STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345437	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eckerd Living Center	**250 Hospital Drive , Highlands, North Carolina, 28741**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/07/2026 through 04/10/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22C695-H1.	E0000		04/21/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/07/26 through 04/10/26. Event ID# 22C965-H1. The following intakes were investigated: 2662582 and 888795. Two (2) of the two (2) complaint allegations did not result in deficiency.	F0000		04/21/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to obtain consent and inform the resident or Responsible Party in advance of the	F0552	F0552 – Right to Be Informed / Psychotropic Medication Consent 1. Corrective Action for Affected Residents Residents #36, #24, and #6 were immediately reviewed on 4/10/26 by Social . Responsible parties/residents were contacted on 4/10/26 by Social Services. Education provided to responsible parties on risks, benefits, and alternatives of medications by Social Services and Team Leads. Written consents were obtained by Social Services and placed in the electronic medical record (EMR) on 4/10/26. 2. Identification of Other Residents An audit of 100% of current residents receiving psychotropic medications was conducted on 4/10/26 by Social Services to ensure informed consent documentation is present.	04/23/2026

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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F0552 SS = D	Continued from page 1 risks and benefits of psychotropic medications prior to initiation for 3 of 5 residents reviewed for unnecessary medications (Residents #36, #24, and #6). Findings Included: 1. Resident #36 was admitted to the facility on 10/21/22 with cumulative diagnoses that included unspecified dementia, anxiety disorder, depression and delusional disorder. A physician order dated 08/16/25 read quetiapine (anti-psychotic medication) 25 milligram (mg) tablet 1 tablet three times per day for anxiety and agitation. A physician order dated 12/10/25 read divalproex (anti-convulsant medication used for mood stabilization) 125 mg capsule 1 capsule three times per day for dementia with aggression and agitation. The order had a stop date of 04/09/26. The quarterly Minimum Data Set (MDS) assessment dated 02/18/26 revealed Resident #36 had moderate cognitive impairment. She received anti-psychotic, anti-depressant and anti-convulsant medications and displayed physical and verbal behavioral symptoms directed towards others and rejection of care for 4-6 days during the lookback period. A physician order dated 04/09/26 read divalproex 125 mg capsule 2 capsules three times per day for dementia with aggression and agitation. Review of the April 2026 Medication Administration Record (MAR) for Resident #36 revealed quetiapine and divalproex were administered as ordered. Review of Resident #36's electronic medical record revealed no documentation that Resident #36's Responsible Party was informed in advance of the risks and benefits of initiating or increasing the dose of quetiapine or divalproex and consented to the treatment. During an interview on 04/10/26 at 11:50 AM the Nurse Team Lead revealed she was responsible for obtaining psychotropic medication consents. She explained when a provider had a new order they gave it to the Nurse Team Lead. She explained when there was a new psychotropic medication ordered a consent form was obtained from the resident or their Responsible Party. The Nurse Team Lead confirmed they were unable to find psychotropic medication consent forms for Resident #36 and could not recall if she had called Resident #36's Responsible Party	F0552	Continued from page 1 Any missing consents were immediately obtained on 4/10/26 by Social Services and our Team Lead Nurses. 3. Systemic Changes A Psychotropic Medication Consent Process was revised to require: Consent prior to initiation or dose change Documentation in EMR before medication administration A two-step verification process implemented: Nurse Team Lead obtains consent Pharmacist verifies completion prior to filling prescription Staff (Social Worker, Team Leads, Pharmacy, Director of Nursing) were re-educated by Nursing Home Administrator on CMS requirements, consent process, two-step verification, audit process, and reporting requirements on 4/10/26. Staff not present were required to review the education prior to the start of their next shift.. 4. Monitoring Weekly audits x 4 weeks, then monthly x 2 months, conducted by Nurse Team Leads: Review of all new psychotropic orders for proper consent Results reported to QAPI committee monthly by Team Leads. All corrective actions and audits will be reviewed by the Quality Assurance and Performance Improvement	04/23/2026

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F0552 SS = D	Continued from page 2 or not. During an interview on 04/10/26 at 2:11 PM with the Director of Nursing (DON), she explained that the process for handling new orders including new or changed psychotropic medication orders was that the provider communicated all new or changed orders to the Nurse Team Lead, who was then responsible for calling the resident's Responsible Party. The DON stated she expected the Nurse Team Lead to document when they call the family in the resident's medical record. The DON stated she believed Resident #36's Responsible Party was called but acknowledged that this was not documented and that the required form had not been completed. During an interview on 04/10/26 at 3:15 PM, the Administrator revealed that she believed this problem occurred because there was no second check in place and once it fell through the cracks it was unknown that the consent form was missing. The Administrator stated the psychotropic medication consent form for Resident #36 was forgotten and should have been documented. 2. Resident #24 was admitted to the facility on 03/17/26 with cumulative diagnoses that included anxiety disorder and depression. A physician order dated 03/18/26 read duloxetine (antidepressant medication) 30 milligrams (mg) capsule one capsule two times a day for depression. The 5 Day Minimum Data Set (MDS) assessment dated 03/24/26 revealed Resident #24 had severe cognitive impairment. She displayed behavioral symptoms not directed toward others that significantly interfered with Resident #24's social interactions and disrupted care. She received anti-anxiety and anti-depressant medications during the MDS assessment look back period. A physician order dated 04/01/26 read; lorazepam 0.5 mg tablet 0.25 mg every 24 hours as needed for daytime anxiety with agitation and lorazepam 0.5 mg tablet 0.5 mg every 24 hours as needed for bedtime anxiety with agitation. Both orders had a stop date of 04/14/26. Review of the April 2026 Medication Administration Record (MAR) for Resident #24 revealed the duloxetine was given as ordered. Further review of the MAR revealed the Lorazepam was given on 04/01/26, 04/02/26, 04/03/26, 04/04/26, 04/06/26, 04/07/26 and 04/09/26.	F0552	Continued from page 2 Committee monthly for 3 months Any trends or repeat issues will trigger: Additional staff education Policy revision Disciplinary action if warranted 5. Completion Date All audits and education were completed and brought to compliance by 4/23/2026.	04/23/2026

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F0552 SS = D	Continued from page 3 Review of Resident #24's electronic medical record revealed no documentation that Resident #24's Responsible Party was informed in advance of the risks and benefits of initiating duloxetine or lorazepam and consented to the treatment. During an interview on 04/10/26 at 11:50 AM the Nurse Team Lead revealed she was responsible for obtaining psychotropic medication consents. She explained when a provider had a new order they gave it to the Team Nurse Lead. She explained when there was a new psychotropic medication ordered a consent form was obtained from the resident or their Responsible Party. The Nurse Team Lead confirmed they were unable to find psychotropic medication consent forms for Resident #24 and could not recall if she had called Resident #24's Responsible Party or not. During an interview on 04/10/26 at 2:11 PM with the Director of Nursing (DON), she explained that the process for handling new orders including new or changed psychotropic medication orders was that the provider communicated all new or changed orders to the Nurse Team Lead, who was then responsible for calling the resident's Responsible Party. The DON stated she expected the Nurse Team Lead to document when they call the family in the resident's medical record. Regarding Resident #24, the DON reported that she believed all consents were obtained verbally over the phone at admission; however, the psychotropic medication consent form was not documented. The DON stated the documentation just fell through the cracks. During an interview on 04/10/26 at 3:15 PM, the Administrator revealed that she believed this problem occurred because there was no second check in place and once it fell through the cracks it was unknown that the consent form was missing. The Administrator stated the psychotropic medication consent form for Resident #24 was forgotten and should have been documented. 3. Resident #6 was admitted to the facility on 10/06/24 with diagnoses that included major depressive disorder and generalized anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 03/25/26 revealed Resident #6 had intact cognition. She displayed no behavioral symptoms and received antidepressant medication during the MDS assessment look-back period.	F0552		04/23/2026

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F0552 SS = D	Continued from page 4 Review of the March 2026 Medication Administration Record for Resident #6 revealed an active physician order dated 09/23/25 for escitalopram oxalate (antidepressant medication) 20 milligrams (mg) one time a day for depression/anxiety. Review of Resident #6's electronic medical record revealed no documentation that Resident #6 was informed in advance of the risks and benefits of initiating escitalopram oxalate 20 mg and consented to the treatment. During interviews on 04/10/26 at 11:50 AM and 04/10/26 at 2:05 PM, the Nurse Team Lead revealed she was responsible for obtaining psychotropic medication consents. She explained when a provider had a new order they gave it to the Nurse Team Lead and if the order was for a new psychotropic medication, the Nurse Team Lead obtained a consent form from the resident or their Responsible Party. The Nurse Team Lead stated she was not sure what had happened and confirmed they were unable to find a psychotropic medication consent form for Resident #6. During an interview on 04/10/26 at 3:04 PM, the Director of Nursing (DON) explained that new orders, including orders for psychotropic medications, were communicated by the provider to the Nurse Team Lead, who was responsible for notifying the resident or their Responsible Party (RP). The DON stated she expected the Nurse Team Lead to document the notification in the resident's medical record. The DON stated she believed Resident #6 was aware of the risks and benefits of the medication because she was followed by the Psychiatric Nurse Practitioner who discussed that information with her. The DON acknowledged they were unable to find a psychotropic medication consent form for Resident #6 and stated it was an oversight. During an interview on 04/10/26 at 3:15 PM, the Administrator revealed that she believed this problem occurred because there was no second check in place and once it fell through the cracks it was unknown that the consent form was missing. The Administrator stated the psychotropic medication consent form for Resident #6 was overlooked and should have been completed.	F0552		04/23/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation.	F0628	F0628 – Discharge Process 1. Corrective Action for Affected Resident	04/23/2026

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F0628 SS = D	Continued from page 5 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. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F0628	Continued from page 5 Resident #47's record was reviewed on 4/13/26 by the Case Manager. A complete discharge summary was reconstructed to include: Course of treatment Functional status Medication reconciliation 2. Identification of Other Residents Audit of all discharges in the past 30 days was conducted by the Social Worker and Case Manager on 4/13/26. Missing elements were corrected where applicable. 3. Systemic Changes New Discharge Summary Template implemented including all required elements: Recapitulation of stay Functional status Care plan goals Discharge checklist implemented for Social Services, Case Management, and Nursing. Social Services, Case Management, Therapy, and Nursing are convening weekly to discuss impending discharges and complete interdisciplinary discharge summary. Staff (Social Worker, Case Manager, Therapy, Team Leads, DON) were re-educated by Administrator on	04/23/2026

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F0628 SS = D	Continued from page 6 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the	F0628	Continued from page 6 CMS requirements, discharge summary template, audit process, and reporting requirements on 4/13/26. Staff not present were required to review the education prior to the start of their next shift. 4. Monitoring Audit of 100% of discharges weekly x 4 weeks, then monthly x 2 months by Case Manager and Social Worker Results reviewed in QAPI All corrective actions and audits will be reviewed by the QAPI Committee monthly for 3 months Any trends or repeat issues will trigger: Additional staff education Policy revision Disciplinary action if warranted 5. Completion Date All audits and education were completed and brought to compliance by 4/23/2026.	04/23/2026

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F0628 SS = D	Continued from page 7 Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of	F0628		04/23/2026

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F0628 SS = D	Continued from page 8 this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §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: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge summary that included a recapitulation of the resident's stay for 1 of 1 sampled resident reviewed for discharge (Resident #47). Findings included: Resident #47 was admitted to the facility on 03/05/26. The 5-Day Minimum Data Set (MDS) assessment dated 03/08/26 revealed Resident #47 had intact cognition and active discharge planning was in place. The discharge-return not anticipated MDS assessment dated 03/08/26 revealed Resident #47 discharged to the community. Review of Resident #47's electronic medical record on 04/10/26 revealed an undated,	F0628		04/23/2026

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F0628 SS = D	Continued from page 9 Transfer/Discharge Report containing the resident's demographic and clinical information including date of birth, date of admission to the facility, age, insurance details, allergies, primary contact information, primary physician information, medical diagnoses, most recent vital signs, and immunization history. It was noted under the section for current medications to refer to the medication administration record. The following sections of the report were left blank: *Advanced directive *Diet type/texture/fluid consistency *Resident-specific information related to behavior(s), ambulation, bladder/bowel status, feeding, and usual level of functioning. *Signature and date indicating the resident or representative received a copy of the Transfer/Discharge Report. During an interview on 04/10/26 at 11:14 PM, the Social Worker (SW) revealed she was responsible for long-term resident discharges and the Discharge Planner/Case Manger handled short-term resident discharges. The SW explained that the discharge process included arranging post-discharge needs, such as follow-up appointments, home health or equipment, and providing the resident or their representative with a satisfaction survey and list of the resident's medications with administration times. She also documented a progress note in the resident's medical record outlining the discharge arrangements. The SW stated if a follow-up appointment was arranged prior to the resident's discharge, the resident's medical records were faxed to the provider that included provider notes, therapy notes, and list of medications. The SW indicated she was not aware that a discharge summary that included a recapitulation of the resident's course of treatment while residing in the facility was also required. The Discharge Planner/Case Manager responsible for short-term resident discharges was unavailable for an interview. During an interview on 04/10/26 at 3:15 PM, the Administrator acknowledged that although the Transfer/Discharge Report they utilized contained some of the required discharge summary components, it did not summarize the resident's course of treatment while at the facility. The Administrator stated a discharge summary that	F0628		04/23/2026

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F0628 SS = D	Continued from page 10 included a recapitulation of Resident 47's stay with input from all disciplines should have been completed per the regulatory guidelines.	F0628		04/23/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.	F0645	F0645 – PASRR Screening 1. Corrective Action for Affected Resident Resident #3 was referred for a Level II Preadmission Screening and Resident Review evaluation immediately on 4/9/2026 by the Social Worker. Documentation was updated in the medical record. On 4/22/26, confirmation was received from NC Department of Health and Human Services confirming the appropriateness of resident for nursing home placement. 2. Identification of Other Residents Audit of all current residents with mental health diagnoses was conducted on 4/13/2026 by the Social Worker. No other residents met criteria for referral for PASRR Level II evaluation. 3. Systemic Changes Admission process revised: Mandatory PASRR verification checklist prior to admission to be completed by Social Worker. Social Services was re-educated on PASRR requirements, verification check list, audit process, and reporting requirements on 4/13/2026 by administrator: Level II required based on diagnosis, not behavior alone. Level II required when a new qualifying diagnosis is added to the medical record.	04/23/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eckerd Living Center	**250 Hospital Drive , Highlands, North Carolina, 28741**

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F0645 SS = D	Continued from page 11 (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for a Level II PASRR (Preadmission Screening and Resident Review) ev aluation for a resident with a serious mental health diagnosis for 1 of 2 residents reviewed for PASRR (Resident #3). Findings included: Review of Resident #3's medical records revealed the only evidence of a PASRR was a snapshot of the most recent evaluation completed on 07/28/22 and Resident #3 was determined as a Level I PASRR. Resident #3 was admitted to the facility on 03/29/24 with diagnosis which included bipolar disorder. The admission Minimum Data Set (MDS) assessment dated 04/05/24 revealed Resident #3 was not currently considered by the state Level II PASRR process to have serious mental illness and/or	F0645	Continued from page 11 Director of Nursing/Administrator oversight added to admission review. New staff will be required to review the education prior to the start of their assignment. 4. Monitoring Audit of 100% of new admissions x 4 weeks, then monthly x 2 months completed by Social Worker Verification of PASRR compliance by Social Worker Results reported to Quality Assurance and Performance Improvement Committee. All corrective actions and audits will be reviewed by the QAPI Committee monthly for 3 months Any trends or repeat issues will trigger: Additional staff education Policy revision Disciplinary action if warranted 5. Completion Date All audits and education were completed and brought to compliance by 4/23/2026.	04/23/2026

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F0645 SS = D	Continued from page 12 intellectual disability or a related condition. The MDS revealed Resident #3 had an active bipolar disorder diagnosis and received antipsychotic medication on a routine basis only. Review of the physician's order dated 04/11/24 was for a psychiatric referral made for antipsychotic medication management. Review of Mental Health Psychiatric Nurse Practitioner (NP) medication management progress note dated 05/12/24 revealed Resident #3 was evaluated to have an active bipolar disorder diagnosis. Review of a Mental Health NP medication management progress note dated 03/17/26 revealed Resident #3 was evaluated for an active psychiatric diagnosis of bipolar disorder and recommended to continue the current treatment that included aripiprazole (antipsychotic) 7.5 milligrams (mg) at bedtime and bupropion (antidepressant) 300 mg extended release 24 hours. Review of the annual MDS assessment dated 04/01/26 revealed Resident #3 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS revealed Resident #3 was taking antipsychotic medications on a routine basis only and an antidepressant medication. Resident #3's comprehensive care plan revised on 04/06/26 included the use of psychotropic medications related to a bipolar disorder diagnosis with the goal to be free from psychotropic drug related complications through the review date. Interventions included to monitor, document, and report any adverse reactions of psychotropic medications. During an interview on 04/08/26 at 4:40 PM, the Social Worker (SW) revealed she had been in her position for five years and was responsible for ensuring newly admitted residents had a PASRR prior to their admission. She was aware Resident #3 had an active bipolar disorder diagnosis and was referred to psychiatric services. She explained no request for a Level II PASRR evaluation was made when Resident #3 was admitted on 03/29/24 because the resident did not demonstrate behaviors. She stated it was her understanding when a resident demonstrated behaviors, she needed to request an evaluation for Level II PASRR. The SW revealed she was not aware an evaluation for a Level II PASRR	F0645		04/23/2026

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F0645 SS = D	Continued from page 13 was needed when a resident was admitted with a mental health diagnosis and had a Level I PASRR. The SW confirmed on 02/28/24 she checked the North Carolina PASRR website prior to Resident #3's admission to ensure the resident had a PASRR but after 02/28/24 no request for a Level II PASRR evaluation had been made. During an interview on 04/10/26 at 3:12 PM, the Administrator confirmed no request was made for a Level II PASRR evaluation when Resident #3 was admitted on 03/29/24 with a mental health diagnosis. The Administrator stated going forward mental health diagnoses would be reviewed for newly admitted residents and if present a request would be made for a Level II PASRR evaluation.	F0645		04/23/2026
F0712 SS = D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident was seen by the physician within 30 days from admission for 1 of 1 sampled resident (Resident #2). Findings included:	F0712	F0712 – Physician Visits 1. Corrective Action for Affected Resident Resident #2 was seen by the physician on 4/21/2026. Documentation completed in EMR by physician and Nurse Team Lead. 2. Identification of Other Residents Audit of all residents admitted in the last 90 days conducted on 4/10/26 by the Nurse Team Leads to ensure physician visits met required timeframes. No other overdue visits were identified at that time. 3. Systemic Changes Physician visit tracking system revised on 4/13/26 and completed by Team Lead Nurses: Separate tracking for physician-required visits vs. NP/PA visits EMR report modified to flag residents requiring physician visit within regulatory timeframe.	04/23/2026

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F0712 SS = D	Continued from page 14 Resident #2 was admitted to the facility on 02/10/26 with diagnoses that included Alzheimer's disease, dementia with agitation, diabetes, severe-protein calorie malnutrition, chronic kidney disease, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 03/04/26 indicated Resident #2 had severe cognitive impairment. Review of Resident #2's electronic medical record (EMR) revealed no evidence he was seen by the physician. Review of Resident #2's EMR revealed he was seen by the Physician Assistant (PA) on 02/10/26 and the Nurse Practitioner (NP) on 03/05/26. During an interview on 04/10/26 at 11:33 AM, the Nurse Team Lead revealed she was responsible for keeping track of when physician regulatory visits were due. The Nurse Team Lead explained she ran a report from the computer system that listed the date residents were last seen by a provider (NP, PA or Physician,) manually marked the provider who conducted the visit on the report and then let the provider know what residents needed to be seen the next time the provider was at the facility. She stated once the resident was seen by the provider, she entered the date in the computer system. The Nurse Team Lead explained that typically the physician saw a resident for the initial admission visit; however, when the physician was at the facility on 02/25/26, Resident #2 did not show up on the list to be seen because the NP and PA had already seen him. She confirmed Resident #2 had not yet been seen by the physician and acknowledged it was an oversight. During an interview on 04/10/26 at 3:15 PM, the Administrator revealed the Nurse Team Lead was responsible for tracking when physician visits were due. The Administrator confirmed that although Resident #2 had been seen by both the NP and PA, he had not yet been seen by the physician. She explained the Nurse Team Lead was typically very good with keeping track of physician visits that were due but since Resident #2 was seen by both the NP and PA shortly after his admission, he did not appear on the physician-visit list and was inadvertently overlooked.	F0712	Continued from page 14 Nurse Team Leads, Medical Director, physician, mid-level providers and Director of Nursing re-educated on CMS requirements, physician visit tracking system, EMR report, audit process, and reporting requirements on 4/21/26 by the Administrator. Staff not present were required to review the education prior to the start of their next shift. 4. Monitoring Weekly audit of physician visit compliance x 4 weeks, then monthly x 2 months completed by Team Leads Results reviewed in Quality Assurance and Performance Improvement Committee meetings All corrective actions and audits will be reviewed by the QAPI Committee monthly for 3 months Any trends or repeat issues will trigger: Additional staff education Policy revision Disciplinary action if warranted 5. Completion Date All audits and education were completed and brought to compliance by 4/23/2026.	04/23/2026