STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345355	(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
Graham Healthcare and Rehabilitation Center	**811 Snowbird Road , Robbinsville, North Carolina, 28771**

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/2/26 through 3/5/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1F1E7F-H1.	E0000		04/01/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/2/26 through 3/5/26 Event ID# 1F1E7F-H1. The following intakes were investigated: Complaint 2792520 and Incident 2582534 3 of the 3-complaint allegations did not result in deficiency.	F0000		03/27/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F0578	Graham Nursing & Rehabilitation-F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive Problem Statement: Based on the record reviews and interviews with the Nurse Practitioner (NP) and the Medical Director, the facility failed to complete a Medical Orders for Scope of Treatment (MOST) form with a required signature for 1 of 3 residents reviewed for advanced directive (Resident #26). Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/5/26, the Unit Manager and the Social Worker reviewed the MOST form with Resident #26 and the resident representative. The new MOST form was completed by the Unit Manager, signed by the resident representative, was reviewed and signed by the Medical Director. The MOST form was then placed in Resident #26's medical record.	04/01/2026

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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F0578 SS = D	Continued from page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, Nurse Practitioner (NP) and Medical Director interviews, the facility failed to complete a Medical Orders for Scope of Treatment (MOST) form with a required signature for 1 of 3 residents reviewed for advance directive (Resident #26). The findings included: Resident #26 was admitted to the facility on 8/15/23. Her diagnoses included dementia. Review of Resident #26's face sheet revealed she had a Resident Representative. A quarterly Minimum Data Set (MDS) assessment dated 1/17/26 documented Resident #26 was rarely/ never understood. The MDS indicated she had short term memory problems, long term memory problems, and her cognitive skills for daily decision making were severely impaired. A MOST form dated 10/6/25 for Resident #26 was reviewed. The MOST form indicated Do Not Resuscitate (DNR), comfort measures, antibiotics if indicated, intravenous (IV) fluids for defined trial period, and no feeding tube. The form indicated it had been discussed with and agreed to by "an individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient". The form was signed by NP #1. The form did not include the name of the individual the form was discussed with. The "patient or representative" signature section at the bottom of the form was not	F0578	Continued from page 1 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/4/26, the Medical Records Coordinator and the Unit Manager completed a 100% audit of all resident MOST forms to ensure all forms were signed, reviewed by the resident or resident representative, and the medical provider prior to placing the form in the resident's medical record. This audit was completed on 3/5/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was conducted by the Director of Nursing (DON)/the Unit Managers (UM) for 100% of all Licensed Nurses, the Social Worker and Medical Records Coordinator. The education included ensuring the MOST form is reviewed with the resident or resident's responsible party and then signed by the resident or the resident's responsible party prior to being reviewed and signed by the Medical Director and placed in the resident's medical record. The education began on 3/23/26 and will be completed by the Director of Nursing (DON)/Unit Managers (UM) by 3/27/26. Any newly hired Licensed Nurses, Social Worker, or Medical Records Staff who have not received the education by 3/27/26 will receive it at their next scheduled shift. Any newly hired Licensed Nurses, Social Worker, or Medical Records staff to include agency staff will be educated by the Director of Nursing/Unit Managers during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 3/30/26, the Director of Nursing/Unit Managers will audit 5 resident records weekly for 4 weeks to ensure the resident has a MOST form that has been reviewed and signed by the resident or resident representative and the Medical Director and then placed in the resident's medical record. Any areas of concern will be addressed by the Director of Nursing (DON) immediately. All audits will be taken to Quality Assurance Performance Improvement (QAPI) monthly x1 month and discussed with the Interdisciplinary team (IDT)	

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F0578 SS = D	Continued from page 2 completed and was blank. A telephone interview was attempted on 3/3/26 at 9:21 AM with Resident #26's Resident Representative but was not successful. An interview was conducted with Medical Records on 3/4/26 at 11:04 AM. She stated after the provider completed a MOST form it was returned to her box. She reported she reviewed the forms to ensure they were completed entirely with dates and all signatures, before she scanned them into the electronic medical record. She then placed the hard copy of the MOST form into the code book at the nursing station. Medical Records stated if the MOST form was missing the Resident Representative signature, she called the Resident Representative and asked them to come to the facility to sign the form. Medical Records stated the form was not valid unless it was signed by the resident and/or their Resident Representative. She stated she missed that Resident #26's MOST form was not signed by her Resident Representative. An interview was conducted on 3/4/26 at 1:59 PM with the Social Worker (SW). She was not sure if the MOST form would be valid if it was not signed by the resident and/or Resident Representative. She stated she conducted audits of MOST forms, but her audit was mainly taking note of who had a MOST form. An interview was conducted with The Medical Director on 3/5/26 at 8:24 AM. She said the form needed to be signed by the resident and/or Resident Representative to be considered a valid form. She reported NP #1 completed Resident #26's MOST form and she was not sure if NP #1 was aware the form had to be signed by the resident and/or representative. She reported that if the form was reviewed by telephone, then there should be documentation on the form of who it was reviewed with and a witness signature. An interview was conducted with NP #1 on 3/5/26 at 8:50 AM. She reported she was not aware the MOST form had to be signed by the resident and/or Resident Representative to be a valid form. She thought the signature box for resident and/or Resident Representative was optional because it stated above the signature box "you are not required to sign this form to receive treatment". She reported she had missed that the section under the bold print "signature of patient or personal representative" stated "signature is required". An interview was conducted with the Director of Nursing	F0578	Continued from page 2 members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 4/1/26	

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F0578 SS = D	Continued from page 3 (DON) on 3/4/26 at 1:00 PM. She reported the MOST form needed to be signed by the resident and/or their Resident Representative to be considered a valid form. She stated Resident #26's MOST form would not be considered a valid MOST form because it was not signed by her Resident Representative. The DON said Medical Records was responsible for reviewing the MOST form and ensuring all signatures and dates were present before scanning the form into the electronic record. An interview was conducted with the Administrator on 3/5/26 at 9:08AM. She stated the MOST form had to be signed by the resident and/or Resident Representative to be considered valid. She said Resident #26's form would not be considered a valid form because it was not signed by her Resident Representative. She explained Resident #26's form needed to be signed by her Resident Representative because she was not cognitive enough to sign the form. The Administrator reported that if the MOST form was reviewed and completed with the Resident Representative by telephone then there should be a witness. She stated the name of the individual the form was reviewed with should be documented in the "Representative Name" box, the form should indicate it was reviewed by telephone, and then two people should sign the form as witnesses. The Administrator stated she had become aware yesterday about the MOST form missing signatures and had completed an audit. She reported during the audit that the facility had found 7 MOST forms that had not been signed by the resident and/or Resident Representative.	F0578		
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	F0644	Graham Health and Rehab-F644 PASARR Screening for MD & ID Problem Statement: Based on the record review and staff and Medical Director interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident diagnosed with intellectual disability for 1 of 2 residents reviewed for PASRR (Resident #15). Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/3/26, the Social Worker submitted a Level II PASRR Screening to NC MUST for Resident #15. The Screening returned on 3/10/26 as a Level II PASRR for Resident	04/01/2026

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F0644 SS = D	Continued from page 4 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, staff and Medical Director interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident diagnosed with intellectual disability for 1 of 2 residents reviewed for PASRR (Resident #15). The findings included: Resident #15 had a Level I PASRR screening completed on 8/16/24 by a physician at the hospital emergency room. The diagnosis listed were diabetes and history of Guillain- Barre Syndrome (autoimmune disorder where the immune system damages peripheral nerves causing muscle weakness). Resident #15 was admitted to the facility from a local hospital's emergency room on 8/20/24 with diagnoses including diabetes and Guillain-Barre Syndrome. The Medical Director's history and physical note dated 8/20/24 indicated a new diagnosis of intellectual disability was added by the Medical Director and added to Resident #15's diagnosis sheet. Review of Resident #15's current diagnosis list in the medical record included the diagnosis of intellectual disability. There was no evidence in the medical record that a request for a Level II PASRR evaluation was submitted. The 2/20/26 quarterly Minimum Data Set (MDS) showed that Resident #15 was cognitively intact. On 3/3/26 at 2:25 PM an interview was conducted with the Social Worker. She stated that she had worked at the facility for numerous years and she knew Resident #15. The Social Worker stated she did not know when Resident #15 was diagnosed with an intellectual disability. She stated that she did know Resident #15 did not take any antipsychotic medications. The Social Worker stated that when a new admission came from the hospital, the hospital completed the PASRR, and if a resident came from home the Social Worker completed the PASRR. The Social Worker could not state her method of keeping track of PASRRs for residents or how she would know about a new diagnosis being added. The Social Worker stated that today she had done an audit and	F0644	Continued from page 4 #15. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/4/26, the Social Worker initiated a 100% audit of all Resident records to ensure residents who were a level I PASARR were submitted for a level II PASARR if applicable. The criteria for submitting a level II PASRR screening include suspicion of Serious Mental Illness or Intellectual/Developmental Disabilities, or a Related Condition, triggering a comprehensive assessment to confirm the condition and determine specialized needs before nursing placement and following a significant change. Any residents requiring submission for a level II PASARR were submitted to NC MUST by the Interim Social Worker by 3/13/26. The audit was completed by 3/13/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was conducted by the Nursing Consultant for the Social Worker and the Director of Nursing on 3/23/2026. The education included the criteria for submitting a Level II PASARR screening for residents. Any newly hired team members to include Social Worker/Director of Nursing who will be submitting PASARRS to NC MUST who have not received the education by 3/23/26 will be educated by the Interim Social Worker/Director of Nursing/Nurse Consultant during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 3/23/26, the Social Worker/Director of Nursing will audit 5 Resident records weekly for 4 weeks to include new admissions to ensure any residents who meet the criteria for a level II PASARR but have a level I PASARR are submitted to NC MUST as applicable. The criteria for submitting a level II PASRR screening includes suspicion of Serious Mental Illness or Intellectual/Developmental Disabilities, or a Related Condition, triggering a comprehensive assessment to confirm the condition and determine specialized needs	

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F0644 SS = D	Continued from page 5 noticed that Resident #15 was diagnosed with an intellectual disability on 8/22/24 and a Level II PASRR should have been submitted within a day or two of a new diagnosis being added. On 3/4/26 at 1:45 PM an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident was admitted to the facility from the hospital, they came with a diagnosis sheet, and if a resident came from home the resident's primary doctor provided the diagnosis sheet. The MDS nurse would then enter the diagnoses at admission. If a resident had a new diagnosis added after admission, then the MDS nurse would notify the staff at the morning meeting. The Social Worker would then be alerted to start a new PASRR if needed. The DON stated that Resident #15 had a diagnosis of intellectual disability and that a request for a Level II PASRR evaluation should have been completed. The DON could not state why this did not happen. On 3/5/26 at 8:34 AM a telephone interview was conducted with the Medical Director. She stated that Resident #15 was not admitted with a diagnosis of intellectual disability. The Medical Director stated on 8/20/24 she reviewed Resident #15's past medical history with his family representative and the family representative informed the Medical Director that Resident #15 had an intellectual disability. The Medical Director stated she had also reviewed Resident #15's past medical records, which revealed he had an intellectual disability diagnosis. On 8/20/24 the diagnosis of intellectual disability was added. The Medical Director stated that back in 2024 the facility had a different method of sharing information. The Medical Director stated that in 2024 she had to inform numerous staff about the details of a new admission and whether the new admission had an additional diagnosis. The Medical Director could not state exactly which staff she had to notify. Presently, after she saw a new admission, she only notified the DON and medical records. The Medical Director stated she did not have anything to do with PASRR. The Medical Director did know that if a resident had a diagnosis of intellectual disability, a Level II PASRR should be completed. She stated she was unaware that the Level II PASRR was not completed. On 3/5/26 at 8:52 AM an interview was held with the Administrator. The Administrator agreed that a Level II PASRR evaluation should have been submitted once the intellectual disability diagnosis was added.	F0644	Continued from page 5 before nursing placement and following a significant change. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. The Interdisciplinary team (IDT) will determine at that time the need for continued monitoring. The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 4/1/26	

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F0644 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Consultant Pharmacist, Supervisor Consultant Pharmacist, and Physician interviews, the Consultant Pharmacist failed to identify and report the lack of documented	F0644 F0756	Graham Health and Rehab-F756 Drug Regimen Review, Report Irregular, Act On Problem Statement: Based on the record review and staff, Consultant Pharmacist, Supervisor Consultant Pharmacist, and Physician interviews, the Consultant Pharmacist failed to identify and report the lack of documented monitoring for a resident who had hold parameters for digoxin (a cardiac glycoside used to strengthen heart contractions and losartan (an hypertensive medication). This failure affected 1 of 5 residents reviewed for unnecessary medications (Resident #52) Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/4/2026 the Director of Nursing reviewed the chart for Resident #52. The nurse practitioner was contacted and appropriate monitoring parameters and hold orders were put in place immediately. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/4/2026 the Director of Nursing initiated a 100% audit of all residents on hypertensive medications and cardiac medications to ensure appropriate monitoring parameters and hold orders are in place and documented. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/4/2026 the Director of Nursing initiated education with all nurses and medication aides to include agency staff on ensuring all hypertensive and cardiac glycoside medications contain monitoring parameters and hold orders. On 3/25/2026 the facility nursing consultant provided education to the pharmacy consultant on identifying residents on digoxin and cardiac medications and reporting any appropriate missing documentation such as	04/01/2026

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F0756 SS = D	Continued from page 7 monitoring for a resident who had hold parameters for digoxin (a cardiac glycoside used to strengthen heart contractions) and losartan (an antihypertensive medication). This failure affected 1 of 5 residents reviewed for unnecessary medications (Resident #52). Findings included: Resident #52 was admitted to the facility on 2/17/21 with diagnoses including paroxysmal atrial fibrillation, congestive heart failure, and hypertension. a. The physician's orders dated 10/16/25 revealed Resident #52 had an order for Digoxin 125 micrograms (mcg) by mouth in the evening with a hold parameter if the pulse was below 60. Review of the Medication Administration Record (MAR) for October 2025, November 2025, December 2025, January 2026, and February 2026 revealed Digoxin 125 mcg was documented as administered every day except for 11/27/25 and 12/24/25 when documentation indicated that Resident #52 was absent from the facility. Review of documentation of Resident #52's pulse in the electronic health record for October 2025, November 2025, December 2025, January 2026 and February 2026 revealed no pulse documented for: October – 30, 31 November – 1, 2, 3, 4, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 18, 20, 23, 24, 25, 28, 29, 30 December – 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 26, 28, 29, 30 January – 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, 31 February – 1, 2, 3, 5, 6, 7, 8, 9, 10 ,11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28 Review of the Consultant Pharmacist medication review for Resident #52 dated 11/06/25 revealed no recommendations related to Digoxin.	F0756	Continued from page 7 pulse rate or hold orders to the Director of Nursing for immediate correction. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 3/27/26 The Director of Nursing will audit 5 Medication Administration records in comparison to the physician's orders weekly x 4 weeks to ensure medications are being administered per physician order and hold and monitoring parameters are in place. This audit will be monitored utilizing a Medication Administration record (MAR) audit tool. The Administrator or DON will present the findings of the Audit Tools to the QAPI committee monthly for 1 month. The QAPI committee will meet monthly for 1 month and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 4/1/26	

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F0756 SS = D	Continued from page 8 Review of the Consultant Pharmacist medication review for Resident #52 dated 12/12/25 revealed no recommendations related to Digoxin. Review of the Consultant Pharmacist medication review for Resident #52 dated 1/07/26 revealed no recommendations related to Digoxin. Review of the Consultant Pharmacist medication review for Resident #52 dated 2/12/26 revealed no recommendations related to Digoxin. b. The physician's orders dated 2/07/25 revealed Resident #52 had an order for Losartan 100 milligrams (mg) by mouth daily with a hold parameter if the systolic blood pressure was less than 110. Review of the Medication Administration Record (MAR) for February 2026 revealed Losartan 100 mg was documented as administered daily beginning 2/08/26. Review of documentation for Resident #52 revealed blood pressures documented for 2/19/26 and 2/21/26. The facility was unable to produce any further documentation for Resident #52's blood pressures during the month of February 2026. An interview on 3/05/26 at 8:52 AM with the Consultant Pharmacist and Supervisor Consultant Pharmacist revealed the facility had not entered the supplementary order for the nurse to enter the pulse for the digoxin medication or blood pressure when administering the losartan medication. The Supervisor Consultant Pharmacist stated the Consultant Pharmacist was fairly new to their company and was unaware of how to look in the system to check. The Supervisor Consultant Pharmacist stated the Consultant Pharmacist did not identify this lack of documentation during the monthly medication review but should have. The Consultant Pharmacist had no comment during this interview. An interview on 3/05/26 at 8:38 AM with the Physician revealed she expected the Consultant Pharmacist to review the residents' medications and to notify the facility when hold parameters were not monitored.	F0756		

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F0756 SS = D	Continued from page 9 An interview on 3/05/26 at 10:26 AM with the Administrator revealed she was not aware the Consultant Pharmacist had not known how to review hold parameter documentation.	F0756		
F0757 SS = E	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 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 staff and the physician, the facility failed to monitor and document a resident's pulse and blood pressure for a resident who had physician ordered hold parameters for digoxin (a cardiac glycoside used to strengthen heart contractions) and losartan (antihypertensive medication) for 1 of 5 residents reviewed for unnecessary medications (Resident #52). Findings included: Resident #52 was admitted to the facility on 2/17/21	F0757	Graham Health and Rehab-F757 Drug Regimen is Free from Unnecessary Drugs Problem Statement: Based on record review and interviews with staff and the physician, the facility failed to monitor and document a resident's pulse and blood pressure for a resident who had physician ordered hold parameters for digoxin (a cardiac glycoside used to strengthen heart contractions) and losartan (antihypertensive medication) for 1 of 5 residents reviewed for unnecessary medications (Resident #52). Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing immediately reviewed the chart for resident #52 with the facility nurse practitioner. Appropriate hold orders and monitoring parameters were put in place Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/4/2026 the Director of Nursing initiated a 100% audit of all residents on hypertensive medications and cardiac medications to ensure appropriate monitoring parameters and hold orders are in place and documented. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/4/2026 the Director of Nursing initiated 100% education with all nurses and medication aides to include agency staff on ensuring all hypertensive and cardiac glycoside medications contain monitoring parameters and hold orders and is documented	04/01/2026

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F0757 SS = E	Continued from page 10 with diagnoses including paroxysmal atrial fibrillation, congestive heart failure, and hypertension. a. The physician's orders dated 10/16/25 revealed Resident #52 had an order for digoxin 125 micrograms (mcg) by mouth in the evening with a hold parameter if the pulse was below 60. The Medication Administration Record (MAR) for October 2025, November 2025, December 2025, January 2026, and February 2026 revealed digoxin 125 mcg was documented as administered every day except for 11/27/25 and 12/24/25 when documentation indicated that Resident #52 was absent from the facility. There was no hold parameter transcribed on the MARs and no pulse documentation on the MARs. Review of the electronic health record documentation for Resident #52's pulse for October 2025, November 2025, December 2025, January 2026 and February 2026 revealed no pulse documented for the following dates: October – 30, 31 November – 1, 2, 3, 4, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 18, 20, 23, 24, 25, 28, 29, 30 December – 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 26, 28, 29, 30 January – 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, 31 February – 1, 2, 3, 5, 6, 7, 8, 9, 10 ,11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28 b. The physician's orders dated 2/07/25 revealed Resident #52 had an order for losartan 100 milligrams (mg) by mouth daily with a hold parameter if the systolic blood pressure was less than 110. The Medication Administration Record (MAR) for February 2026 revealed losartan 100 mg was documented as administered daily beginning 2/08/26. There was no hold parameter transcribed on the MAR and no blood pressure documentation on the MAR.	F0757	Continued from page 10 appropriately in resident's charts Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 3/27/26 The Director of Nursing will audit 5 Medication Administration records in comparison to the physician's orders weekly x 4 weeks to ensure medications are being administered per physician order and hold and monitoring parameters are in place. This audit will be monitored utilizing a Medication Administration record (MAR) audit tool. The Administrator or DON will present the findings of the Audit Tools to the QAPI committee monthly for 1 month. The QAPI committee will meet monthly for 1 month and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring The Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. Date of Compliance: 4/1/26	

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F0757 SS = E	Continued from page 11 Review of the electronic health record for Resident #52 revealed blood pressures documented for 2/19/26 and 2/21/26. The facility was unable to produce any further documentation for Resident #52's blood pressures during the month of February 2026. An interview on 3/04/26 at 12:51 PM with Nurse #3 revealed when the physician's order was clarified, the nurse should have added the parameters in the supplemental documentation section. The supplemental documentation flagged the parameters on the MAR for the nurse to enter the pulse or blood pressure. Nurse #3 stated she should have identified that the order had not been entered correctly without the hold parameters in the supplemental documentation but did not. She also stated that the orders were reviewed in the morning meetings, and the error should have been caught there and did not know why it had not been identified. An interview on 3/04/26 at 1:28 PM with Nurse #4 revealed if she hovered over the medication on the electronic MAR, it would display the hold parameters. She stated she was aware of Resident #52's hold parameters for her digoxin and losartan but was unable to locate documentation of the blood pressure or pulse from prior administration of the resident's medication. Nurse #4 stated she administered Resident #52's medications infrequently and could not recall if she had been aware of the need to monitor and document her pulse and blood pressure. An interview on 3/05/26 at 9:28 AM with Nurse #2 revealed she frequently administered Resident #52's medications. She stated she always checked the pulse and blood pressure but did not document them. Nurse #2 was unable to state why she did not document the pulse and blood pressure. An interview on 3/05/26 at 9:44 AM with Nurse #1 revealed she was responsible for entering and confirming all resident orders. She explained when an order had parameters, there should be supplemental documentation which flagged the nurse to check the pulse or blood pressure. She stated the orders were not always entered in the electronic health record correctly due to lack of staff knowledge. The nurse who confirmed the order was supposed to double-check the orders to ensure accuracy but sometimes the same nurse who entered the order was the one who confirmed it.	F0757		

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F0757 SS = E	Continued from page 12 Nurse #1 stated she had not administered Resident #52's medications but stated orders should be entered accurately on the MAR. An interview on 3/05/26 at 8:38 AM with the Physician revealed she expected the facility nurses to follow her orders for medication hold parameters. The Physician stated the resident could have adverse effects such as low blood pressure, increased risk of falls, exacerbation of heart failure, or low heart rate. An interview on 3/05/26 at 9:08 AM with the Director of Nursing (DON) revealed she was not aware of the lack of parameter monitoring. She stated pulse and blood pressure monitoring and documentation was just missed due to human error and she would educate the staff. The DON indicated she expected the staff to follow the physician's orders and to monitor and document as necessary. An interview on 3/05/26 at 10:26 AM with the Administrator revealed she was not aware of medication orders with hold parameters were not being followed and was unable to say why this was occurring.	F0757		