STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD , ROXBORO, North Carolina, 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 12/14/2025 through 12/17/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event 1DE454-H1.	E0000		06/14/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/14/2025 through 12/17/2025. Event ID# 1DE454-H1. The following intakes were investigated: 857658, 2561931, 2620269, 857660, and 2562022. 12 of the 12 complaint allegations did not result in deficiency.	F0000		06/14/2026
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,	F0605	Corrective action for the residents found to be affected by the deficient practice: The corrective action was taken by the physician and nurse when identified with deficient practice with resident #36. The Medical Administration Record for all residents as of 1/9/26 was reviewed to ensure that all PRN medications for anti-psychotic medications have a stop date of 14 days. Corrective action for other residents having the potential to be affected by the same deficient practice: The interim Director of Nursing, Administrator, and consulting Pharmacist reviewed current practice for medication order reviews on 1/08/26. An analysis of current practice identified a specific area for a more focused review of PRN orders for anti-psychotic medications. All residents have the potential to be affected by the deficient practice. A unit report was produced on 1/9/26 by the consulting Pharmacist to identify all PRN orders for anti-psychotic medications. The consulting	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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F0605 SS = E	Continued from page 1 involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure	F0605	Continued from page 1 Pharmacist reviewed this report and alerted the interim Director of Nursing and Administrator of any PRN orders for antipsychotic medications missing a stop date within 14 days of the initial order. All PRN orders for anti-psychotic medications missing a stop date were updated by the Medical Director and the Electronic Administration Record was updated to include the stop date. Systemic changes are made to ensure that the deficient practice will not recur: The consulting Pharmacist and Physicians with prescribing privileges for residents were educated on the regulation for all PRN antipsychotics medications to have a stop date of 14 days from initial Physician order on 1/09/26. Education included that the PRN medications cannot be renewed unless the prescribing practitioner evaluates the resident for appropriateness of that medication. All new prescribing Physicians will be educating during orientation. Education was provided to the nurses on all PRN orders for anti-psychotic medications on having a stop date of 14 days. If Physician evaluates the resident and determines medication should be written with supporting documentation for continuance for another 14 days. Nurses not educated prior to 1/14/26 will be educated prior to beginning their next shift. A unit report will be run weekly to include all PRN orders for anti-psychotic medications. The consulting Pharmacist will review this report and will alert the new Director of Nursing or Administrator will be responsible for ensuring the PRN order is updated to include a stop date in the Electronic Medical Record. The new Director of Nursing was updated on 1/12/26 by the Administrator on this new process. Plans to monitor its performance to make sure that the solutions are sustained: This information will be reviewed with any new nursing leadership during the orientation process.	

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F0605 SS = E	Continued from page 2 that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff and physician interviews, the facility failed to limit the duration of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as-needed (PRN) basis to 14 days and/or indicate the duration and rationale for extending the PRN order beyond 14 days. This occurred for 1 of 5 residents whose medications were reviewed (Resident #36). Findings Included: Resident #36 was admitted to the facility on 5/9/25 with diagnoses that included anxiety disorder.	F0605	Continued from page 2 Weekly audits all PRN orders for anti-psychotic medications will be performed weekly x 4 weeks, then bi-weekly x 1 month, and monthly x 3 months. This audit will identify if there are any current or new residents with prescribing Providers not including a 14 day stop date for PRN orders for anti-psychotics. Audit will be performed by the Administrator or Director of Nursing. The Director of Nursing will present an analysis of the audits to the Quality Assurance and Performance Improvement committee monthly until sustained compliance is achieved. Date of compliance: 1/14/2026	

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F0605 SS = E	Continued from page 3 On 5/9/25, the physician ordered one (1) milliliter (ml) of Lorazepam Intensol Oral Concentrate (Lorazepam) 2 milligrams/milliliter (mg/ml) to be administered via Percutaneous Endoscopic Gastrostomy (PEG) tube every 2 hours as needed (PRN) for anxiety. Lorazepam is a psychotropic and controlled substance medication. The resident's most recent Minimum Data Set (MDS), dated 11/16/25, indicated that Resident #36 was severely cognitively impaired with no behaviors or rejection of care. The Medication section of the MDS revealed that Resident #36 received an antianxiety medication during the 7-day look-back period. The resident was in hospice care. Resident #36's electronic medical record (EMR) indicated that the physician's PRN Lorazepam order (dated 5/9/25) remained active through the review date of 12/17/25. A review of Resident #36's Medication Administration Records (MARs) revealed that two to three doses of PRN Lorazepam were administered weekly from 5/9/25 through 12/17/25. The last documented dose was administered on 12/16/25. During an interview on 12/15/25 at 2:00 PM, Nurse #1 stated that Resident #36 experienced agitation and anxiety during care. The resident was diagnosed with colon cancer and was under hospice care. The nurse indicated that the resident received PRN Lorazepam at least two (2) to three (3) times per week. During a telephone interview on 12/17/25 at 12:58 PM, the hospice nurse stated that Resident #36 sometimes experienced agitation and anxiety during care. The hospice nurse explained that Resident #36's medications were reviewed every two weeks by the hospice interdisciplinary team, which included the hospice physician. The facility physician reviewed residents' medications and wrote all medication orders. The facility physician could accept or decline any recommendations from hospice. The hospice physician only performed medication reconciliation, while the facility physician managed the medications. During an interview on 12/17/25 at 12:02 PM, the interim DON stated that she had been in the position for one week. She stated that psychotropic medications could be ordered PRN but should include a stop date, and the resident had to be reevaluated if the medication needed to be continued. During an interview on 12/17/25 at 10:00 AM, Physician #1 stated that he served as the Medical Director during October and November 2025. He acknowledged that	F0605		

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F0605 SS = E	Continued from page 4 psychotropic medications should be reviewed, a rationale should be provided, and an end date for PRN medications should be indicated. During a telephone interview on 12/17/25 at 10:15 AM, the current Medical Director stated that he had accepted the position a few weeks earlier. He confirmed that residents who received PRN psychotropic medications needed to be evaluated by the provider within the regulatory timeframe. He further stated that, regardless of whether a resident was on hospice or not, all psychotropic medications should be reviewed by a physician, a rationale for continuation should be provided, and the duration of PRN medications should be specified. During an interview on 12/17/25 at 2:08 PM, the Administrator stated that she was serving as the interim contract Administrator and had been hired a few weeks earlier. The Administrator acknowledged that physicians should review resident medications and that all psychotropic medications should be evaluated per CMS regulations.	F0605		
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a	F0640		01/14/2026

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F0640 SS = A	Continued from page 5 format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure a transmitted quarterly Minimum Data Set (MDS) assessment was accepted into the Internet Quality Improvement and Evaluation System (iQIES) Centers for Medicare and Medicaid Services (CMS) database for 1 of 1 resident reviewed for Resident Assessment (Resident #32). Findings included: Resident #32 was admitted on 1/15/24. Review of Resident #32's Electronic Medical Record	F0640		

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F0640 SS = A	Continued from page 6 (EMR) revealed an annual MDS assessment was completed on 7/22/25 and a quarterly MDS assessment was completed on 10/22/25. The resident's EMR also indicated that the quarterly MDS assessment dated 10/22/25 had been transmitted and accepted on 11/25/25. The iQIES database was reviewed and revealed Resident #32's last MDS assessment received was an annual dated 7/22/25 which had been transmitted and accepted on 9/2/25. No further assessments have been accepted into the database for Resident #32. During a telephone interview on 12/17/25 at 8:30 AM, the MDS Coordinator indicated she was hired at the end of October 2025 and worked as a remote MDS consultant. The MDS Coordinator stated that based on Resident #32's EMR the quarterly MDS assessment dated 10/22/25 had been transmitted by the previous MDS nurse on 11/25/25. She explained she was unable to run the iQIES Final Validation Report to check if it had been accepted into the database or not. During an interview on 12/17/25 at 9:00 AM the Administrator stated all completed MDS assessments should be transmitted on time. The Administrator stated Resident #32's quarterly MDS assessment was completed on time and per the EMR it had been transmitted on 11/25/25. She indicated she was unsure why it was not accepted after it was transmitted.	F0640		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion	F0641		01/14/2026

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F0641 SS = A	Continued from page 7 of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff and resident interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of physical restraints for 1 of 2 residents whose MDS assessments were reviewed (Residents #6). Resident #6 was admitted to the facility on 5/9/25 with diagnoses including stroke, hemiplegia (paralysis of one side of the body) and seizure disorder. The review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated 11/16/25 revealed the resident had moderately impaired cognition. She was coded for a physical restraint and indicated bed rail was used daily. On 12/14/25 at 10:45 AM, during an interview, Resident #6 indicated that she "never had any restraint" in the facility. On 12/14/25 at 1:25 PM, during an interview, Nurse #2 indicated that Resident #6 did not have bed rails. On 12/17/25 at 9:00 AM, during the phone interview, the MDS Coordinator indicated that she accidentally marked the restraint section of Resident #6's MDS assessment, dated 11/16/25. On 12/17/25 at 11:00 AM, during an interview, the Director of Nursing (DON) stated that she expected staff to complete MDS data accurately and on time. She	F0641		

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F0641 SS = A	Continued from page 8 added that the error in Resident #6's MDS assessment was made by the MDS Coordinator.	F0641		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing	F0732	Corrective action for the residents found to be affected by the deficient practice: It is the policy of the facility to update the current date, census, and staffing information on the staffing sheet daily and post in the appropriate location. Upon review the facility was properly staffed. Education was provided on 12/14/25 by the administrator to the charge nurse #1 that one of the responsibilities of the charge nurse is to ensure the staffing form is updated daily including weekends. It is also the responsibility of the charge nurse to ensure that the census staffing form is updated daily by the nurse scheduler and that they are to check for accuracy prior to the sheet being posted. Corrective action for other residents having the potential to be affected by the same deficient practice: No residents were affected by the sheet not being posted. Systematic changes made to ensure that the deficient practice will not recur: The charge nurse and medical records director were educated on 12/14/25 by the Administrator on how to properly fill out the census staffing sheet. It has been established that it is the responsibility of the newly appointed nurse scheduler for posting staffing sheets, updating the sheets, and retaining the sheets and this education was provided on 12/21/25. It has been established that the charge nurse will be responsible for updating and posting the census staffing sheets on the weekends. All of the weekend charge nurses were educated on 1/8/26 by the Administrator with this change. Any new nurses that are hired as a charge nurse will receive this education during orientation. The new Director of Nursing was educated on 1/12/26 on the posting nurse staffing changes. Plans to monitor its performance to make sure that solutions are sustained:	01/14/2026

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F0732 SS = C	Continued from page 9 data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to post an updated daily nurse staffing sheet for residents and visitors on 1 of the 4 days during the survey period (12/14/25). The facility failed to provide upon demand the posted daily nurse staffing sheets for 10 of the 45 daily nurse staffing sheets reviewed (11/8/25, 11/13/25, 11/16/25, 11/17/25, 11/18/25, 11/20/25, 12/2/25, 12/3/25, 12/12/25, and 12/13/25). In addition, of the 35 daily nurse staffing sheets reviewed the facility failed to complete 3 daily nurse staffing sheets with information related to Nursing Assistants (11/2/25, 11/9/25, and 11/29/25). Findings included: a. On 12/14/25 (Sunday), during the initial tour of the facility at 9:05 AM daily nurse staffing sheet posted near the facility elevator was dated 12/11/25 (Thursday). The daily nurse staffing sheet was not updated to reflect the current date, census, and staffing information. The daily nurse staffing sheet posted dated 12/11/25 remained during another observation at 11:00 AM on the same day. During an interview on 12/15/25 at 2:30 PM, Nurse #1 stated the Scheduler prepared the daily nurse staffing sheets and placed them in a folder on Fridays at the nurses' station for nurses to update and post on the weekends. The nurse indicated she worked on 12/13/25 (Saturday), 12/14/25 (Sunday), and the day of the interview (12/15/25), and had not noticed the daily nurse staffing sheet posted near the elevator had not been updated since 12/11/25. During an interview with the Admission Coordinator on 12/17/25 at 2:30 PM, she stated the Scheduler completed and posted the daily nurse staffing sheets. She explained when the Scheduler was unavailable, she tried to complete and post the daily nurse staffing sheets. The facility nurses usually ensured the daily nurse staffing sheet was current and updated to reflect the actual staff working in the facility. The Scheduler was unavailable for interview during the survey. During an interview on 12/17/25 at 1:57 PM, the Administrator stated that it was the Scheduler's	F0732	Continued from page 9 The Administrator or designee is responsible for monitoring and auditing the nurse staffing sheets during the business week days. The charge nurse is responsible for posting and auditing the nurse staffing sheets on the weekends and provide to the administrator. Audits of the nurse staffing sheets will be performed 3 times a week x 4 weeks, then bi-weekly x 1 month and monthly x 3 months. The administrator will present an analysis of the audits to the Quality Assurance and Performance Improvement committee monthly until sustained compliance is maintained. Date of compliance: 1/14/26	

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F0732 SS = C	Continued from page 10 responsibility to complete the daily nurse staffing sheet. On weekdays the Scheduler posted the daily nurse staffing sheet near the elevator, and nurses were responsible for posting it on weekends. The Administrator indicated the daily nurse staffing sheet was not updated because the Scheduler was unavailable. The Administrator stated that going forward, the medical records staff would be responsible for posting and updating the daily nurse staffing sheet so that it would remain accurate and clearly visible to residents and visitors. b. The daily nurse staffing sheets for the period of 11/1/25 to 12/15/25, a 45-day period, were reviewed with the Admission Coordinator on 12/16/25. The following daily nurse staffing postings were missing or unavailable for review: 11/8/25, 11/13/25, 11/16/25, 11/17/25, 11/18/25, 11/20/25, 12/2/25, 12/3/25, 12/12/25, and 12/13/25. A total of 10 daily nurse staffing postings were unavailable for review. During an interview with the Admission Coordinator on 12/16/25 at 2:30 PM, she stated the Scheduler completed the daily nurse staffing sheets and was responsible for maintaining the daily nurse staffing sheets. The Admission Coordinator indicated she was unable to locate the missing daily nurse staffing sheets. The Scheduler was unavailable for an interview during the survey. During an interview on 12/17/25 at 1:57 PM, the Administrator explained the Scheduler filled out the daily nurse staffing sheets and provided these documents to the Director of Nursing. However, due to significant management turnover, the facility was unable to locate the missing daily nurse staffing sheets. c. Daily nurse staffing sheets for the period of 11/1/25 to 12/15/25 were reviewed with the Admission Coordinator on 12/16/25. On 11/2/25, 11/9/25, and 11/29/25, the daily nurse staffing sheets were incomplete. Information regarding Nursing Assistants (NAs) was missing. On 11/2/25 and 11/9/25, the evening shift (3:00 PM to 11:00 PM) NA information and NA hours were missing. On 11/29/25, the day shift (7:00 AM to 3:00 PM) NA information and NA hours were missing. During an interview with the Admission Coordinator on 12/16/25 at 2:30 PM, she stated the Scheduler completed the daily nurse staffing sheets and was responsible for ensuring accuracy. The Admission Coordinator indicated the Scheduler had been unavailable for the past couple	F0732		

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F0732 SS = C	Continued from page 11 of days, and she had started assisting with staff scheduling and daily nurse staffing sheets. The Scheduler was unavailable for an interview during the survey. During an interview on 12/17/25 at 1:57 PM, the Administrator indicated the Scheduler was responsible to complete the daily nurse staffing sheets accurately to reflect the daily census and the actual staff working on the floor.	F0732		
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen	F0756	Corrective Action for the residents found to be affected by deficient practice: Resident #36 was affected by the deficient practice. Resident #36 was receiving an antipsychotic without a stop date. That antipsychotic was discontinued on 1/13/2026 per consultant pharmacist recommendations. An antipsychotic was restarted on 1/14/26 with a 14 day stop date by the medical director. Resident #4 was affected by the deficient practice. Resident #4 was receiving an antipsychotic without a stop date. That antipsychotic was discontinued on 1/9/26 per consultant pharmacist recommendations. An antipsychotic was restarted on 1/10/26 with a 14 day stop date by the medical director. Corrective Action for other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. The December monthly consulting pharmacist recommendations were provided to the medical director and signed then faxed to the pharmacy on 12/31/25. The orders were placed in the electronic medical records (Point Click Care) by the assigned nurse and the signed pharmacy copy placed in the hard medical record. All residents have the potential to be affected by the deficient practice. Monthly consulting pharmacist recommendations from July 2025 through November 2025 were received by the Physician from the Administrator on 1/9/26 to ensure follow up on medication regimens was completed. Medication orders were updated as needed in Point Click Care by the assigned nurse and the	01/14/2026

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F0756 SS = E	Continued from page 12 review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff, consultant pharmacist, and physician interviews, the facility failed to act on recommendations made by the consultant pharmacist and failed to document a response to the pharmacist's findings and recommendations in the resident's medical record for 2 of 5 residents whose medications were reviewed (Resident #36, and Resident #4). Findings included: 1. Resident #36 was admitted to the facility on 5/9/25 with diagnoses that included anxiety disorder. On 5/9/25, the physician ordered one (1) milliliter (ml) of Lorazepam Intensol Oral Concentrate (Lorazepam) 2 milligrams/milliliter (mg/ml) to be administered via Percutaneous Endoscopic Gastrostomy (PEG) tube every 2 hours as needed (PRN) for anxiety. Lorazepam is a psychotropic medication and a controlled substance. Resident #36's Electronic Medical Record (EMR) indicated that the physician's PRN Lorazepam order (dated 5/9/25) remained active through the review date of 12/17/25. A review of Resident #36's Medication Administration Records (MARs) revealed that two (2) to three (3) doses of PRN Lorazepam were administered weekly from 5/9/25 through 12/17/25. The last documented dose was administered on 12/16/25. A review of the consultation reports dated 7/15/25, 8/13/25, 9/11/25, 10/13/25, 11/13/25, and 12/10/25 indicated that the pharmacist recommended the physician address the PRN Lorazepam order, which lacked a stop date. The consultation reports did not show that Resident #36's physician reviewed or responded to the pharmacist's recommendations. A telephone interview with the Consultant Pharmacist on 12/17/25 at 9:30 AM revealed that he completed monthly medication regimen reviews (MMRs) for all residents. He explained that if there were regulatory concerns	F0756	Continued from page 12 signed pharmacy copy placed in the hard medical record by 1/14/25. Systemic changes made to ensure that the deficient practice will not recur: The interim Director of Nursing and Administrator and were educated by the consulting pharmacist of his current Omnicare practice for monthly drug reviews and new admissions on 1/8/26. The physicians with prescribing privileges for residents were educated on the appropriate review and follow up on medication regimens by the Administrator on 1/8/26. The new Director of Nursing was educated by the Administrator on 1/12/26 on the changes to the current process. It has been established that the consulting pharmacist will complete his monthly consultation report by the 20th of every month. This report will be sent directly to the Administrator, New Director of Nursing, and the Medical Record director. The facility will receive the pharmacy recommendations back by the 24th of the month from the Medical Director signed from review. The orders are to be placed by the assigned nurse into Point Click Care by the 25th of the month. The hard copy will be placed into the physical chart. Education was provided to the nurses on how to ensure Physician approved recommendations that impacted medication orders were updated in Point Click Care. Nurses not educated prior to 1/14/2026 will be educated prior to beginning their next shift. This education will be provided to any new nurse hires during the orientation and training process. Plans to monitor its performance to make sure that the solutions are sustained: The Director of Nursing or Administrator will complete an audit of all consulting pharmacist recommendations weekly x 4 weeks, then bi-weekly x 1 month and monthly x 3 months. This audit will review all resident drug regimen recommendations to ensure appropriate documentation and follow up are in the medical record accurately and in a timely manner. The Director of Nursing will present the analysis of	

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F0756 SS = E	Continued from page 13 related to medications, he emailed his recommendation reports to the facility's Director of Nursing (DON) and Administrator. The DON handled nursing recommendations and forwarded physician recommendations to the appropriate physician. The physician either approved or declined the recommendations, signed off on the report, and provided a rationale for any decline. The DON ensured that the physician reviewed the recommendations. The Consultant Pharmacist stated Resident #36 was on PRN psychotropic medication (Lorazepam). He explained that psychotropic PRN medications required a stop date, and the resident needed to be reviewed by the physician before the medication could be ordered again. The Physician had to provide a rationale for the extended time period and the duration of the PRN order. He indicated the reports were sent to the Administrator and DON. The Consultant Pharmacist stated that, for the past couple of months, turnover among DONs and Administrators disrupted the process. He indicated that when he did not receive a response to his recommendation reports, he notified the DON. However, before he could follow up, the DON left the facility, and he did not receive any response. During an interview on 12/17/25 at 12:02 PM, the interim DON stated that she had been in the position for one week and was unaware of the process as to how the pharmacy recommendation reports were handled. She indicated that the physician should review medication recommendations and either accept or decline them. During an interview on 12/17/25 at 10:00 AM, Physician #1 stated that he served as the Medical Director during October and November 2025. He indicated that he had not received any pharmacy recommendation reports for any residents. Physician #1 stated that if the pharmacist or floor nurses had questions regarding medication treatment, they could call him or any of the three other physicians listed in the system. Any of the physicians could approve or decline recommendations. Physician #1 confirmed that the consultation reports for Resident #36 were not reviewed or signed by a physician, and he was unsure who had reviewed the pharmacist's recommendations prior to his tenure. During a telephone interview on 12/17/25 at 10:15 AM, the current Medical Director stated that he had accepted the position a few weeks earlier and was not	F0756	Continued from page 13 the drug regimen review to the Quality Assurance and Performance Improvement Committee monthly x 3 months of sustained compliance is maintained, then quarterly thereafter. Date of Compliance: 1/14/26	

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F0756 SS = E	Continued from page 14 familiar with the detailed process or communication method for irregularities identified during medication regimen reviews. He stated that he was unaware of the issue related to the pharmacist's recommendation reports not being reviewed and signed by a physician. During an interview on 12/17/25 at 2:08 PM, the interim Administrator stated that she had been hired a few weeks earlier. She further stated that she began receiving pharmacy recommendation letters starting November 2025 and she indicated that she reviewed these reports. The Administrator acknowledged that pharmacy medication recommendation reports should be reviewed by the physician, accepted or rejected, and signed. She stated that previously these documents were provided to the DON and the previous Administrator; however, due to management turnover, there was a break in this process. 2. Resident #4 was admitted to the facility on 7/13/19. Her cumulative diagnoses included major depression and anxiety disorder. On 10/14/25, the physician ordered one (1) milligram (mg) of Lorazepam to be given as one tablet by mouth every 8 hours as needed (PRN) for anxiety and agitation. Lorazepam is a psychotropic and controlled substance medication. Resident #4's EMR indicated that the physician's PRN Lorazepam order (dated 10/14/25) remained active through the review date of 12/17/25. A review of Resident #4's Medication Administration Records (MARs) revealed that one (1) to two (2) doses of PRN Lorazepam were administered weekly from 10/14/25 through 12/17/25. The last documented dose was administered on 12/14/25. A review of the consultation report dated 11/12/25 indicated that the pharmacist recommended the physician address the PRN Lorazepam order, which lacked a stop date. The consultation report did not show that Resident #4's physician reviewed or responded to the pharmacist's recommendation. Pharmacy medication regimen review note dated 12/10/25 revealed no noted irregularities and/or recommendation.	F0756		

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F0756 SS = E	Continued from page 15 A telephone interview with the consultant pharmacist on 12/17/25 at 9:30 AM revealed that he completed monthly medication regimen reviews (MMRs) for all residents. He explained that if there were regulatory concerns related to medications, he emailed his recommendation reports to the facility's Director of Nursing (DON) and Administrator. The DON handled nursing recommendations and forwarded physician recommendations to the appropriate physician. The physician either approved or declined the recommendations, signed off on the report, and provided a rationale for any decline. The DON ensured that the physician reviewed the recommendations. The Consultant Pharmacist stated Resident #4 was on PRN psychotropic medication (Lorazepam). He explained that psychotropic PRN medications required a stop date, and the resident needed to be reviewed by the physician before the medication could be ordered again. The Physician had to provide a rationale for the extended time period and the duration of the PRN order. He indicated the November report was sent to the Administrator and DON. The Consultant Pharmacist stated that, for the past couple of months, turnover among DONs and administrators disrupted the process. He indicated that when he did not receive a response to his recommendation reports, he notified the DON. However, before he could follow up, the DON left the facility, and he did not receive any response. During an interview on 12/17/25 at 12:02 PM, the interim DON stated that she had been in the position for one week and was unaware of the process as to how the pharmacy recommendation reports were handled. She indicated that the physician should review medication recommendations and either accept or decline them. During an interview on 12/17/25 at 10:00 AM, Physician #1 stated that he served as the Medical Director during October and November 2025. He indicated that he had not received any pharmacy recommendation reports for any residents. Physician #1 stated that if the pharmacist or floor nurses had questions regarding medication treatment, they could call him or any of the three other physicians listed in the system. Any of the physicians could approve or decline recommendations. Physician #1 confirmed that the consultation reports for Resident #4 were not reviewed or signed by a physician. During a telephone interview on 12/17/25 at 10:15 AM, the current Medical Director stated that he had	F0756		

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F0756 SS = E	Continued from page 16 accepted the position a few weeks earlier and was not familiar with the detailed process or communication method for medication regimen reviews. He stated that he was unaware of the issue related to the pharmacist's recommendation reports not being reviewed and signed by a physician. During an interview on 12/17/25 at 2:08 PM, the interim Administrator stated that she had been hired a few weeks earlier. She further stated that she began receiving pharmacy recommendation letters only in November 2025. She indicated that she reviewed both November and December reports. The Administrator acknowledged that pharmacy medication recommendation reports should be reviewed by the physician, accepted or rejected, and signed. She stated that previously these documents were provided to the DON and the previous Administrator; however, due to management turnover, there was a break in this process.	F0756		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the	F0812	Corrective action for the residents found to be affected by the deficient practice: All potentially affected food items were immediately discarded upon the initial walk-through on 12/14/25. Kitchen equipment (ovens, grill, and fryer) were cleaned, sanitized with removal of food particles on 12/14/25. All leftover foods from the food service meals were properly labeled and dated on 12/14/25 to ensure safe food practices to the residents. Corrective action for other residents having the potential to be affected by the same practice: All residents have the potential to be affected by the deficient practice. All potentially affected food items were immediately discarded upon the initial walk-through on 12/14/25. All leftover foods from the food service meals were properly labeled and dated on 12/14/25. Systemic changes made to ensure that the deficient practice will not recur: On 1/8/26 the Dietary Manager began education with the dietary staff on the new cleaning schedule for equipment within the kitchen. Dietary staff that were not in-serviced prior to 1/14/26 will be educated prior	01/14/2026

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F0812 SS = E	Continued from page 17 facility failed to maintain 2 of 2 double-door ovens and 1 of 1 grill clean and free of grease. The facility also failed to label and date leftover food in 1 of 1 reach-in refrigerator and 1 of 1 walk-in refrigerator. These practices had the potential to affect food served to residents. Findings included: a. The initial kitchen tour was conducted with the Dietary Aide #1 on 12/14/25 from 9:25 AM to 9:50 AM. Observations of double-door oven #1 and double-door oven #2 on 12/14/25 at 9:35 AM revealed black burnt food stains inside the ovens. The oven floors had a black layer of crust that appeared to be burnt food. The oven doors had dark brown oil stains. b. Observation of the grill on 12/14/25 at 9:40 AM revealed the top grill plate had a thick black layer of burnt grease and food, along with some freshly cooked, yellow-colored leftover food. During an interview with the Dietary Aide#1 on 12/14/25 at 9:40 AM, he indicated the grill had been used earlier that morning and the thick burnt layer was due to cooking food that morning. He stated the Dietary Cook had cooked chicken on the grill that morning. He acknowledged that the double-door ovens needed to be cleaned. c. Observation of the reach-in refrigerator on 12/14/25 at 9:45 AM revealed a large aluminum pan with thick white creamy-textured food. The cling wrap covered only three-quarters of the pan. There was no label or date on the pan. A white plastic container with a green lid, half-filled with light yellowish food of smooth-to-chunky texture, was also observed. There was no label or date on the container. During an interview with the Dietary Aide#1 on 12/14/25 at 9:45 AM, he indicated the thick white creamy-textured food was gravy used for the morning breakfast. He was unsure why it was not completely covered. Dietary Aide #1 stated the food in the white container was applesauce but was unsure when it was placed in the reach-in refrigerator. d. Observation of the walk-in refrigerator on 12/14/25 at 9:50 AM revealed a small aluminum pan with creamy white coleslaw. There was no label or date on the pan. During an interview with the Dietary Aide #1 on 12/14/25 at 9:50 AM, he indicated the coleslaw was to be used for the afternoon lunch meal and therefore was	F0812	Continued from page 17 to their next scheduled shift and/or removed from the schedule. This education has been added to the general orientation of all newly hired dietary staff members. On 1/8/26 the Dietary Manager began education with all dietary staff members on proper dating and labeling of stored food items. This included the policy on a standardized labeling and dating procedure for all leftover and prepared foods. Staff was re-educated on food safety and labeling requirements. Dietary staff that were not in-serviced by 1/14/26 will be educated prior to their next scheduled shift and/or removed from the schedule. This education has been added to the general orientation of all new hired dietary staff members. Plans to monitor its performance to make sure that the solutions are sustained: The Dietary Manager and Executive Chef will conduct audits 2 x day x 4 weeks, then bi-weekly x 1 month, and monthly x 3 months. The Dietary Manager will present an analysis of the audit findings to the Quality Assurance and Performance Improvement committee monthly until sustained compliance is maintained. Date of compliance: 1/14/26	

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F0812 SS = E	Continued from page 18 not labeled or dated. During an interview with the Dietary Director on 12/16/25 at 1:20 PM, she indicated the Dietary Cooks should clean the double-door ovens and grill daily after cooking. She stated she was unsure why they were not cleaned. The Dietary Director acknowledged she was aware of food not being labeled in the refrigerator. She stated all Dietary staff were responsible for labeling and dating leftover food placed in the refrigerator. She indicated any leftover or opened food placed in the refrigerators should be labeled and dated. During an interview with the Administrator on 12/17/25 at 8:58 AM, she stated all leftover food should be covered and labeled, even if it was to be used in the upcoming meal. She emphasized that all kitchen equipment should be cleaned after each use and that dietary staff should maintain a cleaning schedule.	F0812		