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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345558**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Black Mountain	**62 Lake Eden Road , Black Mountain, North Carolina, 28711**

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/01/25 through 12/04/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DC99E-H1.	E0000		12/15/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/01/25 through 12/04/25. Event ID# 1DC99E-H1. The following intakes were investigated 735346, 735348, 735350, 735352, and 735354. 11 of 11 complaint allegations did not result in a deficiency.	F0000		12/15/2025
F0645 SS = E	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-	F0645	The facility failed to complete PASARR re-evaluations for Resident #48, Resident #71, Resident #7, and Resident #73 after serious mental health disorder diagnosis was added. On December 10th, 2025, the Social Services Assistant (SSA) submitted PASARR re-evaluations on Resident #48, Resident #71, Resident #7, and Resident #73. Social service assistant has received the submission tracking page and will maintain a copy in the social service office. On December 8th, 2025, through December 12th, 2025, all residents were audited for serious mental health disorders and/or intellectual disabilities by the Administrator, Director of Nursing, Assistant Director of Nursing, Licensed Clinical Social Worker, Social Services Assistant, Nurse Navigator, and Quality Improvement Performance Nurse. The findings of the audit concluded with fifty residents that could have a PASARR re-evaluation due. All residents that have a diagnosis for a serious mental health disorder and/or intellectual disabilities will be submitted for a PASARR re-evaluation by the Social Services Assistant. All residents' submissions will be completed by December 29th, 2025, and SSA will maintain the tracking page.	12/30/2025

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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F0645 SS = E	Continued from page 1 (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. (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 an evaluation	F0645	Continued from page 1 On December 4th, 2025, the Administrator was educated by the State Survey Team that any resident that had a serious mental health disorder or intellectual disability must have a PASARR re-evaluation to ensure that resident has the proper PASARR determination level. On December 5th, 2025, the Medical Records Director, Admissions Director, Licensed Clinical Social Worker, Social Services Assistant and Nursing Administration Team was provided education on PASARR re-evaluations when an individual is considered to have a serious mental health disorder or an intellectual disability by the Administrator. This education will be added to orientation for social service department. The facility does not utilize agency staff. To ensure Quality Assurance, physician and/or physician extender notes will be reviewed 5 days a week by the Medical Records Director, Licensed Clinical Social Worker and the Director of Nursing for any new serious mental health disorder and/or intellectual disabilities diagnoses. Beginning on December 22nd, 2025, a PASARR audit will be performed bi-weekly by the Licensed Clinical Social Worker for two months and then monthly for two months to ensure each resident has the proper PASARR screening or re-evaluation. Licensed Clinical Social Worker will track and trend results and will bring findings to the Quality Assurance Performance Improvement meeting for 4 months or until compliance is maintained. All corrective action will be completed on or before December 30th, 2025.	

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F0645 SS = E	Continued from page 2 for a Level II Preadmission Screening and Resident Review (PASRR) determination for residents with serious mental health disorders for 4 of 6 residents reviewed for PASRR (Resident #48, Resident #71, Resident #7, and Resident #73). Findings included: 1. A PASRR Determination Notification letter dated 04/14/22 revealed Resident #48 had a Level I PASRR with no expiration date. Resident #48 was admitted to the facility on 06/06/22 with diagnoses that included vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #48's list of cumulative diagnoses revealed active diagnoses of Post Traumatic Stress Disorder (PTSD), major depressive disorder, delusional disorder, restlessness and agitation. A care plan last revised on 11/12/25 revealed Resident #48 was at risk for PTSD related his to Navy service during the Vietnam war and active diagnoses of PTSD, depression, insomnia, delusional disorder, and vascular dementia. Interventions included nightmares were triggers and to assist Resident #48 in identifying situations that trigger traumatic feelings. The annual Minimum Data Set (MDS) assessment dated 08/06/25 revealed Resident #48 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #48's active psychiatric/mood disorder diagnoses included anxiety disorder and PTSD. He received antianxiety, antidepressant and anticonvulsant medications during the MDS assessment period. Review of Resident #48's medical record revealed there was no Level II PASRR evaluation. A Psychiatric progress note dated 10/09/25 revealed Resident #48 was seen for follow-up of vascular dementia with mood disturbance that was severe, chronic and progressive. He was taking sertraline (antidepressant) daily for mood disturbance and lamotrigine (anticonvulsant). It was noted Resident #48 had been doing much better since starting lamotrigine and no changes to the medication was needed. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR determination had been submitted for Resident #48.	F0645		

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F0645 SS = E	Continued from page 3 During an interview on 12/02/25 at 4:48 PM with the Administrator present, the Social Worker (SW) revealed since taking over the PASRR process in April 2025, she had not submitted a request for an evaluation for a Level II PASRR determination for any resident. During a follow-up interview on 12/04/25 at 1:30 PM, the SW explained when the previous SW moved to Admissions and then left employment shortly thereafter, she wasn’t really shown what to do regarding PASRR and up to this point, she had not known what to look for or when a Level II PASRR re-evaluation request needed to be submitted. During an interview on 12/04/25 at 2:00 PM, the Administrator revealed she started employment at the facility in April 2025 and was not sure if requests for evaluations for Level II PASRR determinations had been submitted for Resident #48 or any resident since they were unable to locate any documentation. The Administrator stated she would expect the SW to submit a request for an evaluation for a Level II PASRR determination if a resident was admitted with a mental health diagnosis and had a Level I PASRR or when a new mental health diagnosis was later identified. 2. A PASRR Determination Notification letter dated 04/19/21 revealed Resident #71 had a Level I PASRR with no expiration date. Resident #71 was admitted to the facility on 12/02/22 with diagnoses that included atrial fibrillation, hypertension and chronic obstructive pulmonary disease. Review of Resident #71’s cumulative diagnoses revealed the following active diagnoses: depression, bipolar disorder, and anxiety disorder due to known physiological condition. Review of Resident #71’s medical record revealed there was no Level II PASRR evaluation. A Psychiatric progress note dated 07/16/25 revealed Resident #71 was seen for follow-up of bipolar disorder, currently in remission. It was noted Resident #71’s bipolar disorder appeared to be well-managed on current medications of sertraline (antidepressant) and lamotrigine (anticonvulsant). No changes were made to the medications. The annual Minimum Data Set (MDS) dated 09/12/25 revealed Resident #71 was not currently considered by the state Level II PASRR process to have a serious	F0645		

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F0645 SS = E	Continued from page 4 mental illness or intellectual disability. Resident #71's active psychiatric/mood disorder diagnoses included depression (other than bipolar) and bipolar disorder. He received antidepressant and anticonvulsant medications during the MDS assessment period. A physician progress note dated 10/14/25 revealed Resident #71 had a past medical history of bipolar disorder, and his current medications included sertraline 50 milligrams (mg) and lamotrigine 25 mg every morning. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR determination had been submitted for Resident #71. During an interview on 12/02/25 at 4:48 PM with the Administrator present, the Social Worker (SW) revealed since taking over the PASRR process in April 2025, she had not submitted a request for an evaluation for a Level II PASRR determination for any resident. During a follow-up interview on 12/04/25 at 1:30 PM, the SW explained when the previous SW moved to Admissions and then left employment shortly thereafter, she wasn't really shown what to do regarding PASRR and up to this point, she had not known what to look for or when a Level II PASRR re-evaluation request needed to be submitted. During an interview on 12/04/25 at 2:00 PM, the Administrator revealed she started employment at the facility in April 2025 and was not sure if requests for evaluations for Level II PASRR determinations had been submitted for Resident #71 or any resident since they were unable to locate any documentation. The Administrator stated she would expect for the SW to submit a request for an evaluation for a Level II PASRR determination if a resident was admitted with a mental health diagnosis and had a Level I PASRR or when a new mental health diagnosis was later identified. 3. A PASRR Determination Notification letter dated 10/13/23 revealed Resident #7 had a Level I PASRR with no expiration date. Resident #7 was admitted to the facility on 12/30/24 with diagnosis that included Post-Traumatic Stress Disorder (PTSD), adjustment disorder with depressed mood (a mental health reaction to a major stressor characterized by sadness, hopelessness, tearfulness, and low energy), depression, and anxiety. Review of a psychotherapy note dated 4/8/25 revealed	F0645		

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F0645 SS = E	Continued from page 5 Resident #7 was being treated for major depressive disorder, chronic post-traumatic stress disorder, and generalized anxiety disorder. Goals of treatment were to process grief and loss issues. Increase Adjustment to loss of function as indicated by treatment team feedback and resident feedback. Decrease depression by 25% as indicated by the treatment team feedback, improved measure of depression score, and resident feedback. The quarterly MDS assessment dated 9/19/25 revealed Resident #7 was not currently considered by the state Level II PASRR process to have serious mental or intellectual disability. Resident #7's active psychiatric/mood disorder diagnosis included anxiety disorder, depression, adjustment disorder with depressed mood, and PTSD. Resident #7 received antidepressant and anticonvulsant medications during the MDS assessment period. Review of the care plan last revised on 10/02/25 revealed Resident #7 was at risk for complications related to post traumatic stress disorder related to his military time in the United States Marine Core (USMC). He denies having any triggers but reports that he exercises daily to help with his mental and physical state. Goals included Resident #7 will use effective coping mechanisms to manage post-traumatic stress disorder through the next review. Resident #7 joined the USMC and was in Force Recon/Special Forces. Resident #7 was sent to Vietnam where he served. He additionally served in France, Italy and Greece as a mercenary. Interventions included Resident #7 liked all music except opera, he was a drummer in a band and played football. Resident #7 liked Chinese food and chicken wings, but not fish, and was Baptist. Staff could use these things for diversion/redirection as needed. Obtain a psychiatric consult/psychosocial therapy as indicated. Administer medications per orders. Monitor and record for effectiveness. Monitor and report any adverse side effects. Encourage Resident #7 to verbalize his feelings and fears. Maintain a calm environment to approach Resident #7. Assess if PTSD endangers him and/or others. Intervene if necessary. Review of Resident #7's medical record revealed there was no Level II PASRR evaluation. A psychiatry progress note dated 11/26/25 revealed Resident #7 was being treated for major depressive disorder and anxiety disorder. Resident #7 was doing well at this time, and no changes needed to be made to his treatment plan. Resident #7 was taking Lamictal 50 MG (An anticonvulsant and mood stabilizing medication)	F0645		

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F0645 SS = E	Continued from page 6 daily, Wellbutrin 150 MG (a medication used to treat major depressive disorder) daily, and mirtazapine 30 MG (A medication used to treat major depressive disorder) at night for appetite stimulation and depression. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR determination had been submitted for Resident #7. During an interview on 12/02/25 at 4:48 PM with the Administrator present, the Social Worker (SW) revealed since taking over the PASRR process in April 2025, she had not submitted a request for an evaluation for a Level II PASRR determination for any resident. During a follow-up interview on 12/04/25 at 1:30 PM, the SW explained when the previous SW moved to Admissions and then left employment shortly thereafter, she wasn't really shown what to do regarding PASRR and up to this point, she had not known what to look for or when a Level II PASRR re-evaluation request needed to be submitted. During an interview on 12/04/25 at 2:00 PM, the Administrator revealed she started employment at the facility in April 2025 and was not sure if requests for evaluations for Level II PASRR determinations had been submitted for Resident #7 or any resident since they were unable to locate any documentation. The Administrator stated she would expect the SW to submit a request for an evaluation for a Level II PASRR determination if a resident was admitted with a mental health diagnosis and had a Level I PASRR or when a new mental health diagnosis was later identified. 4. A PASRR Determination Notification letter dated 05/11/23 revealed Resident #73 had a Level I with no expiration date. Resident #73 was admitted to the facility on 10/11/23 with diagnosis that included post-traumatic stress disorder (PTSD) and adjustment disorder with depressed mood. A significant change in status Minimum Data Set (MDS) assessment dated 05/19/25 indicated Resident #73 was not considered by the PASRR process to have a serious mental illness. The MDS active diagnoses checked for psychiatric/mood disorders were PTSD and depression. The medications Resident #73 was taking included an antidepressant. The care plan last revised on 10/27/25 revealed	F0645		

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F0645 SS = E	Continued from page 7 Resident #73 was at risk for complications of post-traumatic syndrome related to his service in the Navy, diagnoses of PTSD, insomnia, depression, and anxiety. The care plan indicated there were no known triggers identified. Interventions included to assist with identifying situations that may trigger traumatic feelings, report and document signs and symptoms of post-traumatic syndrome such as social isolation, detachment, guilt, flashbacks, hyper-vigilance, and poor concentration, and obtain a psychiatric consult or psychosocial therapy as indicated. A Psychiatry progress note dated 11/12/25 revealed Resident #73 was seen for major depressive disorder that was recurrent and moderate, PTSD that was chronic, and psychophysiological insomnia that was moderate and chronic. Resident #73 was taking trazodone (antidepressant) at bedtime as needed for managing insomnia and noted to be stable, doing well, and had denied experiencing or re-experiencing trauma. The treatment plan was to continue the current medication regimen and alert provider to any decompensations. Resident #73's active physician orders included trazodone 25 milligrams at bedtime as needed for insomnia. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR determination had been submitted for Resident #73. During an interview on 12/02/25 at 4:48 PM in the presence of the Administrator, the Social Worker (SW) revealed since she took over PASSR in April 2025 she had not submitted a request for an evaluation for a Level II PASRR review for Resident #73. During a second interview on 12/04/25 at 1:30 PM, the SW revealed she was not shown how or what to do related to PASRR and did not know when a referral for a Level II review needed to be submitted or what to look for. During an interview on 12/04/25 at 2:00 PM, the Administrator revealed that since she started her employment at the facility in April 2025, she was not sure if request for evaluations for Level II PASRR determination had been submitted for any resident and was unable to locate the documentation. The Administrator stated she would expect the SW to submit a request for an evaluation for a Level II PASSR determination when a resident was admitted with a mental health diagnosis and had a Level I PASRR or when a new mental health diagnosis was identified.	F0645		
F0880 SS = D	Infection Prevention & Control	F0880	F880 Infection Prevention and Control	12/30/2025

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F0880 SS = D	Continued from page 8 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0880	Continued from page 8 On December 1st, 2025, Nurse Aide #1 did not follow personal protective equipment (PPE) for droplet-contact isolation precautions when entering Resident #14's room who had tested positive for influenza. Resident #14 was removed from droplet contact isolation precaution on 12/2/25. On December 1st, 2025, education on infection prevention and control and following all signage precautions with usage of proper PPE was completed with Nurse Aide #1 by the Infection Preventionist (IP) register nurse. Audit completed on 12/2/25 by Director of Health Service, there are twelve residents who are on enhanced barrier precautions and two residents who are on droplet contact precaution. The two droplet contact precautions residents were removed from isolation on 12/2/25 later in the day. All residents have potential to be affected by PPE noncompliance. The IP RN and Clinical Competency Coordinator made walking rounds observing the fourteen residents' rooms in the facility on 12/2/25 to ensure the staff were performing properly PPE compliance. No other staff were noted out of compliance with proper PPE donning and doffing per isolation precaution signage. Education for 100% facility staff on infection prevention and control and following proper PPE per isolation signage precautions was completed by the Infection Preventionist on December 1st, 2025, through December 2nd, 2025, to ensure that other staff and residents were not at risk for deficient practice. Any staff on FMLA or paid time off will receive education prior to returning to work by Clinical Competency Coordinator. This education has been added to orientation. The facility does not utilize agency staff. On December 8th, 2025, through December 12th, 2025, all staff performed proper donning and doffing of personal protective equipment related to specific isolation signage with the Clinical Competency Coordinator. The Clinical Competency Coordinator provided immediate feedback or corrective action if it was needed. Any staff on FMLA or paid time off will receive education prior to returning to work by Clinical Competency Coordinator. This education has been added to	

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F0880 SS = D	Continued from page 9 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to implement their infection control policy and procedures when a Nurse Aide (NA) did not follow droplet-contact isolation precautions before entering Resident #14's room who had tested positive for influenza. This occurred for 1 of 3 staff members reviewed for infection control (NA #1). Findings included: The facility's Infection Control Policy and Procedure Measures for Influenza (Flu) last revised on 02/26/25 read in part, "Residents will be placed on droplet-contact precautions for 7 days and can be taken off on day 8 if symptoms are improved and afebrile (no fever) for the last 24 hours of isolation period." A review of the test results dated 11/24/25 revealed Resident #14 was positive for influenza A. An observation of meal tray service was conducted on 12/01/25 at 12:44 PM. A droplet-contact precaution sign was posted on the door of Resident #14's room with	F0880	Continued from page 9 orientation for all departments. The facility does not utilize agency staff. To ensure Quality Assurance, all new hires will continue to be educated by the Clinical Competency Coordinator on infection prevention and control during orientation and demonstrate proper donning and doffing prior to transferring to their department. Infection prevention and control education will be added to the monthly all staff meeting agenda and this will be an on-going practice for the facility. Beginning December 15th, 2025, ten random residents' rooms who are on isolation precautions will be monitored focusing on staff for proper personal protective equipment compliance weekly by the Clinical Competency Coordinator or nurse manager for six weeks, five residents' rooms who are on isolation precautions will be monitored focusing on staff for proper personal protective equipment weekly for four weeks and two residents' room who are on isolation precautions will be monitored focusing on staff for proper personal protective equipment weekly for two weeks. Clinical Competency Coordinator will track and trend results and will present and discuss in the Quality Assurance Performance Improvement Meeting monthly for 4 months or until compliance is reached. All corrective action will be completed on or before December 30th, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 10 directions to follow the instructions before entering the room. The instructions included everyone must clean hands before entering and when leaving, wear a gown, a face mask, and gloves when entering and remove before leaving. A storage bin was placed beside the door that contained face masks and disposable gowns and gloves. An alcohol-based hand sanitizer dispenser was placed on top of the storage bin and available for use. NA #1 had on a face mask, knocked on Resident #14's door, entered the room, and placed the meal tray on the overbed table in front of the resident then left the room. NA #1 did not clean her hands or wear a gown and gloves before entering the room as listed on the instructions. During an interview on 12/01/25 at 12:44 PM, NA #1 revealed she had received infection control training that included isolation precautions and the use of personal protective equipment (PPE). NA #1 revealed she entered the room to deliver the meal tray and then left. NA #1 acknowledged the droplet-contact sign on Resident #14's door and PPE storage bin located by the door and stated she should have followed the instructions listed on the sign before she entered the room but had forgotten. An interview was conducted on 12/03/25 at 3:23 PM with the Infection Preventionist. The Infection Preventionist revealed Resident #14 tested positive for influenza and droplet-contact precautions were implemented on 11/24/25. The Infection Preventionist revealed NA #1 was expected to read the precaution signs posted on resident doors and follow the instructions before entering the room. During an interview on 12/04/25 at 1:11 PM, the Director of Nursing (DON) revealed she expected NA #1 to read the sign posted on Resident #14's door and follow the instructions for droplet-contact precautions before entering the resident's room. During an interview on 12/04/25 at 1:54 PM, the Administrator revealed NA #1 was expected to read the sign posted on Resident #14's door and to follow the instructions for droplet-contact precautions before entering the room.	F0880		