STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources - Alamance, Inc	**215 College Street , Graham, North Carolina, 27253**

(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 03/02/26 through 03/05/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F1E90-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/02/26 through 03/05/26. Event ID #1F1E90-H1. The following intakes were investigated: 864800, 864801, 864802, 864804, 864808, 864810, 2568047, 2570054, 2574331, 2621355, 2725918, 2722205, and 2789099. 2 of the 33 allegations resulted in deficiency. The following intakes were withdrawn by the complainants, and the intakes were unable to be delinked from the survey: 2790566, 2629851, 262187, and 2583966. The recertification and complaint investigation had been scheduled earlier in the year, however due to QSO Memo 26-04-ALL documenting the government shutdown and suspension of most survey activity, inclement weather, and an issue with the internet Quality Improvement and Evaluation System (iQIES) survey setup, the entrance date for the recertification and complaint investigation was postponed until 3/2/26.	F0000		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-	F0627	Plan of Correction – F627 (Inappropriate Discharge) 1. Corrective Action for the Resident Affected Resident #148 is no longer residing in the facility and was discharged on 1/31/2025. As the resident is no longer under the care of the facility, corrective action specific to the resident cannot be implemented. 2. Identification of Other Residents Affected A retrospective audit of all discharges within the past	03/25/2026

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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F0627 SS = D	Continued from page 1 (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F0627	Continued from page 1 30 days was conducted by the Social Services Director or designee on 3/23/2026 to ensure: Appropriate post-discharge home health services were arranged and documented prior to discharge All other residents had appropriate documentation for home health services in place. Of the 34 residents discharged in the past 30 days, one resident was identified as having a discrepancy. While caregiver services had been arranged at discharge, home health services for occupational therapy (OT), physical therapy (PT), and speech therapy (ST) were not initially documented. These services were subsequently documented retrospectively by the Social Worker #1 once the discrepancy was identified. No resident suffered any adverse effects related to the alleged deficient practice. 3. Systemic Changes to Prevent Recurrence The facility has implemented the following measures: The Administrator educated the Social Woker#1 and Social Worker #2, all licensed nursing staff, and the Interdisciplinary Team (IDT) members (Medical Director, Director of Nursing, LPN in charge, MDS nurses, Treatment nurse, Dietary manager, Therapy manager)on discharge planning and care planning policies. This includes the policy that requires initiation of discharge planning on the initial care plan upon admission. It also includes the required verification of post-discharge services, including agency acceptance and start-of-care date, prior to discharge. All inservices were completed by 3/25/26. Any IDT member or licensed nursing staff out on leave or PRN status will be educated by the Administrator prior to returning to duty. Any newly hired Social Worker, licensed nurse and/or member of the IDT team is educated on this process during orientation by their Department Manager and or Minimum Data Set (MDS) Nurse. 4. Monitoring for Ongoing Compliance The Administrator or designee will Audit 25% of new admissions weekly for 4 weeks, then monthly for 2 months to ensure discharge planning is included in the initial care plan.	

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

FORM APPROVED
OMB NO. 0938-0391

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F0627 SS = D	Continued from page 2 (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility	F0627	Continued from page 2 Audit 25% of discharges weekly for 4 weeks, then monthly for 2 months to ensure post-discharge services are arranged and documented. Results will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 3 months by the Administrator for further review and recommendations 5. Date of Compliance The facility will be in compliance by 3/25/2026.	

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F0627 SS = D	Continued from page 3 must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about	F0627		

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F0627 SS = D	Continued from page 4 their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any	F0627		

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F0627 SS = D	Continued from page 5 arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with home health, resident, and staff, the facility failed to implement an effective discharge planning process that ensured the resident was referred for home health services prior to discharge to the community to ensure services were not delayed for 1 of 3 residents (Resident #148) reviewed for discharge. The findings included: Resident #148 was most recently readmitted to the facility on 01/07/2025 with diagnoses that included a displaced fracture of the second right metatarsal bone [a break in the second metatarsal (the longest metatarsal or bone in the foot] where the bone fragments are misaligned), cerebral palsy (a brain disorder that permanently affects body movement and muscle coordination), and muscle weakness. A review of Resident 148's Care Plan dated 01/10/2025 revealed no information related to discharge planning. The 5-day Minimum Data Set (MDS) assessment dated 01/13/2025 revealed Resident #148 was cognitively intact. Her Activities of Daily Living abilities were as follows: independent with eating, oral hygiene, and personal hygiene; supervision for toileting and transfers; partial to moderate assistance for bathing, lower body dressing, and footwear; and setup assistance for upper body dressing. Resident #148 was receiving physical therapy and occupational therapy services. Her overall discharge goal was to return to the community and active discharge planning was noted to already be occurring. A review of the Notice of Medicare Non-Coverage (NOMNC) form for Resident #148 revealed her last covered day in the facility was 01/25/2025. The paperwork included instructions on how to appeal the decision and what happened after an appeal. Resident #148 signed the form on 01/23/2025. The Business Office Manager was interviewed on 03/04/2026 at 8:40 AM. She reported she and her two assistants handled the provision of NOMNC forms. She explained that the business office staff spoke with the residents/responsible parties and provided written and verbal information about the last day of Medicare	F0627		

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F0627 SS = D	Continued from page 6	F0627		

coverage and the appeal process. She indicated that she did not recall working with Resident #148, but reviewed the record and the NOMNC was provided to Resident #148 on 01/23/2025, with the last day of coverage being 01/25/2025. Resident #148 appealed to the discharge and remained in the facility until her appeal was declined, after which she discharged on

01/31/2025. The Business Office Manager reported that the resident was responsible for charges from 01/26/2025 through 01/31/2025.

A review of Resident #148's orders revealed an order dated 01/28/2025 stating Discharge Home with Home Health: physical therapy, occupational therapy, and case management services.

The Occupational Therapy (OT) Discharge Summary dated 01/28/2025 for OT services from 01/08/2025 through 01/25/2025 indicated Resident #148 was admitted to the facility on 01/07/2025 with plans to eventually return home. Prior to admission, Resident #148 lived alone in a private two-level home with one step to enter. Resident #148 participated fairly in therapy and demonstrated fair carryover of education; however, Resident #148 exhausted therapy benefits. Resident #148 would require home health occupational therapy.

The Physical Therapy (PT) Discharge Summary dated 01/29/2025 for PT services from 01/08/2025 through 01/25/2025 revealed Resident #148 independently used a manual wheelchair for mobility and managed wheelchair propulsion independently. Therapists educated Resident #148 on a supportive home setup, including converting the first floor into a temporary living space, but Resident #148 declined these recommendations. Resident #148 exhausted therapy benefits and declined further treatment, and the interdisciplinary team was to coordinate a discharge that included home health physical therapy.

A Nurse Practitioner (NP) note (electronically signed on 02/02/2025) documented that on 01/30/2025 the NP certified that Resident #148 was homebound and required health services due to a nondisplaced fracture of the right second metatarsal and cerebral palsy with right-sided weakness. The NP indicated follow-up with podiatry and neurology was arranged and physical therapy for gait training and occupational therapy for assistance with daily activities were ordered. The note indicated a face-to-face encounter with Resident #148 was conducted on 01/30/2025, she reviewed required home health documentation, and communicated with the home health agency.

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F0627 SS = D	Continued from page 7 A review of progress notes from 01/07/2025 through 01/31/2025 revealed no information related to discharge planning for Resident #148. A progress note dated 01/31/2025 written by Nurse #8 indicated that Resident #148 was discharged from the facility on 01/31/2025 at 4:45PM. A review of the Discharge/Transfer Plan of Care dated 01/31/2025 completed by Previous Social Services #1 revealed Resident #148 discharged from the facility on 01/31/2025 at 2:00 PM. The discharge status was to home, and she was transported by car with a friend. Resident #148 was to be set up with home health services for occupational therapy, physical therapy, and casework management with Home Health prior to discharge. A review of a fax confirmation to Home Health from the facility revealed the referral information had been faxed on 02/01/2025, after Resident #148 was discharged from the facility. There was no evidence of a referral being sent to Home Health for Resident #148 prior to 02/01/2025. Resident #148 was interviewed by phone on 03/03/2026 at 3:16 PM. Resident #148 reported she had received a discharge notification from the facility on 01/25/2025 and appealed the decision but lost the case. She reported that she remained in the facility while the appeal was pending. Resident #148 indicated it was her decision to discharge home when the appeal was lost because she did not want to remain in the facility and accrue additional costs. She stated that the Social Worker at the facility had informed her that home health services would be arranged before she discharged home; however she didn't hear from Home Health until a few days after discharge. She explained that she was receiving home health services now. She indicated she also had friends who came over to help her with her needs at home. Previous Social Services #1 was interviewed on 03/05/2026 at 9:06 AM. She stated that the discharge planning process happened when a resident entered the facility and continued until they were discharged. Prior to discharge, services were supposed to be set up for a safe discharge and at the time of Resident #148's discharge she (Previous Social Services #1) was responsible for discharge planning. Previous Social Services #1 reported that she recalled Resident #148 and stated that it was her impression that Resident #148 was anxious but eager to return home when she was	F0627		

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F0627 SS = D	Continued from page 8 discharged. She was unable to recall specific details about this resident's discharge but reported that resident was supposed to go home with home health services. Home Health Nurse #2 was interviewed by phone on 03/04/2026 at 10:09 AM and 10:30 AM. Home Health Nurse #2 reported that the referral paperwork for Resident #148 included a home health order dated 01/28/2025. She stated that she first received the referral paperwork regarding the resident on 02/01/2025. Home Health Nurse #2 indicated that normally referrals were received prior to the resident's discharge, so they were able to obtain authorization for services. She explained that it typically took 2 days to obtain authorization. Home Health Nurse #2 reported that she first contacted Resident #148 regarding admission to services on 02/01/2025 and the authorization for care was received on 02/03/2025. She stated that on 02/04/2025, she attempted to contact the resident, but no one answered the phone, and she was unable to leave a voicemail. She further stated that on 02/05/2025, she successfully reached Resident #148, who consented to services, and she completed an introduction to services call and services were initiated. The Director of Nursing (DON) was interviewed on 03/05/2026 at 1:25 PM. She reported that she had not been the DON at that time, but she stated that she would have expected Social Services to arrange for required home health services before a resident left the facility, not afterward. The Administrator was interviewed on 03/05/2025 at 11:35 PM. She reported that she had not been the Administrator at the time, but based on her review of the record Resident #148 lost an appeal after being served a NOMNC and discharged quickly at the resident's request to avoid accruing additional care costs. The Administrator stated that it was a Friday (01/31/2025) when Resident #148 was discharged and based on her experience, Home Health services would not start until 02/03/2025 at the earliest. She provided an email showing that a referral had been sent to Home Health on Saturday 02/01/2025 around 8:30 AM.	F0627		
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.	F0641	Plan of Correction – F641 (Accuracy of Assessments) 1. Corrective Action for Affected Residents The Minimum Data Set (MDS) assessments dated 11/7/25 and 1/30/26 for Resident #157 were reviewed and corrected to reflect intermittent catheterization	03/25/2026

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F0641 SS = D	Continued from page 9 §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 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 and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of urinary catheter (Resident #157) and medications (Resident #64) for 2 of 29 residents whose MDS assessments were reviewed . The findings included: 1. Resident #157 was admitted to the facility on 9/16/23 with diagnoses which included flaccid neuropathic (underactive) bladder. Review of the physician orders for Resident #157 revealed an order dated 7/6/25 for an indwelling urinary catheter and to provide urinary catheter care every shift.	F0641	Continued from page 9 instead of an indwelling urinary catheter. Modifications were submitted in the MDS system on 3/2/2026 by MDS Nurse #1. The MDS assessment dated 12/17/25 for Resident #64 was reviewed and corrected to: Remove incorrect coding of opioid medication use Accurately reflect medications administered (antipsychotic, antidepressant, diuretic) Include appropriate clinical indications for each medication The modified assessment was submitted on 3/9/2026 by MDS #1. Resident # 157 and Resident #64 did not suffer any adverse effects related to alleged deficient practice. 2. Identification of Other Residents with Potential for Similar Issues An audit of all current residents' MDS assessments completed within the last 90 days was conducted to ensure: Accurate coding of urinary catheter status Accurate coding of medication classifications Documentation of clinical indications for medications The review was completed by MDS Nurse #1 ,MDS Nurse #2, and MDS #3 with each MDS nurse auditing the work of another to ensure accuracy. A total of 583 assessments were reviewed, and 30 assessments were identified as requiring correction and were subsequently corrected. The audits were completed on 3/24/26. No residents experienced any adverse effects related to the alleged deficient practice. 3. Systemic Changes to Prevent Recurrence An in-service training was initiated on 3/23/25 by the Administrator for the MDS nurses. The inservice will be completed as of 3/25/26. The facility implemented the following measures:	

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F0641 SS = D	Continued from page 10 Review of the physician orders, dated 8/13/25, revealed an order for Resident #157 to discontinue use of the indwelling urinary catheter. Review of the physician orders, dated 8/13/25, revealed an order for Resident #157 to use intermittent urinary catheter as needed. Review of Resident #157's July and August 2025 Medication Administration Records (MAR) revealed nurses documented urinary catheter care every shift from 7/6/25 through 8/13/25. The quarterly MDS assessment dated 11/7/25 revealed Resident #157 was coded as having an indwelling urinary catheter. The quarterly MDS assessment dated 1/30/26, revealed Resident #157 was coded as having an indwelling urinary catheter. During an interview with MDS Coordinator #2 on 3/5/26 at 8:45 AM, she indicated that she had completed the 11/7/25 and 1/30/26 MDS assessments for Resident #157 and had coded them incorrectly. She explained at the time of the assessments, Resident #157 no longer had an indwelling urinary catheter and was receiving intermittent urinary catheterizations instead. She stated the MDS should have been coded to reflect intermittent catheterization use. During an interview on 3/5/26 at 12:30 PM the Administrator indicated the expectation was for MDS assessments to be coded accurately for each resident. 2. Resident #64 was admitted to the facility on 8/9/24 with a diagnosis of mood disorder, major depressive disorder and pain. The diagnosis of localized edema was added on 8/29/24. Resident #64's physician orders dated 4/8/25 included: Risperdal (an antipsychotic medication) 1 milligram (mg) one tablet by mouth once daily for mood disorder Duloxetine (an antidepressant medication) 30 mg one capsule by mouth once daily for major depressive disorder Furosemide (a diuretic medication) 20 mg tablet once daily for localized edema	F0641	Continued from page 10 Re-education of MDS Coordinators on accurate MDS coding requirements, including urinary catheter coding and medication classifications Reeducation of RAI Manual guidelines and facility policy 4. Monitoring Plan The monitoring review will be completed by the MDS nurses, with each MDS nurse auditing the work of another to ensure accuracy. Conduct weekly audits of 5 MDS assessments for 4 weeks, then conduct monthly audits of 5 MDS assessments for 2 additional months. Audits will include catheter coding accuracy, medication coding accuracy, and documentation of medication indications. Results will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) meetings by the MDS Nurses monthly X 3 months and corrective actions implemented as needed. 5. Completion Date All corrective actions will be completed by 3/25/2026.	

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F0641 SS = D	Continued from page 11 No orders for opioid (narcotic pain medication) medications were observed. A review of Resident #64's medication administration record (MAR) for December 2025 revealed: Risperdal 1 mg once daily for treatment of mood disorder, Duloxetine 30 mg once daily for treatment of major depressive disorder, and Lasix 20 mg once daily for treatment of localized edema had been received daily as ordered. A review of a quarterly Minimum Data Set (MDS) assessment dated 12/17/25 completed by MDS Nurse #2 noted Resident #64 was taking medication from the drug classifications of antipsychotic, antidepressant, diuretic, and opioid. The MDS assessment did not include documented indications (identified, documented clinical rationale for administering a medication) for the use of any of these medications. During an interview with MDS Nurse #2 on 3/5/26 at 12:59PM she revealed not including the medication indications for use on Resident #64's MDS assessment dated 12/17/25 was an oversite. MDS Nurse #2 confirmed Resident #64 had diagnoses related to the use of antipsychotic, antidepressant, and diuretic medications and acknowledged the resident did not receive any opioid medications. MDS Nurse #2 explained that coding Resident #64 as taking an opioid medication was a mistake. The Director of Nursing was interviewed on 5/5/25 at 1:14PM, she stated she expected the MDS assessments to be coded accurately.	F0641		
F0761 SS = E	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 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	F0761	Plan of Correction – F761 (Labeling and Storage of Drugs and Biologicals) 1. Corrective Action for Identified Issues Station 1 Medication Storeroom: Expired medications (Allegra D and Nicotine patches) were immediately removed and discarded on 3/4/26 by LPN in charge. The glucagon pen stored in the refrigerator was removed and relocated to appropriate room temperature storage per manufacturer guidelines by LPN in charge on 3/4/2026.	03/25/2026

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F0761 SS = E	Continued from page 12 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 observations and staff interviews, the facility failed to discard expired medications stored in 1 of 2 medication storerooms (Station 1 Medication Storeroom), store medications in accordance with the manufacturer's instructions in 1 of 2 medication storerooms (Station 1 Medication Storeroom), and date medications as to when they were opened to allow for the determination of the shortened expiration date in 1 of 2 medication storerooms (Station 3 Medication Storeroom). The findings included: 1. An observation was conducted on 3/4/26 at 11:15 AM of the Station 1 Medication Storeroom. The observation revealed the following medications were stored in the medication storeroom: a. An unopened box of Allegra D (an over-the-counter antihistamine and decongestant) containing 15 tablets was stored on the shelf of the medication storeroom. The manufacturer's expiration date of November 2025 was printed on the box containing the tablets, indicating this medication was expired. b. An opened box containing six (6) 14 milligram (mg) Nicotine Transdermal System Patches was stored on the shelf of the medication storeroom. The manufacturer's expiration date of January 2026 was printed on both the box and packaging of the individual patches, indicating the patches were expired. c. An unopened plastic case containing a 1 mg glucagon pen (an injectable medication used to treat low blood sugar) dispensed from the pharmacy on 2/11/26 for Resident #43 was observed in the medication storeroom's refrigerator. The temperature of the refrigerator was	F0761	Continued from page 12 Station 3 Medication Storeroom: The opened multi-dose vial of Tuberculin PPD without an open date was immediately discarded on 3/4/26 due to inability to determine beyond-use date by LPN in charge 2. Identification of Other Areas at Risk A facility-wide audit of all medication rooms, carts, and refrigerators was conducted on 3/23/26 by the Director of Nursing (DON) or designee to ensure: No expired medications are present Medications are stored according to manufacturer instructions Multi-dose medications are properly labeled with opening dates No discrepancies were identified. There were no expired medications. All medications were stored according to manufacturer instructions. All multi dose medications were properly labelled with opening dates. 3. Systemic Changes to Prevent Recurrence An in-service training was initiated on 3/23/25 by the Staff Development Coordinator (SDC) for all licensed nurses and medication aides. The inservice will be completed by 3/25/26. The facility implemented the following measures: Re-education of all licensed nurses and medication aides on proper medication storage, expiration monitoring, and labeling requirements Reinforcement of dating multi-dose medications upon opening and determining beyond-use dates Implementation of a weekly medication storage inspection checklist for each unit Review and reinforcement of medication storage and labeling policies Any licensed nurse or medication aide out on leave or	

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F0761 SS = E	Continued from page 13 40 degrees Fahrenheit at the time of the observation. The manufacturer's storage instructions on the label of the glucagon pen read in part, "Store at controlled room temperature 20 to 25 degrees Celsius (68 to 77 degrees Fahrenheit)." On 3/4/26 at 11:30 AM, the Station 1 Unit Manager reviewed the medications identified with a concern in the Station 1 Medication Storeroom. When asked, the Unit Manager reported it was her responsibility to check the storeroom to ensure the medications were not expired and stored properly. The Unit Manager was observed as she collected the identified medications for removal from the medication storeroom. An interview was conducted on 3/5/26 at 1:00 PM with the facility's Director of Nursing (DON) in the presence of the Regional Nurse Consultant. During the interview, the medication storage concerns were discussed. When asked, the DON reported that everyone (including the supervisors) was responsible for checking the medication storeroom to ensure all medications were properly stored and within date. The DON also confirmed that glucagon should not be stored in the refrigerator. 2. Accompanied by Nurse #1, an observation was conducted on 3/4/26 at 11:35 AM of the Station 3 Medication Storeroom. The observation revealed the following: One (1) opened, multi-dose vial of Tuberculin PPD (Purified Protein Derivative) injectable solution (used for skin testing in the diagnosis of tuberculosis) dispensed from the pharmacy on 1/28/26 was stored in the medication storeroom refrigerator. Neither the vial nor the manufacturer box it was stored in were labeled as to when the vial had been opened to allow for the determination of its shortened expiration date. The manufacturer's storage instructions for a multi-dose vial of Tuberculin PPD (Purified Protein Derivative) injectable solution (used for skin testing in the diagnosis of tuberculosis) indicated that once opened, the product should be discarded after 30 days. When asked, Nurse #1 reported the vial of PPD solution would need to be discarded. An interview was conducted on 3/5/26 at 1:00 PM with the facility's Director of Nursing (DON) in the presence of the Regional Nurse Consultant. During the interview, the medication storage concerns were discussed. When asked, the DON reported that everyone (including the supervisors) was responsible to check	F0761	Continued from page 13 PRN status will be educated prior to returning to duty by the SDC/designee. Any newly hired licensed nursing staff or medication aide is educated on the medication storage policy by the SDC/designee during orientation. 4. Monitoring Plan The DON or designee will: Conduct weekly audits of all medication rooms and carts for 4 weeks Then conduct monthly audits for 2 additional months Audits will include expiration date compliance, proper storage conditions, and labeling of multi-dose medications. Results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee by the DON monthly x 3 months and corrective actions taken as needed. 5. Completion Date All corrective actions will be completed by 3/25/26 Top of Form Bottom of Form	

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F0761 SS = E	Continued from page 14 the medication storeroom to ensure all medications were properly stored and within date. The DON also stated she would expect the nurse who opened a medication to date the medication on the label as to when it had been opened.	F0761		