STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345350	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland Terrace	**2300 Aberdeen Boulevard , Gastonia, North Carolina, 28054**

(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 survey and complaint investigation was conducted on 02/10/2026 through 02/13/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#1E2FCC-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 02/10/2026 through 02/13/2026. Event ID# 1E2FCC-H1. The following intakes were investigated: 816903, 816904, and 816906. 5 of the 5 complaint allegations did not result in deficiency. This survey was originally scheduled to begin on 01/26/26 but due to Winter Storm Fern and snow/ice travel was unsafe. The survey was rescheduled to start on 02/02/26 but due to QSO 26-04-ALL Federal Government shutdown and Winter Storm Gianna which again made travel unsafe this survey was again rescheduled.	F0000		
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.	F0640		03/12/2026

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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F0640 SS = A	Continued from page 1 (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 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 review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for discharge (Resident #2). The findings included:	F0640		

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F0640 SS = A	Continued from page 2 Resident #2 was admitted to the facility on 10/6/25. A review of a nursing progress note dated 11/24/25 indicated Resident #2 was discharged home. A review of Resident #2's Electronic Medical Record (EMR) revealed no discharge MDS had been completed. An interview with the MDS Coordinator on 2/13/26 at 11:06 AM was conducted. She stated all discharges were listed on the daily census sheet and the MDS office would receive a list regarding the discharges of the day. The MDS Coordinator stated Resident #2's discharge would have also been discussed in the team meeting. She revealed that not completing the discharge MDS for Resident #2 was an oversight and it was missed. A combined interview with the Director of Nursing (DON) and Administrator occurred on 1/20/26 at 11:00 AM. The DON revealed the facility had a detailed team meeting that occurred each Wednesday. The Administrator stated the facility always had a lot of communication regarding resident discharges. The Administrator stated Resident #2's discharge was planned and the discharge MDS was missed by the MDS team.	F0640		
F0641 SS = D	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 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	F0641	Resident #56 admitted to Hospice 10/8/2024. Quarterly assessment with ARD of 1/1/2026 was corrected on 2/13/2026. On 2/12/2026, the Director of Nursing or designee conducted a 100% audit to ensure there are no current hospice residents without Hospice significant change assessment and all subsequent assessments have correct coding of Hospice on Section O of MDS. Minimum Data Set (MDS) coordinators to be educated by the Director of Nursing regarding timely according to RAI manual guidelines for all accurate coding of Hospice admissions. Education was completed on 2/16/2026. Any new MDS coordinator will receive education during the orientation process by the Director of Nursing or designee. The Director of Nursing or designee will audit hospice Residents for accurately coding of hospice patients weekly for x4 weeks then biweekly x2,	03/03/2026

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F0641 SS = D	Continued from page 3 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 record reviews, Responsible Party (RP) interview, and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of Hospice Care for 1 of 7 residents reviewed for MDS accuracy (Resident #56). The findings included: Resident #56 was admitted to the facility on 02/09/2024 with diagnoses which included chronic ischemic heart disease and chronic obstructive pulmonary disease (COPD). Review of Resident #56's electronic medical record (EMR) revealed a Hospice Admission Agreement was signed by Resident #56's RP on 09/08/2025. Resident #56 transitioned to hospice services on 09/08/2025. Review of Resident #56's electronic medical record (EMR) revealed Resident #56's care plan was revised on 09/08/2025 and included the following area of focus, in part: Resident requires Hospice Care and will be kept comfortable through next review. Review of Resident #56's quarterly Minimum Data Set (MDS) assessment dated 01/01/2026 did not indicate Resident #56 was receiving Hospice care. An interview with Resident #56's RP on 02/10/2026 at 11:32 AM revealed Resident #56 had been receiving Hospice care since last fall. The RP stated the Hospice nurse telephoned her weekly and provided her with updates on Resident #56's condition. An interview was conducted with the MDS Coordinator on 02/12/2026 at 2:32 PM. The MDS Coordinator reviewed Resident #56's quarterly MDS assessment dated 01/01/2026 and verified that Hospice services had not	F0641	Continued from page 3 then monthly x1 Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary Completion Date: 3/3/2026	

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F0641 SS = D	Continued from page 4 been captured on the assessment. The MDS Coordinator stated the MDS was coded incorrectly and should have indicated Resident #56 had received Hospice services. An interview was conducted with the Administrator on 02/12/2026 at 2:40 PM. The Administrator stated that her expectation was for all MDS assessments to be completed accurately based on the resident's clinical condition.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interviews, and psychiatrist interview the facility failed to refer one resident with a new mental health diagnosis for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 1 resident for PASRR (Resident #10). The findings included: Review of Resident #10's medical record revealed Resident #10 was admitted to the facility on 10/24/2024. A PASRR level I was completed prior to Resident #10's admission with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition.	F0644	Resident #10 had a level II PASARR screening submitted on 2/11/2026 through the NC MUST System by the Social Worker. An audit of current residents diagnosis was done by assistant administrator on 2/11/2026 by running a diagnosis report out of electronic medical record. All mental health diagnosis that require a level II PASARR were screened appropriately through the NCMUST screening process. During the morning clinical meeting team, social worker will review new admissions for any mental dx and any new dx added. The facility administrator provided education to social work department members on 2/11/2026 regarding ensuring that residents with men tal health diagnosis require a level II PASARR screening. Any member of the social work team not receiving education will be educated prior to the start of their shift by the facility administrator or designee. New social wok members will receive PASARR training during the orientation process from the facility administrator. The director of social work will conduct audits to ensure all residents with mental health diagnosis have Level II PASARR screens 5x/week x 2weeks, then 3x/week x 2weeks, then weekly x4 weeks, and then monthly x 1 month 5. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary	03/03/2026

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F0644 SS = D	Continued from page 5 Review of the electronic medical record (EMR) revealed Resident #10 was diagnosed with post-traumatic stress disorder (PTSD) on 09/30/2025. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. An interview with Resident #10's psychiatrist was conducted on 02/12/2016 at 2:00 PM. The psychiatrist stated when Resident #10 was admitted to the facility, she had no known history of PTSD. The psychiatrist explained Resident #10 started having panic attacks "out of the blue" and during a conversation with Resident #10's family member, the family member asked if Resident #10's past experience of sexual trauma could have anything to do with her panic attacks. The psychiatrist also stated that she added the PTSD diagnosis to Resident #10's EMR on 09/30/2025, removed all male caregivers from her assignment, and made some medication adjustments to Resident #10's medication profile. The psychiatrist further stated that Resident #10's panic attacks had markedly decreased in frequency and severity. An interview on 02/12/26 at 1:00 PM with the Social Worker revealed she was responsible for completing PASRR paperwork for residents. The SW revealed she was aware of Resident #10's diagnosis of PTSD but she failed to submit a request for an evaluation for a Level II PASRR. The SW further explained that she was not sure how she missed requesting the evaluation for a Level II PASRR. The SW also stated that she was aware PASRR level II requests should be completed for residents when they received a new mental health diagnosis including PTSD. The SW stated that based on Resident #10's new mental health diagnosis, a request for PASRR level II should have been completed. The SW stated that she received the information regarding Resident #10's PTSD diagnosis during the morning clinical meetings. During an interview on 02/12/26 at 1:11 PM with the Administrator, she communicated her understanding that PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis.	F0644	Continued from page 5 Completion Date: 3/3/2026	
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F0761	Resident #90's personal medication was removed from the room on 2/11/2026 by Nurse #1. Facility rooms were checked for medications left at bedside. This was completed by Director of Nursing on 2/11/2026. No further meds discovered at bedside.	03/03/2026

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F0761 SS = D	Continued from page 6 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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 record review, observations, and resident and staff interviews, the facility failed to secure medications left unattended in a resident's room for 1 of 1 resident reviewed medication storage (Resident #90). Findings included: Resident #90 was admitted to the facility on 2/3/26 with diagnoses including atrial fibrillation and hypertension. Review of Resident #90's active physician orders included apixaban (anticoagulant) 5 milligrams (mg) twice a day started on 2/3/26, metoprolol (antihypertensive) extended release 25 mg with directions to hold for systolic blood pressure (SBP) less than 100 or diastolic blood pressure (DBP) less than 50 or a heart rate less than 50 started on 2/3/26, and diltiazem hydrochloride (antiarrhythmic) extended release 300 mg with directions to hold for SBP less than 120 or DBP less than 60 started on 2/3/26. There was no active physician's order for dextromethorphan/guaifenesin (analgesic/decongestant) 600 mg.	F0761	Continued from page 6 Current facility staff received education by the Director of Nursing or designee to ensure that medications are not left at bedside. This education was provided on 3/3/2026. Staff not receiving education will receive education prior to the start of their next shift by the Director of Nursing or designee. New staff will receive education during the orientation process by the Director of Nursing or designee. Facility leadership will complete rounds to check current patient rooms for medications left at bedside 5 x week x 4 weeks, then 3x weeks x 4 weeks, then weekly x 1 month. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Completion Date: 3/3/2026	

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F0761 SS = D	Continued from page 7 During an observation on 2/11/26 at 8:29 AM, a clear resealable plastic storage bag was left unattended in Resident #90's room and contained 3 brown colored medication bottles and a single foil package of medication. The bag was left on the counter by the sink in clear view. The labels on the medication bottles indicated it contained apixaban 5 mg, metoprolol extended release 25 mg, and diltiazem hydrochloride extended release 300 mg. The single foil package contained dextromethorphan/guaifenesin (analgesic/decongestant) 600 mg. During an interview on 02/11/26 at 8:29 AM, Resident #90 stated a family member brought the medications in the bag to the facility. Resident #90 revealed the family member brought the medications to help the nurses identify what she had taken prior to being admitted. Resident #90 stated she took the medications the nurses gave her and she did not want to self-administer medications. On 02/11/26 at 8:38 AM, Nurse #1 was made aware that a resealable plastic storage bag containing medications was not securely stored in Resident #90's room. An interview was conducted on 02/11/26 at 9:12 AM with Nurse #1. Nurse #1 confirmed she was assigned to administer Resident #90's medications on 2/11/26 and had been in the room earlier but did not notice the resealable plastic storage bag of medications. Nurse #1 stated medications should be stored in the medication cart for safety. Nurse #1 confirmed she had removed the bag of medications from Resident #90's room after she was made aware by the surveyor. An interview was conducted on 02/11/26 at 8:38 AM with the Director of Nursing (DON). The DON revealed medications should not be left unattended in a resident's room and should be stored in the medication cart. The DON revealed she would review Resident #90's physician orders to ensure the medications in the resealable plastic storage bag had an order. During an interview on 02/13/26 at 11:56 AM, the Administrator stated medications should not be left in a resident's room and she expected unsecured medications were removed by staff when identified. The Administrator stated the medications were removed from Resident #90's room when the nurse was made aware. It was explained to the Administrator during the interview that the nurse was made aware of the medications left in Resident #90's room by the surveyor.	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	Case of raw chicken was discarded on 2/13/2026 by the	03/03/2026

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F0812 SS = E	Continued from page 8 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 facility failed to ensure thawed, raw chicken available for use was labeled with a use by date in 1 of 4 walk-in refrigerators. This practice had the potential to affect food served to residents. Findings included: An observation of the walk-in refrigerator in the main kitchen was conducted on 2/10/26 at 10:18 AM with the Kitchen Operations Manager. At the front of the walk-in refrigerator on the bottom shelf was an opened 20-pound case with one package of raw chicken and one 20-pound case of raw chicken with a sticker that read “use first.” There was no use by date to specify when the chicken should not be used. The delivery dates on the cases was 2/3/26. During an interview on 2/10/26 at 10:18 AM, the Kitchen Operations Manager revealed when the raw chicken was delivered on 2/3/26 it was frozen and now it had thawed and was ready for use. He revealed the system in place was to rotate frozen raw chicken using a “First In	F0812	Continued from page 8 Kitchen operations manager. An inventory of current refrigerated items was conducted by the Kitchen operations manager to ensure all items were dated and in rotation to use on 2/13/2026. No concerns identified. The Dietary Department received education by the kitchen operations manager on the process of dating items and current process of first in, first out. This education was completed on 2/23/2026 Any member of the dietary department not receiving education will receive education prior to the start of their shift by the kitchen operations manager or designee. New dietary employees will receive education during the orientation process by the Kitchen operations manager or designee. The kitchen operations department will audit the facility refrigerator for accurate dating and usage 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary Completion Date: 3/3/2026	

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F0812 SS = E	Continued from page 9 First Out" policy and explained when raw chicken was delivered it was frozen and placed in the back of the walk-in refrigerator to thaw and rotated towards the front and a "use first" sticker was placed on the case to identify which one needed to be used. He did not state a use-by date was needed on thawed, raw chicken and confirmed it was not placed on chicken that was stored in the walk-in refrigerator. The Kitchen Operations Manager stated chicken stored in the walk-in refrigerator was typically used within seven days. During an interview on 02/13/26 at 12:06 PM, the Administrator revealed a use by date should be placed on thawed, raw chicken stored in the walk-in refrigerator and available for use.	F0812		