aides.<br><br>(iv) Resident census. | F0732 | As of 12/18/25 accurate and complete nurse staffing data to include the census is currently posted in the facility.<br><br>Residents residing in the facility have been identified as having the potential to be affected.<br><br>On 1/12/26 the Nursing Home Administrator (NHA) provided education to the Human Resources Director and Director of Nursing on having accurate and complete daily staff nursing posting to include the census.<br><br>The NHA will conduct random observational audits once a week for 12 weeks to validate accurate nurse staffing posting to include the census on the daily staff nursing posting forms. Results of the observational audits will be presented by the Administrator in the monthly Quality Assurance Performance Improvement (QAPI) meeting monthly for three months. The QAPI committee will review the observational audits and make recommendations based on findings to assure compliance is sustained ongoing.<br><br>Date of Compliance:<br><br>1/14/26 | 01/14/2026 |

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| F0732 SS = C | Continued from page 16<br>§483.35(i)(2) Posting requirements.<br><br>(i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift.<br><br>(ii) Data must be posted as follows:<br><br>(A) Clear and readable format.<br><br>(B) In a prominent place readily accessible to residents, staff, and visitors.<br><br>§483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and staff interviews, the facility failed to ensure accurate daily staff nursing postings for 13 of 30 days reviewed for accurate nurse staffing information (11/17/25, 11/18/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/27/25, 11/29/25, 11/30/25, 12/2/25, 12/11/25, 12/12/25 and 12/13/25).<br><br>The findings included:<br><br>The daily staff nursing postings from 11/15/25 through 12/15/25 did not include the resident census on 11/17/25, 11/18/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/27/25, 11/29/25, 11/30/25, 12/2/25, 12/11/25, 12/12/25 and 12/13/25.<br><br>An interview conducted with the Director of Nursing (DON) on 12/18/25 at 12:11 PM revealed she was responsible for updating the daily nurse staffing information postings. The DON stated the daily nurse staffing posting was usually filled out the previous evening and updated with the current daily census after the morning clinical meeting. The DON stated that Unit Manager #2 was responsible for updating the census on the weekends and the daily nurse staffing postings had been overlooked by the Unit Manager on the days it was not updated. | F0732 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Ahoskie Health and Rehabilitation Center** | **604 Stokes Street East , Ahoskie, North Carolina, 27910** |

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| F0732 SS = C | Continued from page 17<br>An interview conducted with the Administrator on 12/18/15 at 12:54 PM revealed she expected that the daily staff posting would be completed to include the resident census. | F0732 | | |
| F0761 SS = D | Label/Store Drugs and Biologicals<br><br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, manufacturers' instructions, and staff and Pharmacy Consultant interviews, the facility failed to remove one (1) multi-dose insulin injector pen that was expired and 2 bottles of expired eye drops in 1 of 4 medication carts (East Annex Medication Cart #1) reviewed for medication storage and labeling.<br><br>The findings included:<br><br>The manufacturer's instructions for insulin lispro injector pen stated it should be discarded 28 days after opening. | F0761 | On 12/17/25 the expired injector pen and two bottles of eye drop on the East Annex Medication Cart were discarded and replacements were ordered.<br><br>Residents who have physician's orders for medication have been identified as having the potential to be affected.<br><br>On or before 1/13/26 the Director of Nursing and Unit Manager initiated education to each Licensed Nurse and Certified Medication Aid, including agency, on medication storage. Beginning 1/14/26 all Licensed Nurses and Medication aides, including agency, will complete this education prior to their next scheduled shift. After 1/14/26 no Licensed Nurse nor Medication Aid, including agency, will be permitted to work without receiving the education. The DON will provide education on Medication Storage for newly hired Licensed Nurses and Medication Aides during classroom orientation.<br><br>Once weekly for twelve weeks the Director of Nursing or Unit Manager will randomly audit a medication cart for proper storage of medications according to the facility policy. During the auditing, if it is noted that that the process was not followed, the assigned Licensed Nurse or Medication Aid will be removed from patient care, and a one-to-one educational in-service will be provided by the Director of Nursing. The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for twelve months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing including providing re-education as staffing changes or if any concerns are observed.<br><br>Date of Compliance:<br><br>1/14/26 | 01/14/2026 |

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| F0761 SS = D | Continued from page 18<br>The manufacturer's instructions for latanoprost solution (eye drop used to treat glaucoma) stated once the bottle was opened it could be used for 6 weeks.<br><br>The manufacturer's instructions for dorzol/timolol solution (eye drop used to treat glaucoma) stated once bottle was opened it should be discarded 28 days after opening.<br><br>An observation of the East Annex medication cart #1 on 12/17/25 at 2:09 pm revealed one (1) insulin lispro injector pen that was open which had an opened date of 11/3/25, one (1) bottle of latanoprost solution 0.05 percent (%) which had an opened date of 10/29/25 with an expiration date handwritten on the bottle of 12/10/25, and one (1) bottle of dorzol/timolol solution which had an opened date of 11/13/25 and an expiration date handwritten on the bottle of 12/11/25.<br><br>During an interview with Nurse #2 during the medication cart observation on 12/17/25 at 2:09 pm she stated the insulin pen should have been removed after 28 days and the eye drops should have been discarded on the expiration dates written on the bottles.<br><br>During a phone interview with the Pharmacy Consultant on 12/17/25 at 4:53 pm, he stated the insulin pen should have been discarded 28 days after opening, the latanoprost eye drops should have been discarded 6 weeks after opening and the dorzol/timolol eye drops should have been discarded 28 days after opening.<br><br>During an interview with the Director of Nursing (DON) on 12/18/25 at 11:55 am, she explained the Unit Managers and floor nurses were responsible for checking the medication carts for expired medications on a daily basis and discard any expired medications. The DON further stated her expectations of the nursing staff were to check the medication carts daily and remove any expired medications.<br><br>During an interview with the Administrator on 12/18/25 at 12:04 pm, she stated her expectations were the nursing staff would check the medication carts daily and have no expired medications in the medication carts. | F0761 | | |
| F0812 SS = D | Food Procurement,Store/Prepare/Serve-Sanitary | F0812 | Both the refrigerator and freezer in the South Hall | 01/14/2026 |

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| F0812<br>SS = D | Continued from page 19<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations and staff interviews, the facility failed to maintain 1 of 2 nourishment room refrigerators and freezer clean, and in a sanitary manner to prevent cross contamination by failing to clean up spills (South Unit refrigerator).<br><br>The findings included:<br><br>On 12/17/25 at 11:17 AM the South Unit nourishment refrigerator was observed with the South Unit Nurse. The clear refrigerator drawers were noted with small, dried food particles and there was a brown sticky substance spilled on the bottom shelf of the freezer section. The South Unit Nurse indicated during the observation she was not aware who was responsible for cleaning the refrigerator.<br><br>A second observation of the South Unit nourishment room, on 12/18/25 at 10:36 AM revealed the refrigerator and freezer were in the same condition.<br><br>In an interview on 12/18/25 at 10:25 AM Housekeeper #1 stated that she was assigned to clean the South Unit | F0812 | Continued from page 19<br>Nourishment Room were cleaned by the Nutritional Services Manager on 12/18/25.<br><br>Residents who receive nourishment from the nourishment refrigerators have been identified as having the potential to be affected.<br><br>On 1/12/26 the provided train the trainer education to the Administrator Nutritional Services Director regarding maintaining the cleanliness of nourishment room refrigerators and freezers daily to prevent cross contamination from any potential spillage. The Dietary Staff was educated by the Nutritional Services Director on or before 1/14/26 on maintaining the cleanliness of nourishment room refrigerators and freezers daily to prevent cross contamination from any potential spillage.<br><br>The Nutritional Services Manager will perform a random observation audit the Nutritional Refrigerators and freezers weekly to validate cleanliness to prevent any cross contamination. and will provide the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for a minimum of three months or until the Committee determines compliance has been sustained.<br><br>Date of Compliance: 1/14/26 | |

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| F0812 SS = D | Continued from page 20<br>refrigerator once a week and had not looked at or cleaned the freezer that week.<br><br>In an interview on 12/18/25 at 11:29 AM the Administrator stated the dietary department was responsible for cleaning the nourishment room refrigerators and she expected them to be clean. | F0812 | | |