STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345363	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Compass Healthcare and Rehab Hawfields, Inc.	**2502 S NC 119 , Mebane, North Carolina, 27302**

(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 1/20/26 through 12/23/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E1319-H1.	E0000		02/05/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/20/26 through 1/23/26. Event ID #IE1319–H1. The following intakes were investigated: 876372, 876373, 876374, 876376, 263492 and 2672998. 2 of the 13 complaint allegations resulted in deficiency.	F0000		02/05/2026
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident, staff, pharmacy and physician, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 1 of 1 resident reviewed for misappropriation of residents' property (Resident #2). The findings included: The facility's Abuse and Neglect Prohibition policy last revised 6/12/25 indicated that each resident had the right to be free from abuse which included misappropriation of property which was defined as	F0602	F602 Free From Misappropriation/Exploitation This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. The resident whose medication was diverted received her medication as ordered as staff were able to pull the medication from the automated dispensing machine. The employment of the nurse in question has been terminated; her license reported to the NCBON and reported to local law enforcement.	02/13/2026

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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F0602 SS = D	Continued from page 1 deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Resident #2 was admitted to the facility on 7/26/19. Review of her recent quarterly Minimum Data Set (MDS) assessment, dated 9/31/25, revealed the resident was cognitively intact. Record review of the physician's order for Resident #2, dated 1/20/25, revealed Oxycodone (narcotic medication) 5 mg (milligrams), to give 1 tablet by mouth, 4 times a day as needed for chronic pain syndrome. Record review of the physician's order for Resident #2, dated 6/6/25, revealed Oxycodone 5 mg, to give 1 tablet by mouth at bedtime for chronic pain syndrome. Review of the Medication Administration Record (MAR) for Resident #2 for October 2025, revealed that scheduled and as needed Oxycodone 5 mg tablets were administered as ordered, including 10/6/25 and 10/7/25. On 1/23/26 at 12:10 PM, during the phone interview, Nurse #2 indicated that she worked from 11:00 PM on 10/6/25 to 7:00 AM on 10/7/25. She counted the narcotics on the medication cart with Nurse #1 at the beginning of her shift on 10/6/26 and the count was correct. Nurse #2 stated she could not recall what the count was but there was no discrepancy. Nurse #2 explained during the shift, Resident #2 did not require as needed narcotic medications. On 10/7/25 at 7:00 AM, during the shift change report with Medication Aide #1, the narcotic count was correct. Nurse #2 confirmed that during her shift, she did not remove the narcotic medication card or narcotic count sheet for Resident #2. Nurse #2 indicated the staff and Staff Development Coordinator (SDC) started the investigation. On 1/22/26 at 9:30 AM, during an interview, Medication Aide #1 indicated that on 10/7/25 she worked 7:00 AM to 3:00 PM shift on medication cart utilized for the A-hall. At 7:00 AM she completed the shift change report, including narcotic count for the medication cart with Nurse #2. Medication Aide #1 stated that when they completed the narcotic count, the number of narcotic medication cards in the locked drawer of the medication cart matched the number of the narcotics noted on the controlled drug count record (used to monitor narcotics that were added and removed from the medication cart). At 7:15 AM, during the medication administration on A-Hall, Medication Aide #1 could not locate the narcotic medication card or controlled drug	F0602	Continued from page 1 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with current orders for narcotic medications have been identified as having the potential to be affected by the deficient practice. DON and SDC performed a facility-wide audit of residents with narcotic medication orders. No other misappropriation was identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed nurses and medication aides will be re-educated by 2/13/2026 by DON and SDC on the residents' right to be free from abuse and misappropriation of property, to include medication diversion. Staff were made to understand that misappropriation and diversion is theft and will lead to potential loss of licensure and criminal charges. Any licensed nurses or medication aides not reeducated by 2/13/2026 will be removed from the schedule until the education has been completed. The in-service on medication diversion/misappropriation above will be provided to licensed nurses and medication aides on a quarterly basis without an end date. Unit managers have been in-serviced by DON on 2/5/2026 on the requirement to review the narcotic sheets daily, and report any discrepancy, improper documentation or missing signatures to the DON immediately. Unit managers have been instructed by DON on 2/5/2026 to report all narcotic medication changes in the daily clinical meeting and verify that provider orders support any changes made. This keeps the clinical leadership informed and up to date on all narcotic medication changes. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F0602 SS = D	Continued from page 2 count record for Resident #2 in the medication cart. She reported it to SDC, who was at the facility at the time. The SDC began looking through the medication cart with Medication Aide #1 to determine if any narcotics were missing. It was found that Resident #2 had narcotic medication card and narcotic count sheet for this medication missing from the medication cart. Record review of the Initial Allegation Report, completed by the Administrator, revealed the facility became aware of misappropriation of Resident 2's property on 10/7/25 when the Staff Development Coordinator (SDC) and Director of Nursing (DON) notified the Administrator that Resident #2 had missing narcotics and the medications were unable to be located in the facility. All medication carts were audited to locate the missing card of oxycodone. All residents were assessed for pain and alert, and oriented residents were interviewed for concerns with pain medication administration. Record review of the Investigation Report, completed by the Administrator on 10/16/25, revealed that the allegation of misappropriation of resident property for Resident #2 was substantiated by the facility. The facility's investigation indicated that Resident #2 had one medication card, which contained 53 tablets of Oxycodone 5 mg, that was unable to be located in the facility. Nurse #1, named in the investigation report, was terminated on 10/10/25. The attempts to conduct a telephone interview with Nurse #1 on 1/21/26 at 1:45 PM and 1/22/26 at 9:30 AM were not successful. Nurse #1 was not available for interview. On 1/22/26 at 9:15 AM, during an interview, Resident #2 indicated that she received pain medications every day and had no concerns related to pain management. On 1/22/26 at 10:35 AM, during a phone interview, the Pharmacy Manager indicated that when narcotics were sent from the pharmacy to the facility, each narcotic medication pack was sent with an individual count down sheet. He confirmed that on 10/7/25, the facility notified the pharmacy about alleged drug diversion with Oxycodone 5 mg tablets. The facility submitted new prescription for Oxycodone 5 mg tablets. The Pharmacy Manager stated that according to the facility, the affected resident continued to receive her narcotics per order with no pain management interruption.	F0602	Continued from page 2 a.) DON/Designee to audit 20% of narcotic sheets each month. This audit will be conducted indefinitely as a best practice to ensure ongoing compliance and oversight of narcotic medication administration and records. b.) DON/Designee to audit, through direct observation, a minimum of 10 narcotic medication administrations weekly for 4 weeks then monthly for 3 months ensure all narcotic handling is done appropriately and all procedures are followed. The QAPI committee will determine the need for ongoing auditing once a pattern of compliance has been established. Compliance Date: 2/13/2026	

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F0602 SS = D	Continued from page 3 On 1/23/26 at 12:30 PM, during an interview, the Director of Nursing (DON) indicated that a complete investigation was initiated when it was discovered that Resident 2's Oxycodone medication and substance control sheet were missing from the medication cart. She stated that on 10/7/25, Medication Aide #1 and SDC reported that Resident 2's narcotic and control sheets were missing. The investigation included reviewing the staff schedule of all person's working the A-hall medication cart from 10/6/25 to 10/7/25. The SDC reported that narcotic card for Resident #2 with 60 tablets of Oxycodone 5 mg was delivered to the facility on 1/3/26, which was verified with pharmacy. The DON, SDC and Unit Coordinator audited all the pertinent pharmacy packing slips, MARs, prescription order tracking records, controlled medication return sheets and comparing controlled medication in all the medication carts. It was found that a total of 53 tablets of Oxycodone 5 mg for Resident #2 were missing and Resident #2 was the only resident affected by this incident. All the staff members, who worked on A-hall medication cart on 10/6/25 to 10/7/25 indicated they did not remove the narcotic medication card or narcotic count sheet for Resident #2 from the medication cart. The facility could not contact Nurse #1 and she did not come to work her next shift on 10/8/25. The Administrator reported the incident to the Department of Health and Human Services (DHHS), Law Enforcement agency, North Carolina Board of Nursing, and Medical Director. The missing Oxycodone was reordered and paid for by the facility. All residents were assessed, and alert and oriented residents were interviewed for possible harm. In-service related to narcotic accountability and process was conducted to all the current employees and agency staff. The DON, SDC and Unit Coordinator completed the audit of all medication carts and the documentation for residents, who received controlled substance once weekly for 4 weeks and then monthly for 2 months. The audit report was presented to Quality Assurance Performance Improvement (QAPI) meeting for 3 months. After the incident, she did not recall having any additional incident related to controlled medication discrepancies or drug diversion. In result of investigation, Nurse #1 was terminated. On 1/22/26 at 1:00 PM, during the phone interview, the Medical Director indicated the facility notified her immediately about alleged drug diversion incident on 10/7/25. She confirmed the affected resident (Resident #2) was assessed immediately without any adverse consequences noted. The missing pain medication was obtained from the Pyxis backup system without delays. The Medical Director expected the nurses to use the	F0602		

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F0602 SS = D	Continued from page 4 Pyxis backup medication until the missing medications were replaced. The Medical Director continued that the new prescription for Oxycodone 5 mg tablets was submitted to the pharmacy on 10/7/25. The facility provided a plan of correction that was not acceptable to the State Agency as the facility did not present interventions to prevent misappropriation of resident's property (narcotic medications for Resident #2).	F0602		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on records review, and staff interviews, the facility failed to implement the abuse policy and procedure in the area of reporting when the facility failed to report an abuse allegation to the State Agency within the specified timeframes, and failed to notify the Adult Protection Services (APS) for 1 of 1	F0609	F609 Reporting of Alleged Violations This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Adress how corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. The resident whose medication was diverted received her medication as ordered as staff were able to pull the medication from the automated dispensing machine. The employment of the nurse in question has been terminated; her license reported to the NCBON and reported to local law enforcement. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have been identified as having the potential to be affected by the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	02/06/2026

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F0609 SS = D	Continued from page 5 resident reviewed for misappropriation of residents' property (Resident #2). The findings included: The facility's Abuse and Neglect Prohibition policy last revised 6/12/25 indicated that each resident had the right to be free from abuse which included misappropriation of property which was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The allegations are reported immediately, but no later than 2 hours if the events that cause the allegation involve abuse or result in serious injury, or no later than 24 hours if the events that cause the allegations do not involve abuse or result in serious injury to the Administrator, and other officials (including to the State Survey Agency and Adult Protection Services were state law provides for jurisdictions in long-term care facilities). This included an allegation regarding any individual against whom an allegation was made. The Administrator or designee will ensure that a completed Initial Allegation Report is submitted to DHSR in the required timeframe. The Administrator or designee will ensure that a report of the investigation is submitted within 5 working days of the allegation using the DHSR Investigation Report. Record review of the Initial Allegation Report, completed by the Administrator, revealed the facility became aware of misappropriation of resident property on 10/7/25 when the Staff Development Coordinator (SDC) and Director of Nursing (DON) notified the Administrator that Resident #2 had missing narcotics and the medications were unable to be located in the facility. The Administrator submitted an Initial Allegation Report to the Division of Health Service Regulation for misappropriation of resident property for Resident #2 on 10/10/25. The police department was notified of suspicion of crime on 10/10/25 at 5:00 PM. The report did not indicate Adult Protective Services was notified. Record review of the Investigation Report, completed by the Administrator on 10/16/25, revealed that the allegation of misappropriation of resident property for Resident #2 was substantiated by the facility. The facility's investigation indicated that Resident #2 had one medication card, which contained 53 tablets of Oxycodone 5 mg, that was unable to be located in the facility. Nurse #1, named in the investigation report, was terminated. The Nursing Board and Law Enforcement were notified of the missing narcotics.	F0609	Continued from page 5 Administrator and DON have been re-educated by a Member of the Governing Body on 2/5/2026 on the Abuse Prohibition Policy, to include the timely reporting of any alleged violation of resident rights to be free from all forms of abuse including exploitation and medication diversion. Initial report of suspected misappropriation/diversion to be submitted prior to initiating the investigation. A checklist has been created for reporting abuse allegations. The checklist includes information about the reporting timelines and includes a checkbox for reporting all alleged abuse to Adult Protective Services. Administrator and DON have been instructed to use the abuse reporting checklist for all abuse allegations and suspected abuse situations. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted monthly x 6 months. Audits will include a review of 100% of the facility reported events, including misappropriation and abuse to ensure timely reporting and that all required agencies have been notified. Audits to be completed by the facility Social Worker/designee. Results to be reported to monthly QAPI committee meeting until a pattern of compliance is established. Compliance Date: 2/6/2026	

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F0609 SS = D	Continued from page 6 On 1/23/26 at 1:10 PM, during an interview, the Administrator indicated that on 10/7/25, he was notified of the narcotic discrepancy with one of the medication carts at the facility, but it was not confirmed until 10/10/25. He continued the DON, SDC and nursing staff initiated the investigation to locate the missing medications and after pharmacy confirmation and full search of the facility, the missing narcotics were confirmed. The Administrator stated that the facility replaced the missing narcotics for the resident immediately to prevent medication treatment interruption. He did not report the allegation to the State until 10/10/25, because the facility was not sure if the narcotics were missing. The Administrator continued that the facility did not report the allegation to the Adult Protective Service (APS) because the resident was not affected by the situation. The facility reported the drug diversion to the Law Enforcement, North Carolina Board of Nursing, substantiated the allegation and terminated the accused employee Nurse #1. The facility was unable to speak with Nurse #1 about the missing narcotics. The Administrator confirmed that the facility was unable to locate Resident 2's missing narcotics, that the narcotics were removed from the facility, and that Nurse #1 was the named nurse in the allegation.	F0609		