STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345333	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbotts Creek Center	**877 Hill Everhart Road , Lexington, North Carolina, 27295**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/04/26 through 01/07/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DF915-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/04/26 through 01/07/26. Event ID# 1DF915-H1. The following intakes were investigated: 2687000, 2581593, 2566714, 855950, 855913, 855954, 855952, 855953, 855949, 855947, 855946, 855943, 855942, 855941, 855940, 855938, 855939, and 2707365. 2 of the 56 complaint allegations resulted in deficiency.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584	F584 Safe/Clean/Comfortable/Homelike Environment The Packaged Terminal Air Conditioner (PTAC) in rooms 113 and 120 were cleaned on 1/06/2026 by the Maintenance Director. All residents have the potential to be affected. All resident room Packaged Terminal Air Conditioners (PTACs) were inspected and cleaned by the Maintenance Director on 1/06/2026 and 1/07/2026. The Licensed Nursing Home Administrator provided education to the Maintenance Director on 1/07/2026 regarding the inspection of the Packaged Terminal Air Conditioners (PTAC) units to ensure units are clean on a routine basis. To monitor and maintain ongoing compliance, the Maintenance Director will inspect the Packaged Terminal Air Conditioners (PTACs) units 3 times per week for 4 weeks, 2 times per week for 4 weeks, and then 1 time per week for 4 weeks and monthly thereafter to ensure resident room Packaged Terminal Air Conditioners (PTACs) units are clean. - An Emergency Quality Assurance Performance Committee meeting was held by the Administrator on 1/20/2026 with the Quality Assurance	02/04/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345333**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/07/2026**

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F0584 SS = D	Continued from page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to clean the Packaged Terminal Air Conditioner (PTAC) vents in 2 of 6 on the upper 100 hall. This deficient practice affected 2 of 6 residents reviewed for comfortable, clean, and homelike environment (Resident #46 and Resident #54). The findings included: a. An observation was conducted of Resident #46’s room on 1/4/26 at 10:00 AM. The PTAC unit was noted to have dark brown spots that covered every vent slat of the unit. The room was occupied, and the PTAC was running at the time of the observation. b. An observation was conducted of Resident #54’s room on 1/4/26 at 12:55 PM. The PTAC unit was noted to have a dark brown substance caked in the corners of every vent slat of the unit. The room was occupied, and the PTAC was running at the time of the observation. On 1/6/26 at 3:00 PM an observation of Resident #46’s and Resident #54’s room was conducted during a round with the Maintenance Director. He explained the Maintenance Department was responsible for cleaning the vents and filters of the PTAC units every 2 months. The	F0584	Continued from page 1 Performance Committee Members, which consist of but not limited to the Administrator, Director of Nursing, Infection Preventionist, Medical Director, Nurse Manager, Social Services Director, Activities Director, and Maintenance Director, Minimum Data Assessment Nurse and at least one direct care staff. The Director of Nursing/Designee will report the results of the monitoring to the Quality Assurance Performance Committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Date of Compliance: 2/04/2026.	

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F0584 SS = D	Continued from page 2 Maintenance Director stated the last time he cleaned the PTAC units was October 2025. The Maintenance Director stated he was the only person who worked in the department and was behind in cleaning the PTAC units for December. The Housekeeping Manager was interviewed on 1/7/26 at 9:27 AM. He stated the Housekeeping Department was responsible for wiping down the top and front of the PTAC units when they clean the residents' rooms, but housekeeping does not have the required tools to clean the vents on the units. According to the Housekeeping Director, it was the responsibility of Maintenance to clean the vents of the PTAC units. On 1/7/26 at 1:44 PM the Administrator was interviewed and stated it was the responsibility of the Maintenance Director to ensure the PTAC units were kept clean. She stated maintenance should follow the every 2 month scheduled plan to clean the units.	F0584		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews with staff, the Nurse Practitioner, and the Medical Director, the facility failed to obtain a physician's order for supplemental oxygen use for 1 of 1 resident reviewed for respiratory care (Resident #23). Findings included: Resident #23 was admitted to the facility on 10/24/22 with diagnoses that included chronic obstructive pulmonary disease (COPD). A review of the quarterly Minimum Data Set (MDS) assessment dated 10/16/25 indicated the resident was cognitively intact. She was not coded as using supplemental oxygen.	F0695	F695 Respiratory/Tracheostomy Care and Suctioning Upon notification, Resident #23 was assessed by the Medical Director on 1/06/2026 noting the resident was not at risk for any adverse outcome due to oxygen use at 2L/min. Resident #23 was also assessed by the Nurse Practitioner on 1/06/2026 nothing resident's breathing is improved, lungs clear to auscultation. Per Nurse Practitioner, Resident #23's Sp02 was stable on room air and may discontinue oxygen continuously. Physician order was obtained and verified on 1/06/2026 for oxygen therapy at 2L/Min via Nasal Cannula as needed. Registered Nurse Manager reviewed Resident #23 MAR and care plan to reflect the correct oxygen orders on 1/06/2026. All residents have the potential to be affected. The Director of Nursing/Designee conducted a facility wide audit of all residents requiring oxygen therapy to ensure physician orders are verified and in place for oxygen therapy for residents requiring respiratory support on or before 1/28/2026. No other residents were found to be receiving oxygen without a current physician order. Education completed by the Director of Nursing/Designee to all licensed nurses for Residents on Oxygen Therapy via simple mask will be administered as ordered by a physician and will include correct flow rate, mode of delivery, and frequency and the expectation the expectation that supplemental oxygen must have a physician's order or on or before 1/30/2026. Agency	02/04/2026

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F0695 SS = D	Continued from page 3 The active orders reviewed for Resident #23 did not include one for supplemental oxygen use. A review of the nurse's progress notes dated 12/28/25 revealed she assessed Resident #23 to have shortness of breath and reported it to the Medical Director for the resident to be assessed. A review of the progress notes revealed a written statement by the Nurse Practitioner during her assessment dated 12/31/25 to continue oxygen for Resident #23; however, there was no order written for supplemental oxygen use. An observation of Resident #23 on 1/4/26 at 10:02 AM revealed she was receiving supplemental oxygen by nasal cannula at a rate of 2 liters per minute (L/min), as indicated on the gauge of the bedside oxygen concentrator. Subsequent observations on 1/5/26 at 11:15 AM and on 1/6/26 at 10:15 AM revealed she continued to receive supplemental oxygen at a rate of 2 L/min by nasal cannula. Resident #23 was interviewed on 1/4/26 at 10:02 AM and stated she was placed on oxygen "a few days ago when she had trouble breathing." An interview with Nurse #2 on 1/6/26 at 10:33 AM revealed that Resident #23 had an order for supplemental oxygen when she originally entered the facility "a long time ago" but was eventually weaned from it. Nurse #2 explained that Resident #23 had increased coughing and shortness of breath a week ago and was assessed by the Medical Director. She indicated she thought the Medical Director ordered supplemental oxygen for the resident at that time. However, Nurse #2 was unable to find an order for oxygen use in the medical record. On 1/6/26 at 10:53 AM, an interview was conducted with the Medical Director, who stated he assessed Resident #23 on 12/28/25 and noted she had increased wheezing and looked weaker than usual, but her oxygen saturation level was 95% on room air. He indicated he ordered nebulizer treatments and a steroid for the resident, but he did not order supplemental oxygen. The Medical Director stated he reviewed Resident #23's medical record later that evening and noted the resident was documented as receiving supplemental oxygen in the nurse's progress notes. He stated the resident should have had an order for administering supplemental oxygen before it was initiated. However, he indicated the resident was not at risk for any adverse outcome due to oxygen use at 2 L/min.	F0695	Continued from page 3 licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/Designee. To monitor and maintain ongoing compliance, the Director of Nursing/Designee will monitor all residents requiring oxygen therapy to ensure physician orders are in place. Monitoring will occur 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 4 weeks. - An Emergency Quality Assurance Performance Committee meeting was held by the Administrator on 1/20/2026 with the Quality Assurance Performance Committee Members, which consist of but not limited to the Administrator, Director of Nursing, Infection Preventionist, Medical Director, Nurse Manager, Social Services Director, Activities Director, and Maintenance Director, Minimum Data Assessment Nurse and at least one direct care staff. The Director of Nursing will report the results of the monitoring to the Quality Assurance Performance Committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Date of Compliance: 2/04/2026.	

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F0695 SS = D	Continued from page 4 The Nurse Practitioner (NP) was interviewed on 1/7/26 at 10:55 AM and stated that when she assessed Resident #23 on 12/31/25, the resident was already receiving supplemental oxygen at 2 L/min by nasal cannula. The NP indicated she wrote in her progress note to continue oxygen use since the resident was benefiting from it and a review of the resident's oxygen saturation level revealed she registered 93% on 2 L/min of supplemental oxygen. The NP explained she did not review the resident's orders and did not notice there was no order for oxygen use. According to the NP, the nurse should have obtained an order for supplemental oxygen use before applying it. On 1/7/26 at 1:47 PM, the Director of Nursing (DON) was interviewed and stated Resident #23 did have an order for oxygen use in the past, but it was discontinued. The DON indicated that if the resident needed supplemental oxygen again, staff should have obtained an order before applying it.	F0695		
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	F0732	F732 Posted Nurse Staffing Information The facility immediately reviewed and corrected the posted nurse staffing information to ensure it accurately reflected actual Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistant hours worked for the applicable reporting period as well as the accurate census. Updated staffing information was reposted in the required prominent and public location. The facility implemented a standardized daily staffing posting process requiring verification of actual worked hours and census prior to posting. The Daily Staffing Form from prior day will be reviewed daily by Director of Nursing/Unit Manager/Scheduler/Administrator, or Weekend Supervisor to ensure accurate care hours were posted for licensed and unlicensed staff to ensure regulatory compliance. The Scheduler and Weekend Supervisor were reeducated by Licensed Nursing Home Administrator on 1/26/2026 on the Center Operations Policies and Procedures for Posting Staffing and the expectation to have accurate staffing posting daily including weekends. The Administrator or Director or Nursing will be responsible for reviewing master scheduling records daily to ensure accuracy before posting. The	02/04/2026

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F0732 SS = C	Continued from page 5 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 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 record review, observations, and staff interviews, the facility failed to post accurate staffing information as compared to the daily staff scheduled for licensed and unlicensed nursing staff for 28 out of 30 days reviewed (12/6/25 to 1/2/26). The facility also failed to ensure the resident census was present on the daily nurse staffing sheets for 2 of 3 days reviewed (1/3/26 and 1/4/26). The findings included: 1) A review of the facility's daily posting for nursing staff for the past 30 days as compared to the daily staffing schedule included an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 12/6/25 indicated that one (1) Medication Aide (MA) worked 7:00 AM to 7:30 PM. The daily posted nurse staffing sheet for 12/6/25 documented that One (1) MA worked 3:00 PM to 11:30. b. The nursing schedule for 12/7/25 indicated that one (1) MA worked from 7:00 AM to 7:30 PM. The daily posted nurse staffing sheet for 12/7/25 documented that one (1) MA worked 3:00 PM to 11:30 PM.	F0732	Continued from page 5 Administrator or Director of Nursing/Designee will conduct weekly audits of posted staffing information for accuracy and completeness. Monitoring will occur 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, 1 time weekly for 4 weeks, then monthly audits for an additional two (2) months. -An Emergency Quality Assurance Performance Committee meeting was held by the Administrator on 1/20/2026 with the Quality Assurance Performance Committee Members, which consist of but not limited to the Administrator, Director of Nursing, Infection Preventionist, Medical Director, Nurse Manager, Social Services Director, Activities Director, and Maintenance Director, Minimum Data Assessment Nurse and at least one direct care staff. The Director of Nursing will report the results of the monitoring to the Quality Assurance Performance Committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Date of Compliance: 2/4/2026.	

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F0732 SS = C	Continued from page 6 c. The nursing schedule for 12/8/25 indicated that 3 Licensed Practical Nurses (LPNs) worked from 3:00 PM to 7:30 PM, 1 LPN worked from 7:00 PM to 7:30 AM and 3 Nurse Aides (NAs) worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/8/25 documented that one (1) LPN worked from 3:00 PM to 7:30 PM, no LPN worked 7:00 PM to 7:30 AM and 5 NAs worked 11:00 PM to 7:00 AM. d. The nursing schedule for 12/9/25 indicated that 4 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 12/9/25 documented that 6 NAs worked from 7:00 AM to 3:00 PM. e. The nursing schedule for 12/10/25 indicated that 3 LPNs worked from 7:00 AM to 3:00 PM, 3 LPNs worked from 3:00 PM to 7:30 PM, one (1) Registered Nurse (RN) worked 7:00 PM to 7:30 AM, one (1) LPN worked 7:00 PM to 7:30 AM, 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/10/25 documented that one (1) LPN worked 7:00 AM to 3:00 PM, no LPN worked 3:00 PM to 7:30 PM, no RN worked 7:00 PM to 7:30 AM and 2 NAs worked 11:00 PM to 7:00 AM. f. The nursing schedule for 12/11/25 indicated that 4 NAs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, one (1) RN worked 7:00 PM to 7:30 AM and one (1) LPN worked 7:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/11/25 documented that 6 NAs worked 7:00 AM to 3:00 PM, 6 NAs worked 3:00 PM to 11:00 PM, no RN worked 7:00 PM to 7:30 AM and 2 LPNs worked 7:00 PM to 7:30 AM. g. The nursing schedule for 12/12/25 indicated that 2 LPNs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, no MA worked that day, and one (1) LPN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/12/25 documented that 3 LPNs worked 7:00 AM to 3:00 PM, 6 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM and 3 LPNs worked 11:00 PM to 7:30 AM. h. The nursing schedule for 12/13/25 indicated that 2 LPNs worked 3:00 PM to 11:00 PM, no MA worked any shift, 2 LPNs worked 11:00 PM to 7:30 AM, one (1) RN worked 11:00 PM to 7:30 AM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/13/25 documented 3 LPNs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, 4 LPNs worked	F0732		

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F0732 SS = C	Continued from page 7 11:00 PM to 7:30 AM, 3 RNs worked 11:00 PM to 7:30 AM and 6 NAs worked 11:00 PM to 7:00 AM. i. The nursing schedule for 12/14/25 indicated that 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, 4 NAs worked from 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM, one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/14/25 documented 3 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, 7 NAs worked 11:00 PM to 7:00 AM, 3 LPNs worked 11:00 PM to 7:30 AM and 3 RNs worked 11:00 PM to 7:30 AM. j. The nursing schedule for 12/15/25 indicated that 2 LPNs worked 7:00 AM to 3:00 PM, 4 NAs worked the 3:00 PM to 11:00 PM shift, one (1) LPN worked 3:00 PM to 11:00 PM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/15/25 documented 4 LPNs worked 7:00 AM 3:00 PM, 8 NAs worked 3:00 PM to 11:00 PM, 2 LPNs worked 3:00 PM to 11:00 PM, and no RN worked 11:00 PM to 7:30 AM. k. The nursing schedule for 12/16/25 indicated that 5 NAs worked 3:00 PM to 11:00 PM, one (1) RN worked 7:00 PM to 11:00 PM, 4 NAs worked 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/16/25 documented 2 NAs worked 3:00 PM to 11:00 PM, no RN worked 7:00 PM to 11:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, no LPN worked 11:00 PM to 7:30 AM and no RN worked 11:00 PM to 7:30 AM. l. The nursing schedule for 12/17/25 indicated that 6 NAs worked 7:00 AM to 3:00 PM, 3 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/17/25 documented 8 NAs 7:00 AM to 3:00 PM, one (1) NA worked 3:00 PM to 11:00 PM, no MA worked 3:00 PM to 11:30 PM, and 2 NAs worked 11:00 PM to 7:00 AM. m. The nursing schedule for 12/18/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, 1 RN worked 3:00 PM to 11:30 PM, one (1) RN worked 7:00 PM to 7:30 AM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/18/25 documented 8 NAs worked from 7:00 AM to 3:00 PM, 3 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, no RN worked	F0732		

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F0732 SS = C	Continued from page 8 3:00 PM to 11:30 PM, no RN worked 7:00 PM to 7:30 AM and 2 NAs worked 11:00 PM to 7:00 AM. n. The nursing schedule for 12/19/25 indicated 5 NAs worked 7:00 AM to 3:00 PM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/19/25 documented 4 NAs worked 7:00 AM to 3:00 PM and 2 RNs worked 11:00 PM to 7:30 AM. o. The nursing schedule for 12/20/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 5 NAs worked 3:00 PM to 11:00 PM, 3 LPNs worked 3:00 PM 11:00 PM, no MA worked any shift, and 2 LPNs worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/20/25 documented 4 NAs worked 7:00 AM to 3:00 PM, 3 NAs worked 3:00 PM to 11:00 PM, 4 LPNs worked 3:00 PM 11:00 PM, one (1) MA 3:00 PM to 11:30 PM, and 3 LPNs worked 11:00 PM to 7:30 AM. p. The nursing schedule for 12/21/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, and 2 LPNs worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/21/25 documented 4 NAs worked from 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, and 3 LPNs worked from 11:00 PM to 7:30 AM. q. The nursing schedule for 12/22/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 2 LPNs worked 7:00 AM to 3:00 PM, 2 RNs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, and 3 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/22/25 documented 3 NAs worked 7:00 AM to 3:00 PM, 4 LPNs worked 7:00 AM to 3:00 PM, no RNs worked 7:00 AM to 3:00 PM, one (1) NA worked 3:00 PM to 11:00 PM, and 2 NA worked 11:00 PM to 7:00 AM. r. The nursing schedule for 12/23/25 indicated 6 NAs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, 4 NAs worked 11:00 PM to 7:00 AM, no LPNs worked 11:00 PM to 7:30 AM and 2 RNs worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/23/25 documented 5 NAs worked 7:00 AM to 3:00 PM, one (1) NA worked 3:00 PM to 11:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM and one (1) RN worked 11:00 PM to 7:30 AM.	F0732		

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F0732 SS = C	Continued from page 9 s. The nursing schedule for 12/24/25 indicated one (1) RN worked 7:00 AM to 3:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/24/25 documented no RN worked 7:00 AM to 3:00 PM and 3 NAs worked 11:00 PM to 7:00 AM. t. The nursing schedule for 12/25/25 indicated 5 NAs worked 3:00 PM to 11:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/25/25 documented 4 NAs worked 3:00 PM to 11:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. u. The nursing schedule for 12/26/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, one (1) LPN worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/26/25 documented 4 NAs worked 7:00 AM to 3:00 PM, 2 LPNs worked 7:00 AM to 3:00 PM, 2 NAs worked 3:00 PM to 11:00 PM and 3 NAs worked 11:00 PM to 7:00 AM. v. The nursing schedule for 12/27/25 indicated 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/27/25 documented 4 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM and 3 NAs worked 11:00 PM to 7:00 AM. w. The nursing schedule for 12/28/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, no MA worked any shift, and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/28/25 documented 6 NAs worked 7:00 AM to 3:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, and 3 NAs worked 11:00 PM to 7:00 AM. x. The nursing schedule for 12/29/25 indicated 6 NAs worked 7:00 AM to 3:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, and 2 RNs worked from11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/29/25 documented 5 NAs worked from 7:00 AM to 3:00 PM, 6 NAs worked 11:00 PM to 7:00 AM, and no RNs worked from 11:00 PM to 7:30 AM. y. The nursing schedule for 12/30/25 indicated 4 NAs worked 7:00 AM to 3:00 PM, 4 NAs worked 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/30/25 documented 5 NAs	F0732		

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F0732 SS = C	Continued from page 10 worked 7:00 AM to 3:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, no LPN worked 11:00 PM to 7:30 AM and no RN worked 11:00 PM to 7:30 AM. z. The nursing schedule for 12/31/25 indicated 5 NAs worked 7:00 AM to 3:00 PM and 4 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 12/31/25 documented 7 NAs worked 7:00 AM to 3:00 PM and 2 NAs worked 3:00 PM to 11:00 PM. aa. The nursing schedule for 1/1/26 indicated 3 LPNs worked the 7:00 AM to 3:00 PM shift, 5 NAs worked the 3:00 PM to 11:00 PM shift, one (1) RN worked 3:00 PM to 11:30 PM and one (1) RN worked 7:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 1/1/26 documented 4 LPNs worked the 7:00 AM to 3:00 PM shift, 4 NAs worked the 3:00 PM to 11:00 PM shift, no RN worked 3:00 PM to 11:30 PM and no RN worked 7:00 PM to 7:30 AM. bb. The nursing schedule for 1/2/26 indicated 5 NAs worked 7:00 AM to 3:00 PM, one (1) LPN worked the 7:00 AM to 3:00 PM shift, 4 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, 4 NAs worked 11:00 PM to 7:00 AM and 2 LPNs worked the 11:00 PM to 7:30 AM shift. The daily posted nurse staffing sheet for 1/2/26 documented 6 NAs worked 7:00 AM to 3:00 PM, 3 LPNs worked the 7:00 AM to 3:00 PM shift, 2 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, 2 NAs worked 11:00 PM to 7:00 AM and one (1) LPN worked the 11:00 PM to 7:30 AM shift. On 1/6/26 at 9:36 AM, an interview occurred with the Scheduling Manager. She was able to review the staffing schedule and daily postings and verified the number of staff working from 12/6/25 to 1/2/26 did not match. She explained the facility had recently gone to a new payroll/scheduling system and stated the system was pulling staff for the daily postings from a data report rather than the actual working schedule. She stated she didn't know how to edit in the system to reflect the actual number of staff that worked in a day. The Administrator was interviewed on 1/7/26 at 11:03 AM. The staffing schedule and daily postings were reviewed, which did not match for the actual staff that worked on a certain day. She confirmed that the facility recently began using a new payroll/scheduling system and there was not a way for the Scheduling Manager to edit the daily postings to reflect the	F0732		

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F0732 SS = C	Continued from page 11 correct number of staff that had worked. She had reached out to the company that manages the system several times but has been unsuccessful in getting feedback. The Administrator added that the daily staff schedule posting and the staffing schedule should match for the number of staff worked on any given shift. 2) An observation was made in the lobby of the facility on 1/4/26 at 9:45 AM. A review of the facility's daily posting for nursing staff for 1/3/26 revealed no resident census number for the 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM or 11:00 PM to 7:00 AM shifts. Additionally, the daily posting for the 7:00 AM to 3:00 PM shift on 1/4/26 demonstrated no resident census number. The Weekend Supervisor was interviewed on 1/5/26 at 1:15 PM. She reported the Staff Scheduler was responsible for completing the staff posting sheets for all days of the week. The Staff Scheduler was interviewed on 1/05/26 at 1:21 PM. She reviewed the daily nursing staff postings and noted that they did not include a resident census for the weekend dates of 1/3/26 and 1/4/26. She stated that she does not work on the weekends and completed the daily nursing staff postings on Monday when she returned to work. She stated that there was not a staff member assigned to complete the daily staff postings on the weekends. The Scheduler stated she was responsible for all the daily staffing sheets for the week, Sunday through Saturday. She stated that when she completed them on Friday, 1/2/26, her plan was to finish completing the resident census for 1/3/26 and 1/4/26 when she returned to work on Monday, 1/5/26. The Administrator was interviewed on 1/07/26 at 1:12 PM and stated she expected the resident census to be present on the daily nursing staff posting as required. The Administrator stated the weekend supervisor should have filled in the census on the posting and was not aware this was not being done.	F0732		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F0757	F757 Drug Regimen is Free from Unnecessary Drugs Upon notification, the Medical Director assessed Resident #2 on 1/6/2026 and reviewed Resident #2's the medical record to include the December 2025 Medication Administration Record, stating there were no negative	02/04/2026

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F0757 SS = D	Continued from page 12 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with the Medical Director and staff, the facility failed to hold blood pressure medication as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Residents #2 and #3). The findings included: 1) Resident #2 was admitted to the facility on 10/15/25 with diagnoses that included hypertension. An admission Minimum Data Set (MDS) assessment dated 10/22/25, indicated Resident #2 had severe cognitive impairment. Review of Resident #2's physician orders included an order dated 11/10/25 for Metoprolol (a medication for high blood pressure) 25 milligrams (mg) one tablet by mouth one time a day for hypertension. Hold for heart rate less than 60 or systolic blood pressure (the top number in the blood pressure reading) less than 100 or diastolic blood pressure (the bottom number in the blood pressure reading) less than 60.	F0757	Continued from page 12 outcomes from receiving Metoprolol outside the ordered parameter. The resident was monitored for adverse effects, with no negative outcome noted. Follow-up visits from the Nurse Practitioner on 1/14/2026, 1/19/2026, and 1/22/2026, with no issues or negative outcomes noted. Immediate education to the nurses who administered medication outside of the parameters was completed on 1/07/2026, with no further medication errors up until discharge on 1/23/2026. Upon notification, the Medical Director assessed Resident #3 on 1/6/2026 and reviewed Resident #3's medical record, to include the January 2026 MAR, and stated there were no negative outcomes from receiving Metoprolol outside the ordered parameter. A physician order was obtained to discontinue the Metoprolol on 1/6/2026 on Resident #3 due to comfort measures related to exacerbation of on-going respiratory failure and heart failure. Family elected palliative hospice approach with comfort care. Resident #3 discharge on 1/9/2026. All residents have the potential to be affected. A facility-wide audit was conducted on all residents receiving anti-hypertensive medications with hold parameters on 1/27/2026. Medication Administration Records were reviewed for the past 30 days to identify any additional occurrences. Any identified issues were addressed immediately with provider notification and corrective individual performance improvement plans completed with nurses on Medication administration procedures and hold parameters. Education completed by the Director of Nursing/Designee to all licensed nurses on the Centers' Nursing Policies for Medication Errors and the expectation of following medications with parameters per the physician orders on or before 1/30/2026. Any licensed Nurse that cannot be reached within the initial time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/Designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/Designee. To monitor and maintain ongoing compliance, the Director of Nursing/Designee will monitor anti-hypertensive medications administration in the clinical meeting. Monitoring will occur 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 4 weeks. -An AD HOC Quality Assurance Performance Committee meeting was held by the Administrator on 1/20/2026 with the Quality Assurance Performance Committee Members, which consist of but not	

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F0757 SS = D	Continued from page 13 The December 2025 Medication Administration Record (MAR) was reviewed and revealed Resident #2 had received Metoprolol despite the heart rate below 60 on the following dates:12/13/25 heart rate was 52 administered by Nurse #3.12/14/25 heart rate was 52 administered by Nurse #3.12/16/25 heart rate was 53 administered by Nurse #4.12/18/25 heart rate was 55 administered by Nurse #5.12/20/25 heart rate was 59 administered by Nurse #4. On 1/6/26 at 8:47 AM, an interview occurred with the Medical Director. He reviewed Resident #2's medical record to include the December 2025 MAR and stated there were no negative outcomes from receiving Metoprolol outside the ordered parameter, however he would expect the nursing staff to follow the orders for the Metoprolol parameter as written. Nurse #5 was interviewed on 1/6/26 at 1:00 PM. Resident #2's December 2025 MAR was reviewed with her, and she verified that Metoprolol was administered on 12/18/25 despite the heart rate being below 60 when it should have been held and stated it was an oversight. Nurse #4 was interviewed via the phone on 1/6/26 at 1:56 PM. Resident #2's December 2025 MAR was reviewed with her and she verified that she had administered medications to Resident #2 on 12/16/25 and 12/20/25. She was unable to state why the Metoprolol was administered outside the parameter on 12/16/25 and 12/20/25, other than to say it was an oversight and the medication should have been held. Attempts to contact Nurse #3 were made without success. An interview was conducted with the Director of Nursing on 1/7/26 at 10:55 AM and stated she expected the nursing staff to follow physician orders including blood pressure medications with parameters to hold the medication. 2) Resident #3 was admitted to the facility on 11/18/25 with diagnoses that included hypertension. A quarterly Minimum Data Set (MDS) assessment dated 12/24/25, indicated Resident #3 was cognitively intact.	F0757	Continued from page 13 limited to the Administrator, Director of Nursing, Infection Preventionist, Medical Director, Nurse Manager, Social Services Director, Activities Director, and Maintenance Director, Minimum Data Assessment Nurse and at least one direct care staff. The Director of Nursing will report the results of the monitoring to the Quality Assurance Performance Committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Date of Compliance: 2/4/2026.	

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F0757 SS = D	Continued from page 14 Review of Resident #3’s physician orders included an order dated 12/18/25 for Metoprolol (a medication for high blood pressure) 50 milligrams (mg) one tablet by mouth three times a day for hypertension. Hold for heart rate less than 60 or systolic blood pressure (the top number in the blood pressure reading) less than 100 or diastolic blood pressure (the bottom number in the blood pressure reading) less than 60. The January 2026 Medication Administration Record (MAR) was reviewed and revealed Resident #3 had received Metoprolol despite the systolic blood pressure below 100 on 1/2/26 at the 1:00 PM dose, the systolic blood pressure was 97 and was administered by Nurse #6.1/2/26 at the 9:00 PM dose, the systolic blood pressure was 97 and was administered by Nurse #7. On 1/6/26 at 8:47 AM, an interview occurred with the Medical Director. He reviewed Resident #3’s medical record, to include the January 2026 MAR, and stated there were no negative outcomes from receiving Metoprolol outside the ordered parameter, however he would expect the nursing staff to follow the orders for the Metoprolol parameter as written. Nurse #6 was interviewed on 1/6/26 at 12:08 PM. Resident #3’s January 2026 MAR was reviewed with him, and he verified that Metoprolol was administered on 1/2/26 at 1:00 PM, despite the systolic blood pressure being below 100 when it should have been held and stated it was an oversight. Attempts to contact Nurse #7 were made without success. An interview was conducted with the Director of Nursing on 1/7/26 at 10:55 AM and stated she expected the nursing staff to follow physician orders including blood pressure medications with parameters to hold the medication.	F0757		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F0761	F761 Label/Store Drugs and Biologicals No specific residents were identified with the deficient practice. Upon notification, the Maintenance Director changed the lock to the permanently affixed box in the medication refrigerator within the medication storage room (103 Medication Room) and a new	02/04/2026

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F0761 SS = D	Continued from page 15 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to store and secure a controlled medication that required refrigeration within a separately locked, permanently affixed box within the medication room refrigerator. This deficient practice was for 1 of 2 medication storage rooms reviewed (103 Medication Storage Room). The findings included: An observation and interview were conducted on 01/04/26 at 10:35 AM of the 103 medication storage room refrigerator with Nurse #1. The observation revealed a 30 ml (milliliter) bottle of liquid lorazepam (a benzodiazepine) 2 mg (milligram) /ml located in the refrigerator door. Nurse #1 stated staff did not have a key to the lock box inside of the refrigerator and there was not a lock for the refrigerator door. Nurse #1 explained she was unsure why there was no key for the lock box within the refrigerator and it had been that way for “a long time”. Nurse #1 confirmed the lorazepam should have been secured within the medication storage refrigerator inside the affixed lock box. An interview was conducted on 01/06/26 at 11:27 AM with the Director of Nursing (DON). She stated she was unaware nurses did not have a key to the internal lock	F0761	Continued from page 15 key was issued to the nurses and Director of Nursing for back-up on 1/04/2026. The controlled medication requiring refrigeration was locked in the permanently affixed box within the refrigerator with the medication room 103. The controlled medication was discharged with the resident going home with hospice on 1/05/2026. All residents have the potential to be affected. The Maintenance Director and Director of Nursing completed an audit on the other Medication Room refrigerator for the permanently affixed box within the refrigerator to ensure there was a lock box and key on 1/04/2026. No other issues were identified. Education completed by the Director of Nursing/Designee to all licensed nurses on the medication storage policy and the expectation that controlled medications requiring refrigeration are stored within a separately locked, permanently affixed box within the refrigerator on or before 1/30/2026. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/Designee. To monitor and maintain ongoing compliance, the Director of Nursing/Designee will monitor the medication refrigerator's permanently affixed box located in the medication rooms to ensure all controlled medications requiring refrigeration are stored within a separately locked, permanently affixed box within the refrigerator. Monitoring will occur 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 4 weeks. -An Emergency Quality Assurance Performance Committee meeting was held by the Administrator on 1/20/2026 with the Quality Assurance Performance Committee Members, which consist of but not limited to the Administrator, Director of Nursing, Infection Preventionist, Medical Director, Nurse Manager, Social Services Director, Activities Director, and Maintenance Director, Minimum Data Assessment Nurse and at least one direct care staff. The Director of Nursing will report the results of the monitoring to the Quality Assurance Performance Committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Date of Compliance: 2/04/2026.	

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

FORM APPROVED
OMB NO. 0938-0391

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F0761 SS = D	Continued from page 16 box in the medication refrigerator. She explained the controlled medications, including lorazepam, were to be stored in the secured lock box affixed within the refrigerator. An interview was conducted on 01/06/26 at 3:57 PM with the Administrator. She indicated she was unaware staff could not access the internal lock box in the medication refrigerator. She expected controlled medications that required refrigeration to be stored in the secured lock box affixed to the inside of the refrigerator.	F0761		