STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	**1601 Brenner Ave., Building #10 , Salisbury, North Carolina, 28145**

(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
E0001	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:	E0001	Corrective action for the residents found to be affected by the deficient practice. On 1/4/2026 the administrator began pulling information needed to be added to the emergency preparedness binder in order to correct the deficient practice. A. The EP (emergency preparedness) plan did not address patient/client population, including, but not limited to, people at-risk; the type of services the Long-Term Care (LTC) facility could provide in an emergency; and continuity of operations. a. On 1/7/2026 the facility added a facility profile sheet that includes patient/client population. b. On 1/8/2026 a brief description of services the long-term care facility could provide in an emergency is included in the sheltering mutual aid sharing agreements. B. The EP plan did not have a policy/procedure to address medical and pharmaceutical supplies, sewage, and waste disposal. a. On 1/7/2026 the facility added a policy/procedure for sewage and waste disposal. b. On 1/7/2026 the facility also developed an agreement with a local waste disposal service to utilize in case of an emergency. c. On 1/7/2026 the facility added a policy for pharmaceutical supplies during an emergency event. d. The facility also added a medical supplies inventory log on 12/18/2025 that is to be updated on a monthly basis.	01/13/2026

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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E0001	Continued from page 1 This CONDITION is NOT MET as evidenced by: Based on record review, and staff interviews, the facility failed to maintain an Emergency Preparedness (EP) Program by not addressing patient/client population, including, but not limited to, persons at-risk; the type of services the Long Term Care (LTC) facility has the ability to provide in an emergency; and continuity of operations, no policy/procedure to address medical and pharmaceutical supplies, sewage and waste disposal; no system to track the location of on-duty staff; no transportation plan, identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance; no development and maintaining an EP communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually; communication plan did not include residents' physicians and/or other LTC facilities; no means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This deficient practice had the potential to affect all residents and staff. The Findings included: The facilities Emergency Preparedness (EP) program dated for August 2025 was reviewed and revealed: a. The EP plan did not address patient/client population, including, but not limited to, people at-risk; the type of services the Long-Term Care (LTC) facility could provide in an emergency; and continuity of operations. b. The EP plan did not have a policy/procedure to address medical and pharmaceutical supplies, sewage and waste disposal. c. The EP plan did not have a system to track the location of on-duty staff. d. The facility's EP plan did not address transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. e. The Development and maintaining an EP communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually was not present.	E0001	Continued from page 1 C. The EP plan did not have a system to track the location of on-duty staff. a. On 1/7/2026 the facility added a tool to use when tracking on-duty staff during an emergency event. D. The facility's EP plan did not address transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. a. On 1/7/2026 the facility added a document stating what transportation to use in the event of an emergency and included a mutual agreement with a transportation company to use for non-emergent transport. Also included a policy from parent company that would provide other transportation resources in the event of an emergency. b. Facility is purchasing a satellite phone as an alternate means of communication if primary means fails there is also other alternate means of communication listed in the communications policy which is located in the facility's EP binder. E. The Development and maintaining an EP communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually was not present. a. The facility will have the maintenance director review emergency manual upon orientation with new staff and bi-annually with all current staff during bi-annual skills fair meetings. b. Facility will also continue to hold quarterly meetings to discuss and update emergency preparedness plan. Administrator and the Maintenance Director reviewed the EP plan on 1/8/2026. F. The facility's EP plan did not have a communication	

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E0001	Continued from page 2 f. The facility's EP plan did not have a communication plan that included residents' physicians and/or other LTC facilities. g. The EP plan did not have a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. The Administrator and the Maintenance Director were interviewed on 12/12/25 at 11:00am. The Administrator discussed the EP binder being reviewed quarterly by the management staff. The Administrator assisted in reviewing and finding information in their EP binder. He was observed having to pull information from other areas and stated he was unaware all the information needed to be centralized in his EP binder. The Administrator was unable to locate/produce the above-mentioned items, and he stated he was unaware those items were required as part of the EP program.	E0001	Continued from page 2 plan that included residents' physicians and/or other LTC facilities. a. On 1/7/2026 the facility included a directory of the facility's medical director's phone number and local long-term care facilities. G. The EP plan did not have a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. a. On 1/8/2026 a line of communication has been established with Allyson Summitt, Interim- Fire Division Chief / Fire Marshal and Planner, Rowan County Emergency Management for the purpose of communicating the facility's occupancy, needs, and its ability to provide assistance during an emergency situation. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice in an emergency situation. Systemic changes made to ensure that the deficient practice will not recur. On 1/8/2026 the administrator, maintenance director, and director of health services were educated by the Regional Nurse Consultant on all items necessary to maintain an Emergency Preparedness program. On 1/9/2026 the maintenance director started education for all current facility staff on the Emergency Preparedness plan and its location in the administrator's office. Anyone on paid time off (PTO) or Family Medical Leave Absent (FMLA) will receive education prior to the start of their next shift by Maintenance Director. The facility does not currently utilize agency	

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E0001		E0001	Continued from page 3 staffing. The maintenance director will review the EP plan during orientation for new hires. Plans to monitor its performance to make sure that the solutions are sustained. The administrator and maintenance director will audit the Emergency Preparedness Program to ensure all items that were found to be missing during the annual survey are present weekly for four weeks and then monthly for eight weeks. The Maintenance Director will track and trend the EP plan and any findings during the audits will be taken to the Quality Assurance and Performance Improvement (QAPI) meetings on a monthly for 3 months or until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 1/13/2026	
F0000	INITIAL COMMENTS A recertification and complaint survey was conducted from 12/08/25 through 12/12/25. The following intakes were investigated 874886, 874888, 2674318, 2656476, and 874884. 2 of the 9 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity J Immediate Jeopardy began on 12/09/25 and was removed on 12/11/25.	F0000		01/04/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F0550	Corrective action for the residents found to be affected by the deficient practice: 1. NA #3 was removed from Resident #13's assignment immediately upon report of occurrence and suspended from further assignments pending investigation	01/13/2026

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F0550 SS = D	Continued from page 4 self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to honor a resident's request for a shower to be stopped when the resident told Nursing Assistant (NA) #3 to stop because he was "man handling" him. Resident #13 stated he was fearful of NA #3 and felt like no one was listening to him when he told staff about the incident. Additionally, the facility failed to maintain a resident's dignity by not placing a privacy/ dignity cover over his urine collection bag exposing his urine which was visible from the hallway to other residents,	F0550	Continued from page 4 completion on 10/4/25. Resident #13 was followed up by the Director of Health Services (DHS) about two additional showers on 10/6/25 and 10/16/25 which were provided by Certified Nursing Assistant (CNA) to confirm he was treated well and comfortably and voiced no complaints. He reported to Director of Health Services (DHS) per interview on 10/6/25 and 10/16/25 no other incidents of asking a care provider to stop a procedure and them not stopping. Social Service Director (SSD) interviewed resident #13 on 01/06/26 and resident denied any further issues with roughness nor requested staff to stop a shower. NA #3 was terminated on 11/17/25. 2. The floor nurse on 12/12/25 provided a privacy/dignity cover for Resident #3 indwelling catheter bag to prevent the visualization of urine by anyone within sight of the catheter bag. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. All residents with a Brief Interview of Mental Status (BIMS) of eight or greater were interviewed for feelings of being unsafe or other incidents of "rough" handling on 01/06/26 – 01/07/26 by the SSD. The review of skin assessments for residents with a BIMS of 7 or below by Assistant Director of Health Services (ADHS) was performed on 01/07/26-01/08/26 with no significant findings. There were no findings to indicate other residents were handled "roughly" such as discolorations or areas with pain or was there any documentation of an occurrence where the resident requested the procedure to be stopped and staff failure to respect the residents requires. Seventeen residents in the building with an indwelling catheter were confirmed as having a privacy/dignity cover for their catheter bag as of 12/12/25 per observation by the Director of Health Services (DHS) and ADHS.	

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F0550 SS = D	Continued from page 5 staff and visitors. This occurred for 2 of 3 residents reviewed for dignity (Resident #13 and Resident #3). The findings included: 1. Resident #13 was admitted to the facility on 7/30/25 with diagnoses that included chronic pain and dementia. The admission Minimum Data Set (MDS) dated 8/5/25 revealed Resident #13 was moderately cognitively impaired. The MDS documented the resident as having behavioral symptoms not directed towards others for 4-6 days during the look back period. Resident #13 was also documented as being dependent on staff for toileting and bathing. Resident #13's active care plan edited on 10/28/25 revealed resident needed extensive to dependent assistance with most activities of daily living. The goal for Resident #13 was that he would have safe transfers. The interventions included encourage participation with activities of daily living, do not rush resident, provide extensive assistance as needed. Resident #13 was interviewed on 12/8/25 at 4:18pm. Resident #13 discussed NA #3 was "rough" with him a "couple of months ago." Resident #13 stated it started when NA #3 transferred him from his wheelchair onto the shower chair. He stated NA #3 handled him roughly. Resident #13 explained he told NA #3 to stop being rough with him, but the NA did not listen. He stated throughout his shower NA #3 was "man handling" and being "rough." He stated he told NA #3 to stop because he was hurting him, but NA #3 did not stop or say anything. Resident #13 explained once he was back in his room, he told people what happened (could not remember who) but no one was listening to him. He stated he was fearful of NA #3 and upset no one was listening. Resident #13 stated NA #3 had not been assigned to him since the incident. During a telephone interview with NA #3 on 12/11/25 at 8:44am, NA #3 confirmed he had been assigned to Resident #13 on 10/2/25 and provided Resident #13 with a shower. NA #3 described the incident saying as soon as he began to transfer Resident #13 from his wheelchair to the shower chair, Resident #13 began yelling telling him to stop and saying NA #3 was "man handling him." NA #3 stated he proceeded to take Resident #13 to the shower and once the water was adjusted right, he put soap on the washcloth and began washing Resident #13. NA #3 explained Resident #13 began telling him to stop and saying NA #3 was being too "rough." NA #3 stated he rinsed Resident #13 off,	F0550	Continued from page 5 Systemic changes made to ensure that the deficient practice will not recur: Education will be provided to 100% of all facility staff starting 01/08/26 by the DHS, ADHS, Dietary Manager, Maintenance Director, Business Office Manager, and Environmental Director regarding honoring what the patient feels is too hard or too rough when providing activity of daily living (ADL) care and honoring the directive to STOP the procedure if the resident says to stop. If staff observes roughness or hears a directive of stop given by the residents, they are to immediately report it to the floor nurse and/or nurse management. All facility staff will be provided with education regarding use of a privacy/dignity cover for any catheter bag to prevent visualization of urine by anyone within sight of the catheter bag by 01/12/2026. This training will be provided by the DHS, ADHS, Dietary Manager, Maintenance Director, Business Office Manager, and Environmental Service Director. This education includes ensuring the use of privacy covers whether the patient is in bed or in the wheelchair. This education will be included in orientation for all new hires. The facility does not use any agency staff. Education for staff on paid time off or Family Medical Leave Absent will be completed prior to their next scheduled shift by Clinical Competency Coordinator and/or nurse management. Plans to monitor its performance to make sure that the solutions are sustained. Audits conducted through interviewing five random residents weekly to also include weekends to assess concerns or complaints of mishandling or times when they asked to stop a procedure, but staff did not comply. Auditing will be performed by the DHS, ADHS, Social Service Director, Activity Director, and/or Nurse Manager and will begin 1/13/2026 for 12 weeks. Audits will be conducted randomly for five residents weekly, including weekends to assess compliance with the privacy/dignity covers for any resident with a catheter bag. Auditing will be performed by the DHS, ADHS, Social Worker, Activity Director, and/or Nurse	

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F0550 SS = D	Continued from page 6 got him dressed, and returned him to his room. NA #3 stated he never told a staff member or his supervisor what had occurred with Resident #13. He also stated he did not stop when the resident asked because he was not "man handling" him or being "rough." The Director of Nursing (DON) was interviewed on 12/12/25 at 2:14pm. The DON stated she would have wanted to know what happened between Resident #13 and NA #3 when it happened, not later. She also stated NA #3 should have stopped when Resident #13 had requested NA #3 to stop and treated the resident in a dignified manner. The DON confirmed the facility had removed Resident #13 from NA #3's assignment. The Administrator was interviewed on 12/12/25 at 2:58pm. The Administrator stated NA #3 should have stopped when requested by Resident #13 and reported the incident to the nurse. 2. Resident #3 readmitted to the facility on 11/05/2025. Resident #3's significant change Minimal Data Set (MDS) assessment dated 11/12/2025 revealed Resident #3 was severely cognitively impaired and had an indwelling catheter in place. Resident #3's care plan dated 11/05/2025 revealed he was at risk for rehospitalization related to recent hospital stay for urinary tract infection (UTI) and has an indwelling catheter in place. Interventions included staff to provide catheter care as ordered and staff to change catheter as ordered. An observation from the hallway was completed of Resident #3 on 12/09/2025 at 10:55 AM. Resident #3 was observed in bed resting. His bed was in a low position, and his urine collection bag was observed from the hallway. The urine collection bag was observed to be one fourth full of amber colored urine. Visitors, nursing staff (nurses and nurse aides), residents, and other staff (housekeepers) were observed passing Resident #3's room. An observation from the hallway was completed of Resident #3 during lunch meal service on 12/09/2025 at 1:41 PM. Resident #3 was observed in his bed, watching television, and eating his lunch meal. His urine collection bag was observed from the hallway with amber colored urine. The urine collection bag was one fourth full. Visitors, nursing staff (nurses and nurse aides), residents, and other staff (housekeepers) were observed	F0550	Continued from page 6 Manager and will begin 1/13/2026 for 12 weeks. Quality Improvement Coordinator with track and trend the audits for concerns of mishandling with ADLs, audits for asking to stop procedures but staff did not comply, and audits for assessing compliance with privacy/dignity covers for catheter bags and bring results to the Quality Assurance Performance Improvement (QAPI) monthly meeting x 3 months or until substantial compliance maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	

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F0550 SS = D	Continued from page 7 passing Resident #3's room. An interview with Nurse Aide (NA) #13 was completed on 12/09/2025 at 2:37 PM. NA #13 stated she has worked at the facility since October of 2025. NA #13 explained she had 2 residents with catheters, and she was responsible for emptying the urine collection bag when needed. She explained she generally emptied the urine collection bags on her assignment at the end of her shift (7:00 AM to 3:00 PM) to report to the nurse the resident's urinary output. NA #13 further stated she emptied the urine collection bags as needed as well. An observation of Resident #3 was completed with NA #13 at 2:42 PM. NA #13 stated she had just emptied Resident #3's urine collection bag and reported the urinary output to Nurse #9. NA #13 verbalized she had not noticed Resident #1's catheter bag not having a privacy/ dignity cover in place and his urine being visible from the hallway. NA #13 stated Resident #3 needed a privacy/ dignity cover, and she would inform Nurse #9. An interview was completed with Nurse #9 regarding Resident #3 on 12/09/2025 at 2:48 PM. Nurse #9 stated Resident #3 had a catheter in place and required a catheter bag for urine collection. Nurse #9 and this writer made an observation of Resident #3 from the hallway at 2:50 PM. Nurse #9 verbalized that Resident #3 did not have a privacy/ dignity cover on his urine collection bag. Light yellow colored urine was visible from the hallway in the urine collection bag. Nurse #9 explained Resident #3 had a recent procedure at the urology office and his catheter was changed while out of the facility. Nurse #9 continued to explain when Resident #3 returned from this procedure, staff should have made sure the privacy/ dignity cover was in place on his urine collection bag. Nurse #9 voiced the privacy/ dignity cover was important to maintain the resident's dignity and privacy. An interview was completed with Nurse #17 on 12/09/2025 at 2:55 PM who stated nurses were trained on dignity and ensuring Resident's privacy/ dignity was maintained when having a catheter with a urine collection bag was in place. Nurse #17 explained Resident #3 slipped through the cracks when he returned from his urology appointment. Nurse #17 stated Resident #3 would have a privacy/ dignity cover for his urine collection bag in place immediately. An interview was completed with Resident #3's Family Member via telephone call on 12/09/2025 at 3:47 PM. Resident #3's Family Member stated he (Resident #3) would not appreciate others being able to see his urine	F0550		

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F0550 SS = D	Continued from page 8 from the hallway. The Family Member stated they would prefer his urine collection bag to be covered to maintain his privacy/ dignity. The Family Member indicated they visited 2 to 3 times per month as their health allowed and could not recall if Resident #3's urine collection bag had been covered or not when they visited. An observation and interview was completed with the Director of Nursing (DON) on 12/10/2025 at 8:50 AM. Resident #3's urine collection bag remained uncovered and Resident #3's urine remained visible from the hallway. The DON stated nurses and nurse aides should check to make sure that privacy/ dignity covers on the urine collection bags were in place to maintain the resident's privacy/ dignity throughout their shift. Staff were trained on dignity inclusive of ensuring privacy/ dignity covers were in place for those residents that have urine collection bags. Staff were trained annually and upon hire on dignity and catheter care inclusive of ensuring the privacy/ dignity covers were in place. If a privacy/ dignity cover was missing from the urine collection bag, nurses and nurse aides should go to the supply room to obtain a replacement cover. The DON was not certain why Resident #3 did not have a privacy/ dignity cover in place after his procedure and return to the facility.	F0550		
F0575 SS = C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding	F0575	Corrective action for the residents found to be affected by the deficient practice: On 12/11/2025, the surveyor completed a walking tour of the facility related to all the required postings with the administrator. The administrator was able to locate and print the information posters for the State survey agency, adult protective services, state long term care ombudsman, the resident advocacy network, home and community based service programs, and contact for Medicaid fraud control and posted the information on the front hallway bulletin board on 12/11/2025 to correct the deficient practice. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. Systemic changes made to ensure that the deficient	01/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	**1601 Brenner Ave., Building #10 , Salisbury, North Carolina, 28145**

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F0575 SS = C	Continued from page 9 returning to the community. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all required state agencies and advocacy groups, including the State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. These observations occurred on 4 of the 5 days of the onsite recertification survey. The findings included: An observation completed on 12/08/2025 at 10:51 AM of the front hallway bulletin board revealed no signage in place for the State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An observation completed on 12/09/2025 at 11:43 AM of the front hallway bulletin board revealed no signage in place for State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An observation completed on 12/10/2025 at 9:55 AM of the front hallway bulletin board revealed no signage in place for State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local	F0575	Continued from page 9 practice will not recur: Regional nurse consultant provide education to the administrator, Activity Director, and Social Service Director on 1/7/2026 on the required postings that are needed to be always displayed in the facility. See attached/uploaded file titled NCVA Salisbury F0575 staff education for content and attendance sheet. Plans to monitor its performance to make sure that the solutions are sustained. Administrator will audit the bulletin board in the front hallway monthly until compliance is maintained to ensure that all required postings remain posted as resources to residents, staff, and visitors. All results of monitoring will be taken to the Quality Assurance Performance Improvement (QAPI) committee monthly until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	

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F0575 SS = C	Continued from page 10 Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An observation completed on 12/11/2025 at 8:30 AM of the front hallway bulletin board revealed no signage in place for State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An interview with the Recreation Director completed on 12/11/2025 at 9:17 AM revealed she put up Resident Rights posters with the local Ombudsman's contact information in the front lobby hall bulletin board and at each nurse's station. She explained she changed the local Ombudsman's contact information when a new person started earlier this year. She did not mention why the second-floor poster information hadn't been changed. The Recreation Director stated she didn't have anything to do with the other signs on the main bulletin board and wasn't sure who did but thought it might be the Social Worker. An interview with the Social Worker completed on 12/11/2025 at 9:26 AM revealed she wasn't the person who put the posting signs up on the front hallway bulletin board and didn't know if they were up to date. She stated the Administrator would know if any posting signs needed to be changed. An interview and walking tour was completed with Administrator on 12/11/2025 at 9:35 AM who explained the Recreation Director kept Resident's Rights and Ombudsman's information up to date in the front hallway bulletin board and at the two nurses' stations. The Administrator stated he thought current postings on the front hallway bulletin board had included what had been required but he would investigate it. The Administrator revealed the information for State Survey Agency, Adult Protective Services, State Long Term Care Ombudsman, and the Resident Advocacy Network, Home and Community Based Services Program, and Medicaid Fraud Control	F0575		

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F0575 SS = C	Continued from page 11 hadn't been posted since he had been the Administrator for over three years. He further explained there were also Resident Rights posters with the local Ombudsman's contact information on the upstairs and downstairs resident halls. He stated if something had changed, he would have let the social worker or someone know to make sure the updated information had been posted and hadn't realized the local Ombudsman's information hadn't been updated on the second-floor Resident Rights poster. During a follow up interview on 12/11/2025 at 4:15 PM, the Administrator stated it was important for residents, families and visitors to have access to information in the required postings in case they had any questions or concerns.	F0575		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0605	Corrective action for the residents found to be affected by the deficient practice: Resident #1 had additional records sought out through review of History and Physicals, Neurologist and Psychiatrist notes from outside providers were added to his in-house facility electronic medical record (EMR) to assist medical provider in providing a diagnosis that was most appropriate for the antipsychotic and antidepressant medications prescribed. Orders were provided 12/10/25 by the Physician extender to adjust the diagnoses for the medication usage for his antipsychotic and his antidepressant based on new medical records received. The antipsychotic medications had a gradual dose reduction then discontinued on 12/13/25. Depression disorder was added to his medical diagnosis on 12/10/25 after provided was able to review previous medical records from outside providers. Resident # 2 was on Haldol as needed; this medication was discontinued on 12/24/25. Resident #2 also had an updated diagnosis procured and updated in the electronic medical record on 12/10/25 by physician extender. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents who receive antipsychotic and/or antidepressants have the potential to be affected by the alleged deficient practice.	01/13/2026

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F0605 SS = D	Continued from page 12 §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F0605	Continued from page 12 Reports were pulled 12/10/25 by the Assistant Director of Health Services (ADHS) and physician extender of all residents receiving antipsychotics and antidepressants to ensure each resident had an appropriate diagnosis for the antipsychotic or antidepressant prescribed. If an PRN antipsychotic was prescribed, it was confirmed to have a 14 day stop date. All variances as of 12/10/25 were addressed with pharmacy and with the physician and/or physician extender for updated orders to include correct diagnosis. Physician extender reviewed eight residents with antipsychotics, and forty-two residents with antidepressants; after final review, there were thirty-seven residents that required an adjustment for diagnosis matching medication orders and updated diagnosis in the EMR. Systemic changes made to ensure that the deficient practice will not recur: Education will be provided to all licensed nurses by the Director of Health Services (DHS), ADHS, Quality Improvement Coordinator, and Clinical Competency Coordinator (CCC) by 01/12/26 to include that all psychotropic medications have to have an appropriate diagnosis and if not, we must contact the provider for next steps or clarification immediately; PRN antipsychotics have to have a 14 day stop date with NO EXCEPTIONS; non-pharmacological interventions, such as distraction, offering food/drink, decreasing noise level, dimming lights, repositioning, music therapy, etc., must be attempted and documented PRIOR to administration of a PRN psychotropic medication; there are only 4 diagnoses that are appropriate for use with an antipsychotic medication and the include schizophrenia, schizoaffective, Tourette's, and Huntington's Disease. This education will be added to orientation for all licensed nurses. This facility does not utilize agency staff. Education for staff on paid time off or Family Medical Leave Absent will be completed prior to their next scheduled shift by Clinical Competency Coordinator and/or nurse manager. Plans to monitor its performance to make sure that the	

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F0605 SS = D	Continued from page 13 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Consultant Pharmacist and Physician interviews, the facility failed to ensure Resident #2 had a diagnosis for the use of antipsychotic medication and the as needed (PRN) antipsychotic medication, Haldol, used to regulate mood, behaviors, and thoughts, had a stop date of 14 days. The facility also failed to ensure Resident #1 had a diagnosis for the use of antipsychotic medication and antidepressant medication. This occurred for 2 of 5 residents reviewed for unnecessary medications (Resident #2, and Resident #1). The findings included: 1. Resident #2 was admitted to the facility on 8/18/25 with diagnoses that included mild dementia with agitation, brief psychotic disorder and anxiety. The admission Minimum Data Set (MDS) dated 8/28/25 revealed Resident #2 was severely cognitively impaired. The MDS documented Resident #2 had physical behavioral symptoms directed towards others for 1 to 3 days during	F0605	Continued from page 13 solutions are sustained. The Facility Activity Report (FAR) which includes physician medication orders will be pulled by Senior Care Partner register nurse each morning, Monday through Friday with Monday's report including the weekend statistics, starting 01/13/26 and reviewed by the DHS, ADHS, and/or Nurse Managers for any new orders. Any new orders added are reviewed by the DHS, ADHS and/or nurse manager for appropriate diagnoses if an antipsychotic or an antidepressant is identified and any as needed antipsychotic medications have appropriate stop date. If any irregularities are identified, physician and/or physician extender will be notified, and clarification will be entered into EMR. This audit will be completed for 12 weeks. Weekly reports of 100% of all residents who receive antipsychotics or antidepressants medication will be pulled by the DHS or ADHS and audited for appropriate diagnoses starting 01/13/26. Pharmacy and physician and/or physician extender will be contacted immediately when an inappropriate diagnosis is identified from the reports and needs to be adjusted for prompt clarification and the EMR will be updated. Auditing these reports for appropriate diagnoses or needed stop dates will be performed by the DHS, ADHS, and/or Nurse Managers. Auditing will begin 1/13/26 for 12 weeks. The Quality Improvement Coordinator will track and trend the results from audits and present them to Quality Assurance Performance Improvement (QAPI) meeting monthly x 3 months or until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	

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F0605 SS = D	Continued from page 14 a 7-day period. The resident was not documented as receiving an antipsychotic medication. Physician order dated 11/3/25 revealed Resident #2 was ordered Haldol lactate solution (antipsychotic) 5 milligrams (mg)/1 milliliter (ml), administer 2mg intramuscular (IM) every 4 hours PRN for agitation. The end date was 1/3/26. Resident #2's active care plan revised on 11/20/25 revealed a problem with mood state. The goals for Resident #2 included he would not exhibit signs of drug related sedation, hypotension, or anticholinergic symptoms. The interventions included resident was on hospice, administering medications as ordered, following pharmacy recommendations, and pharmacy consult review monthly. Pharmacy review dated 12/5/25 read "per hospice, haloperidol 2mg IM every 4 hours PRN agitation for 60 days." During an interview with the Physician Assistant (PA) and Physician on 12/10/25 at 3:15pm, the PA stated she and the hospice Physician wrote the Haldol order together for Resident #2. She stated the end date was written for 60 days because Resident #2 had behaviors and was non-compliant with oral medications. The PA also stated Resident #2's diagnosis of brief psychotic disorder was the mental health diagnosis justifying the use of Haldol and was unaware the Haldol order was written for agitation. The PA stated she was unaware antipsychotic PRN medication could only be written for 14 days. The Consultant Pharmacist was interviewed by telephone on 12/10/25 at 3:52pm. The Consultant Pharmacist discussed during her monthly medication reviews, she reviewed all the medications, ensured there was a diagnosis for the medication and that the stop dates, if needed, were correct. She confirmed Resident #2's PRN Haldol was written for 60 days but was unaware, since the resident was on hospice, that a diagnosis of agitation could not be used. The Consultant Pharmacist stated the PRN Haldol should be written for 14 days and stated she did not question the order because the order came from the hospice Physician. An interview with the Director of Nursing (DON) conducted on 12/12/25 at 2:27pm revealed the facility relied on the pharmacy's review to check medication orders. She explained the facility did not have staff verify medication orders for accuracy. The DON stated no one was aware until recently (12/10/25) that there	F0605		

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F0605 SS = D	Continued from page 15 were time frames for PRN antipsychotic medications. The Administrator was interviewed on 12/12/25 at 3:03pm and stated he had nothing to add. 2. Resident #1 was admitted to the facility on 10/8/25 with diagnoses that included unspecified dementia without behavioral or psychotic disturbances. There were no mental health diagnoses. The admission Minimum Data Set (MDS) dated 10/13/25 revealed Resident #1 was cognitively intact with no behaviors. The MDS also documented Resident #1 was on antipsychotic and antidepressant medication. Physician order dated 10/8/25 for olanzapine (antipsychotic) 5 milligrams (mg) at bedtime for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Physician order dated 10/9/25 for sertraline (antidepressant) 50mg once a day for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #1's active care plan dated 10/20/25 revealed a problem with mood state. The goal for Resident #1 was he would not exhibit signs of drug related sedation, hypotension, or anticholinergic symptoms. The interventions included administer medication as ordered, assessing/record effectiveness, follow up on pharmacy recommendations, and pharmacy consult review monthly. Physician order dated 12/3/25 olanzapine 5mg at bedtime for unspecified dementia without behavioral and/or psychotic disturbances. Physician order dated 12/3/25 sertraline 50mg once a day for unspecified dementia without behavioral/mood/anxiety disturbances. Progress notes reviewed from 11/9/25 through 12/9/25 revealed no documentation of Resident #1 having behaviors other than yelling out for help instead of using his call light. An interview occurred with the Physician Assistant (PA) and the Physician on 12/10/25 at 3:15pm. The PA confirmed there were no diagnosis of depression or psychosis currently for Resident #1. The PA stated she	F0605		

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F0605 SS = D	Continued from page 16 had seen these diagnoses in past medical records. She presented a record from a neurologist dated 8/26/25 where Resident #1 had been diagnosed with Alzheimer's dementia with mood disturbance. The PA stated his mood disturbance was hallucinations/delusions which she stated he was currently exhibiting by hollering out and being physically aggressive with staff. The PA stated she was unaware Resident #1 hollered out to get his needs met and/or his aggressive behaviors were mainly during direct care. She also stated she was unaware Resident #1's antipsychotic and antidepressant were noted to be given for his dementia without behaviors. The Assistant Director of Nursing (ADON) was interviewed on 12/11/25 at 2:48pm. The ADON stated the process for entering medication orders was to receive the written order from the Physician, clarify with the Physician the order, and then place the order into the electronic medical record. She stated Resident #1's olanzapine and sertraline orders were entered for dementia without behaviors because Resident #1 did not have any mental health diagnoses until 12/10/25. An interview with the Director of Nursing (DON) conducted on 12/12/25 at 2:27pm revealed the facility relied on the pharmacy's review to check medication orders. She explained the facility did not have staff verify medication orders for accuracy or diagnosis. The DON stated she was unaware until 12/10/25 that Resident #1 did not have a diagnosis for his olanzapine or sertraline. The Administrator was interviewed on 12/12/25 at 3:03pm. The Administrator stated he had nothing to add.	F0605		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F0607	Corrective action for the residents found to be affected by the deficient practice: NA #3 and NA #9 did not report to Administration any suspicions of rough handling of Resident #13 prior to 10/04/25. Once Administration was made aware on 10/04/25, immediate action was taken. NA #3 was suspended throughout the investigation and removed from resident #13's assignment permanently. NA #3 was terminated 11/17/25. NA #9 was re-educated with all staff between 10/06/25 – 10/10/25, during education with the full staff by the Clinical Competency Coordinator, regarding company policy of reporting abuse immediately even when it is	01/13/2026

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F0607 SS = D	Continued from page 17 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, and resident, Resident Representative, Physician Assistant, and Psychiatric Nurse Practitioner interviews, the facility failed to follow and implement their abuse policy and procedures in the areas of protecting and reporting to the Administrator for 1 of 3 residents reviewed for abuse (Resident #13). Resident #13 told Nursing Assistant (NA) #3 that the NA was treating him roughly and “man handling” him and to stop care. NA #3 did not stop the care. NA #9 heard Resident #13 state that NA #3 treated him “roughly” and was “man handling” him during his shower. Neither NA #3 or NA #9 reported the incident to administration or the charge nurse on duty allowing NA #3 to finish his shift and to return to work the next day. This failure resulted in a lack of protection for other residents. The findings included: The facility’s policy “Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property” reviewed on 12/7/22 stated any allegation, suspicion, or identified occurrences involving patient abuse should be immediately reported to the Administrator. The policy also documented that all staff involved were required to cooperate with internal/external investigative procedures and the provider was responsible for safeguarding the patient and preventing a reoccurrence.	F0607	Continued from page 17 only suspected so that further investigation can occur and resident safety remains a top priority. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. All residents with a Brief Interview of Mental Status (BIMS) of eight or greater on the same hall were interviewed for feelings of being unsafe or other incidents of “rough” handling on 01/06/26 – 01/07/26 by the Social Service Director (SSD). Review of all skin assessments for Residents with a BIMS of 7 or below by Assistant Director of Health Services (ADHS) was performed on 01/07-08/26. There were no reported findings to indicate other residents were handled “roughly” such as discolorations or areas with pain, or that had documentation of an occurrence where they asked someone to stop during a procedure and staff did not comply. Systemic changes made to ensure that the deficient practice will not recur: Education will be provided by 01/12/26 to all facility staff by the Director of Health Services (DHS), ADHS, and/or Nurse Managers on the facility’s abuse policy and the mandatory requirement to report abuse or suspected abuse immediately to a supervisor for further investigation. This education will be included in orientation for all new hires. This facility does not use any agency staff. Education for staff on paid time off or Family Medical Leave Absent will be completed prior to their next scheduled shift by Clinical Competency Coordinator and/or nurse manager. Plans to monitor its performance to make sure that the solutions are sustained. Audits conducted through interviewing five random residents weekly for twelve weeks to also include	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0607 SS = D	Continued from page 18 Resident #13 was admitted to the facility on 7/30/25 with multiple diagnoses that included unspecified dementia, chronic obstructive pulmonary disease, and chronic pain. Resident #13 was interviewed on 12/8/25 at 4:18pm. Resident #13 discussed NA #3 was “rough” with him a “couple of months ago.” Resident #13 stated it started when NA #3 transferred him from his wheelchair onto the shower chair. He stated NA #3 handled him roughly. Resident #13 explained he told NA #3 to stop being rough with him, but the NA did not listen. He stated throughout his shower NA #3 was “man handling” and being “rough.” He stated he told NA #3 to stop because he was hurting him, but NA #3 did not stop or say anything. Resident #13 explained once he was back in his room, he told staff what happened (could not remember who) but no one was listening to him. He stated he was fearful of NA #3 and upset no one was listening. Resident #13 stated NA #3 had not been assigned to him since the incident. Review of the facility’s schedules for 10/2/25 revealed NA #3 was assigned to Resident #13 and NA #3 completed his whole shift (7:00am to 3:00pm) on 10/2/25. During a telephone interview with NA #3 on 12/11/25 at 8:44am, NA #3 confirmed he had been assigned to Resident #13 on 10/2/25 and provided Resident #13 with a shower. NA #3 described the incident saying as soon as he began to transfer Resident #13 from his wheelchair to the shower chair, Resident #13 began yelling telling him to stop and saying NA #3 was “man handling him.” NA #3 stated he proceeded to take Resident #13 to the shower and once the water was adjusted right, he put soap on the washcloth and began washing Resident #13. NA #3 explained Resident #13 began telling him to stop and saying NA #3 was being too “rough.” NA #3 stated he rinsed Resident #13 off, got him dressed, and returned him to his room. NA #3 stated he never told a staff member or his supervisor what had occurred with Resident #13. He also stated he did not stop when the resident asked because he was not “man handling” him or being “rough.” NA #3 confirmed he finished his shift on 10/2/25 and that he worked on 10/3/25 and was assigned to the 2nd floor, not to Resident #13 on 10/3/25. He stated on 10/5/25 he received a call from the Director of Nursing (DON) telling him he was suspended during the investigation. NA #3 stated he was suspended for a week and then returned to work. He stated once he returned to work, he was not assigned to Resident #13. Review of the facility’s schedules for 10/3/25 revealed	F0607	Continued from page 18 weekends to assess concerns or complaints of mishandling or times when they have asked to stop a procedure, but staff did not comply. Auditing will be performed by the DHS, ADHS, Social Service Director, Activity Director, and/or Nurse Manager and will begin 1/13/26 and continue for 12 weeks. Random audits performed by the DHS, ADHS, and/or Nurse Managers beginning 01/13/26 of 5 residents weekly for twelve weeks will be performed of the skin assessments done on patients each week to provide oversight of those skin assessments and ensure identification of signs and symptoms of abuse are identified. Audits will begin 1/13/26 and continue for 12 weeks. Five random interviews of facility staff will be conducted weekly covering allegations of abuse, reporting process of abuse, words that may trigger abuse investigation; these audits will be completed by DHS, ADHS and/or nurse manager. Audits will begin 1/13/26 and continue for 12 weeks. The Quality Improvement Coordinator will track and trend the findings from the audits of residents’ interviews, residents’ skin observations and staff interviews/questionnaire and present the findings to Quality Assurance Performance Improvement (QAPI) monthly for 3 months or until substantial compliance maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	

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F0607 SS = D	Continued from page 19 NA #3 had worked that day and was assigned to the 2nd floor, not with Resident #13. NA #9 was interviewed on 12/11/25 at 9:24am. NA #9 discussed working on the same hall as NA #3 on 10/2/25 but was not assigned to Resident #13. She stated she was on the hall when NA #3 brought Resident #13 back from the shower and heard Resident #13 stating that he was “man handled” and treated “rough” while in the shower. NA #9 explained that she did not report the allegation by Resident #13 because, “I didn’t know what was going on.” NA #9 went on to explain she was in the dining room shortly after lunch with Resident #13 when NA #3 came to take Resident #13 to be changed. She stated she heard Resident #13 state, “please don’t be rough with me again like you were in the shower.” NA #9 stated she reported the incident to Nurse #15 and then stated, “everyone knew what the resident said.” A telephone interview occurred with Nurse #15 on 12/11/25 at 9:43am. Nurse #15 confirmed she had been working in the same hall as NA #3 and NA #9 and was assigned to Resident #13 on 10/2/25. The nurse stated she did not remember any staff member telling her that Resident #13 felt he was “man handled” in the shower. Nurse #15 explained if she had been told a resident was being “man handled” she would have reported it right away to management. A telephone interview occurred with Resident #13’s Representative on 12/11/25 at 9:00am. The Representative discussed Resident #13 calling him on 10/2/25 and telling him that NA #3 had been “rough” with Resident #13 while in the shower that day (10/2/25). The Representative stated he did not call and reported what Resident #13 had said because he did not feel it was serious. Resident #13’s Representative stated it was not until he came to visit Resident #13 on 10/4/25 that he felt something had happened. The Representative explained when he arrived on 10/4/25, Resident #13 had repeated the same story and was upset. Resident #13’s Representative stated Resident #13 did not usually keep telling the same stories unless there was something wrong. The Representative stated he went to Nurse #14 and told her what Resident #13 had reported which was NA #3 had been “man handling” and treating him “rough” during his shower within the past week. The Representative stated Resident #13 did not know the exact date/day. Resident #13’s Representative stated he did not remember seeing any bruises or marks on Resident #13. Nurse #14 was interviewed on 12/10/25 at 11:24am. Nurse #14 discussed being informed of the incident between	F0607		

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F0607 SS = D	Continued from page 20 Resident #13 and NA #3 during the evening on 10/4/25 when Resident #13's Representative came to her and told her that Resident #13 had said he was "man handled" and treated "rough" while in the shower within the last week. Nurse #14 stated the representative did not discuss the phone call he had with Resident #13 on 10/2/25. The nurse stated she immediately called the Assistant Director of Nursing (ADON) who had instructed her to complete a skin and assessment. Nurse #14 stated she performed a skin and pain assessment which were both negative. She stated she did not document her assessment of the resident because "no one told me to." During an interview with the ADON on 12/10/25 at 7:16am, the ADON explained she had completed the initial report for abuse from home on 10/4/25 after Nurse #14 had called her on 10/4/25. She stated she was unaware staff knew of the concern on 10/2/25. The ADON stated Nurse #14 had told her Resident #13 was alleging NA #3 had 'man handled" and treated him "roughly" during Resident #13's shower. She discussed telling Nuse #14 to go and perform a skin and pain assessment on Resident #13. The ADON stated she called Nurse #14 back and was told by Nurse #14 that Resident #13 did not have any skin impairment or pain. The ADON stated she was aware a skin assessment was not documented until 10/5/25 and did not know why Nurse #14 did not document her assessments. The Director of Nursing (DON) and the Corporate Nurse Consultant were interviewed on 12/12/25 at 2:14pm. The DON discussed staff were trained on abuse/reporting through the facility's computer training annually and through their annual skills training. She discussed that the first person (NA #9) who heard the allegation should have reported it to management immediately. The Corporate Nurse Consultant discussed staff being "complacent" and that was why the allegation was not reported on 10/2/25. The DON confirmed NA #3 had continued to finish his shift on 10/2/25 and worked on 10/3/25. She stated NA #3 worked on 10/3/25 because they were not made aware of the incident until 10/4/25. The DON also confirmed NA #3 had not been assigned to Resident #13 on 10/3/25 or after the investigation when NA #3 returned to work. During an interview with the Administrator on 12/12/25 at 2:58pm, the Administrator stated the facility filed the report as soon as they found out about the accusation on 10/4/25 and completed their investigation accordingly. The Administrator had no further comments. The facility's investigation report dated 10/10/25 by the Director of Nursing (DON) documented the occurrence	F0607		

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F0607 SS = D	Continued from page 21 was reported to Administration on 10/4/25 at 8:20pm by Resident #13's Representative. It was documented that Resident #13 had reported to his Representative that Nursing Assistant (NA) #3 was "rough" with him during his shower "this past week." Documentation showed NA #3 was suspended pending an investigation. The conclusion of the investigation was that staff were re-educated on the facility's abuse policy and proper handling of dementia residents. NA #3 was also no longer allowed to provide care to Resident #13. The allegation was unsubstantiated.	F0607		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and physician interviews, the facility failed to administer lidocaine 4% external pain patches per the Physician order for 1 of 6 residents reviewed for medication regimen review (Resident #34). The findings included: Resident #34 was admitted to the facility on 07/16/2025 with diagnoses of pain in right hip and low back pain. A review of Resident #34's physician orders revealed an order dated 08/13/2025 for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily. A review of Resident #34's Medication Administration Record (MAR) revealed Nurse #8 signed the MAR for the four Lidocaine patch administration on 12/11/2025. The MAR specified for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily. A record review and interview with Nurse #6 on 12/11/2025 at 11:00 am revealed that she had only placed two lidocaine patches on Resident #34 for all of the dates she worked in November, which included	F0658	Corrective action for the residents found to be affected by the deficient practice: The physician was contacted regarding Resident #34's orders to request clarification and discuss changes in patient needs. New orders were obtained from physician extender on 12/10/25 and 12/11/25 to clarify placement of the lidocaine patches and reduction of the dosage by the Assistant Director of Health Services (ADHS). Education was provided to Nurse #8 and Nurse #6 by the Director of Health Services (DHS) on 12/15/25 and 01/08/26 on the 10 Rights for Accurate Medication Provision and following physician orders as written or notify physician if clarification is needed. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. Audits were completed for all residents with Lidocaine orders on 12/12/25 by the ADHS and were reviewed to see if clarification was needed on the orders to ensure clear understanding of the directions for application/administration. There were six residents' charts who had lidocaine patches ordered, and no additional clarification orders were required. Systemic changes made to ensure that the deficient practice will not recur:	01/13/2026

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F0658 SS = D	Continued from page 22 November 2nd, 12th, 15th, 18th, 19th, 20th, 24th, 25th, 26th, 27th, and 29th of 2025. Nurse #6 stated she had placed the two patches either on Resident #34's low back or on her hips, but not both. Nurse #6 confirmed the order had not been changed but verbalized in her opinion Resident #34 no longer needed to have four patches, so she did not apply the four patches per the physician's order. Nurse #6 voiced she could have requested a new order from the physician, but she did not. A record review and interview with Nurse #8 on 12/11/2025 at 10:50 am revealed she had not ever placed four patches on Resident #34 when she provided her medications in the past. When reviewing the MARs for the dates that she worked in September, October, and November of 2025, Nurse #8 explained she had only placed one lidocaine patch on Resident #34 for those dates, which included September 7th, 9th, 15th, 16th, 21st, 24th, 25th, 29th, and 30th of 2025; October 2nd, 4th, 5th, 8th, 9th, 16th, 19th, 21st, 27th, and 30th, of 2025; and November 1st, 5th, 6th, 7th, 10th, 11th, 13th, 22nd, and 30th of 2025. Nurse #8 stated she understood the order stated to place four lidocaine patches on Resident #34. Nurse #8 could not say why she did not follow the order. Nurse #8 expressed that she did not request a new order or clarification of the existing order from the physician. During an interview with the Physician on 12/10/2025 at 3:15 pm he stated he read the lidocaine order for Resident #34 to indicate that four lidocaine patches should be provided to Resident #34 daily but stated he believed staff were only providing 2 patches to Resident #34. He explained no one contacted him for clarification or to have the order changed and that he would rewrite the order so it would be written more clearly. He further explained the nurses should have asked for clarification if an order was not clearly written or if they had questions. During an interview on 12/11/2025 at 2:05 pm with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON stated the nurses providing the lidocaine patches to Resident #34 should have followed the physician's order or clarified the order with the physician.	F0658	Continued from page 22 Education will be provided to all licensed nurses by the DHS, ADHS, and/or Nurse Managers by 01/12/26 on following orders as written, calling the physician or physician extender for clarification if needed, utilizing the 10 Rights for Medication Administration, and following the facility policy Medication Administration: General Guidelines policy including the prep, pull, pass, and document procedure. This education will be added to orientation for all new licensed nurse hires. This facility does not use any agency staff to cover clinical shifts. Education for staff on paid time off or Family Medical Leave Absent will be completed prior to their next scheduled shift by Clinical Competency Coordinator and/or nurse manager. Plans to monitor its performance to make sure that the solutions are sustained. Weekly random audits of 5 licensed nurses providing Lidocaine patches to residents will be performed by the DHS, ADHS, and/or Nurse Managers to observe proper procedures being followed including the utilization of the 10 Rights for Medication Administration as well as the steps within the Medication Administration: General Guidelines policy. Auditing will begin 1/13/2026 and continue for 12 weeks. Results of medication observations for lidocaine patch will be tracked and trended by the Quality Improvement Coordinator and reported in Quality Assurance Performance Improvement (QAPI) monthly for three months or until substantial compliance maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	Corrective action for the residents found to be affected by the deficient practice: Resident #48 had an updated smoking observation performed and documented on 12/17/25 by Nurse Manager.	01/13/2026

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F0689 SS = D	Continued from page 23 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to complete a smoking safety screen in August 2025 for 1 of 1 resident reviewed for smoking (Resident # 48). The findings included: An undated facility policy titled, “Tobacco, Vapes, and Alcohol Use in the North Carolina State Veterans Home,” stated “Staff will evaluate each resident’s ability to safely use cigarette lighters, lit cigarettes, cigars, pipes, and Vape devices to determine if a resident can be permitted to use these without direct supervision (independently) or if the resident must be directly supervised in order to safely use them.” Resident #48 was admitted to the facility on 12/02/22 with diagnoses which included tobacco use, cerebral vascular accident, and vascular dementia. A review of Resident #48’s Nursing Quarterly Assessment that included the smoking safety screen dated 5/19/25 indicated the resident was a supervised smoker and did not have the ability to hold his own cigarette or extinguish it. Review of Resident #48’s annual Minimum Data Set (MDS) assessment dated 8/13/25 revealed the resident was moderately cognitively impaired and coded for tobacco use. Review of Resident #48’s medical record revealed the August 2025 Nursing Quarterly Assessment did not include a smoking safety screen. Review of Resident #48’s care plan revised on 11/3/25 revealed Resident #48 had a history of smoking. The goal for Resident #48 was to be compliant with the smoking policy. The interventions included supervision of the resident when smoking, assisting the resident to the smoking area at assigned times as needed, educating resident and family on the smoking policy, educating	F0689	Continued from page 23 Resident #48 smoking observation was reassessed for changes on 01/06/26 by the Assistant Director of Health Services (ADHS) with no changes noted. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. All residents including smoking and non-smokers had a smoking observation completed for accurate and current smoking observation on 1/8/26 by ADHS. There are currently five residents who have been identified who are actively smoking tobacco. Systemic changes made to ensure that the deficient practice will not recur: Education will be provided for all licensed nurses by the Director of Health Services (DHS), ADHS and/or Nurse Managers by 01/12/26 on how to conduct an accurate smoking observation and how to document it thoroughly within the electronic medical record. This education will be added to orientation for all licensed nurses. This facility does not use any agency staff to cover clinical shifts. Education for staff on paid time off or Family Medical Leave Absent will be completed prior to their next scheduled shift by Clinical Competency Coordinator and/or nurse manager. Plans to monitor its performance to make sure that the solutions are sustained. Weekly random audits of five residents for twelve weeks who had quarterly or annual assessments will be completed by the DHS, ADHS, and/or Nurse Managers to ensure an accurate smoking observation is documented within the medical record beginning 01/13/26 for 12 weeks.	

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F0689 SS = D	Continued from page 24 the resident on smoking times and location, and utilizing a smoking apron. Resident #48 was interviewed on 12/08/2025 at 12:58 PM. Resident #48 discussed being a smoker and going out to smoke during the designated times. He explained he did not go all the time, but when he felt well, he enjoyed going out to smoke. The Director of Nursing (DON) was interviewed on 12/10/25 10:12 AM. She stated residents must have a quarterly smoking safety screen completed in their medical records. During a follow up interview on 12/10/25 at 12:00 PM, the DON stated the staff nurses were responsible for completing the Nursing Quarterly Assessment, which included the smoking safety screen. She confirmed the smoking safety screens must be done quarterly. When asked, the DON was able to provide Resident #48's Nursing Quarterly Assessment for May 2025, but she did not provide any other assessments. She stated the facility did not have a system in place to ensure the assessments were completed. The DON stated that she would be the party responsible for ensuring the assessments were completed by the assigned due date and specific for each resident. The DON indicated she expected the assessments to be completed accurately and by the date they were due to be completed.	F0689	Continued from page 24 Admission and readmission smoking observations will be reviewed daily by DHS, ADHS and/or nurse managers to ensure the residents who smoke tobacco have accurate observation. Audits will begin 1/13/26 for 12 weeks. The findings of smoking observation completion will be tracked and trended by the Quality Improvement Coordinator and reported in Quality Assurance Performance Improvement (QAPI) monthly for three months or until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is	F0690	Corrective action for the residents found to be affected by the deficient practice: Resident #51 was observed on 12/12/25 by Assistant Director of Health Services (ADHS) that catheter bag was located on side of bed with bag not touching the floor. On 12/12/25, NA #4 and Nurse #6 were provided education on keeping catheter bags off the floor by the Director of Health Services (DHS) and ADHS. NA #6 is no longer employed as of 12/21/25. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. 100% audit of all residents with catheters was conducted on 12/12/2025 to ensure all catheter bags were off the floor and below the level of the bladder.	01/13/2026

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NC State Veterans Home - Salisbury	**1601 Brenner Ave., Building #10 , Salisbury, North Carolina, 28145**

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F0690 SS = D	Continued from page 25 assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, staff, and Physician Assistant interviews, the facility failed to keep a urinary catheter collection bag from touching the floor to reduce the risk of infection for 1 of 3 residents reviewed for urinary catheters (Resident #51). The findings included: Resident #51 was admitted to the facility on 07/21/2025 with diagnoses which included stage four kidney disease, and obstructive and reflux urinary disease. A quarterly Minimum Data Set (MDS) assessment dated 10/15/2025 revealed Resident #51 was severely cognitively impaired. Resident #51 was coded for an indwelling urinary catheter. Resident #51's care plan revised 11/21/2025 indicated Resident #51 had a goal that she would not develop any complications or injury associated with urinary catheter usage. An initial observation was conducted on 12/08/2025 at 9:19 am of Resident #51 while she was sitting up in her chair in the dining area. Her urinary catheter collection bag was observed to be laying on the floor under her chair. It had a privacy cover on it so urine was not visible. An additional observation on12/9/2025 at 9:49 am revealed Resident #51 laying in her bed, resting with her eyes closed and her urinary catheter collection bag was lying on the floor. It had a privacy cover on it so urine was not visible.	F0690	Continued from page 25 There were seventeen residents observed with indwelling catheters and the catheter bag position was below bladder and located on the side of bed not on the floor. This observation was completed by ADHS. Systemic changes made to ensure that the deficient practice will not recur: On 1/8/26, education was started for all facility staff about preventing catheter bags from touching the floor and additionally being below the level of the bladder by the Director of Health Services (DHS), ADHS, and/or Nurse Managers and will be completed by 01/12/26. This education will be added to orientation for all facility new hires. This facility does not utilize agency staff. Education for staff on paid time off or Family Medical Leave Absent will be completed prior to their next scheduled shift by Clinical Competency Coordinator and/or nurse manager. Plans to monitor its performance to make sure that the solutions are sustained. Weekly audits of 100% of residents in the building with indwelling catheters will be performed by the DHS, ADHS, and/or Nurse Managers to ensure that the catheter bags are off the floor and below the level of the bladder beginning 01/13/26 for twelve weeks. Any issues identified will be corrected immediately. Catheter bag location findings will be tracked and trended by the Quality Improvement Coordinator and reported in Quality Assurance Performance Improvement (QAPI) monthly for three months or until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	

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F0690 SS = D	Continued from page 26 An interview on 12/10/2025 at 10:40 am with Nursing Assistant (NA) #6 who worked with Resident #51 on 12/08/2025 revealed she had not seen the urinary catheter collection bag lying on the floor. She stated that Hospice staff had been there that day and explained on the days Hospice worked with Resident #51, NA #6 didn't do any care for Resident #51. NA #6 stated that if Resident #51 had a bowel movement before Hospice arrived, she would have cleaned her up, but otherwise on those days, she didn't provide any care to Resident #51. NA #6 added that the urinary catheter collection bag should not have been on the floor and had she noticed it, she would have picked it up and hung it back on the bed. During an interview with NA #4 on 12/10/2025 at 4:24 pm who worked with Resident #51 on 12/09/2025, she stated the urinary catheter collection bag always needed to be hung up off the floor. NA #4 said she had not seen it on the floor on 12/09/2025 and she would have picked it up and hung it up off the floor if she had. An interview on 12/10/2025 at 10:27 am with Nurse #6 who was the nurse working with Resident #51 on 12/09/2025 revealed that the urinary catheter collection bag should hang below the level of the bladder and should not be touching the floor. She stated if she saw the urinary collection bag on the floor, she would have picked it up and placed it back on the bed frame. Nurse #6 stated she did not see Resident #51's urinary catheter collection bag on the floor on 12/09/2025. During an interview with Assistant Director of Nursing on 12/10/2025 at 3:15 pm she stated that it was never acceptable for the urinary catheter collection bag to be on the floor and she would have changed the bag immediately if she had found it lying on the floor. An interview with the Physician's Assistant on 12/10/2025 at 3:20 pm revealed that the urinary catheter collection bags should be hung up off the floor and below the bladder. The Physician Assistant stated it was never acceptable for the urinary catheter collection bag to be on the floor and that being placed on the floor could increase the risk for urinary infections. An interview and record review was conducted on 12/12/2025 at 1:12 pm with the Director of Nursing and Senior Nurse Consultant. The Director of Nursing stated that all nursing staff including all nurses and nurse aides received training on urinary catheters at the annual skills fair last held on 09/16/2025. The	F0690		

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F0690 SS = D	Continued from page 27 Director of Nursing stated that the nurses were trained in the insertion of indwelling catheters, and the nursing aides were trained on how to provide catheter care for individuals with indwelling catheters. The Senior Nurse Consultant provided a printout from their electronic education platform titled Clinical Procedure: Urinary Catheter Care dated 2025 and stated that was the education that would have been covered at the skills fair as well. The printout did not address where the urinary drainage bag should or should not have been placed. The Senior Nurse Consultant stated that knowing where the urinary catheter collection bag should have been hung was “CNA (certified nursing assistant)101” and they all knew where it was supposed to be hung. The Director of Nursing added that the urinary catheter collection bag should never be found on the floor as this would increase the risk of the resident getting an infection.	F0690		
F0756 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	F0756	Corrective action for the residents found to be affected by the deficient practice: On 12/10/25, pharmacy consultant provided a physician recommendation for Resident #1 for the need for an appropriate diagnosis for the antipsychotic and antidepressant medications. These recommendations were presented to the physician and physician extender on 12/10/26. New appropriate diagnoses were added to the electronic medical record as of 12/10/25 per the physician extender. Resident #2 had his PRN antipsychotic order adjusted immediately by Assistant Director of Health Services (ADHS) to a 14 day stop date on 12/10/25 and then resulted in his Antipsychotic medication being discontinued at the end of the 14 days for non-use as of 12/24/25. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents who received psychotropic medications have the risk of being affected by alleged deficient practice. Reports were pulled from 100% of residents by the Assistant Director of Health Services (ADHS) on 12/12/25 to ensure all other residents with Antipsychotics or Antidepressants in the building at that time had the appropriate diagnosis for the medication as well as having a stop date of 14 days for any PRN antipsychotics. There were eight residents assessed with an antipsychotic, and forty-two residents	01/13/2026

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F0756 SS = D	Continued from page 28 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 interviews with staff, Consultant Pharmacist, and the Physician Assistant, the Consultant Pharmacist failed to identify drug irregularities related to the indicated use and scheduled stop date of an as needed (PRN) antipsychotic, and the indicated use of an antidepressant for 2 of 5 residents (Resident #2 and Resident #1) reviewed for drug regimen review. The findings included: 1. Resident #2 was admitted to the facility on 8/18/25 with multiple diagnoses that included mild dementia with agitation, brief psychotic disorder and anxiety. A physician order dated 11/3/25 revealed Resident #2 was ordered Haldol lactate solution (antipsychotic) 5 milligrams (mg)/1 milliliter (ml), administer 2 mg intramuscular (IM) every 4 hours PRN for agitation. The order indicated the end date was 1/3/26. A monthly pharmacist Medication Regimen Review (MRR) dated 12/5/25 read “per hospice, haloperidol 2 mg IM every 4 hours PRN agitation for 60 days.” The pharmacist review did not document any recommendations or irregularities. During an interview with the Physician Assistant (PA) on 12/10/25 at 3:15 pm, the PA stated she and the hospice Physician wrote the Haldol order together for Resident #2. The PA stated the end date was written for 60 days because Resident #2 had behaviors and was non-compliant with oral medications. The PA also stated Resident #2’s diagnosis of brief psychotic disorder was the mental health diagnosis justifying the use of Haldol and was unaware the Haldol was written for Resident #2’s dementia with agitation. The PA stated she was unaware antipsychotic PRN antipsychotic medication could only be written for 14 days.	F0756	Continued from page 28 assessed with an antidepressant, there were thirty-seven residents that required an adjustment with an updated diagnosis in the electronic medical record (EMR). Some of the adjustments were only associating correct diagnosis with the medication in the EMR. Systemic changes made to ensure that the deficient practice will not recur: Education was provided to the Consultant Pharmacy Manager by the Assistant Director of Health Services (ADHS) regarding the requirement of an appropriate diagnosis for all antipsychotics and antidepressants prescribed. Consultant Pharmacy Manager was further educated by the ADHS on the requirement for all PRN psychotropic medications requiring a 14 days stop date as of 01/08/2026. The Consultant Pharmacy Manager then educated the Pharmacist assigned to the facility on the noted requirements as of 01/09/2026. Plans to monitor its performance to make sure that the solutions are sustained. Audits of 100% of all PRN Antipsychotics will occur weekly by the DHS, ADHS, and/or Nurse Managers to ensure there is a 14-day stop date written into the order with appropriate diagnosis. Audits will begin 1/13/26 and continue for 12 weeks. Audits of 100% of all Antidepressants and Antipsychotics will occur weekly by the DHS, ADHS, and/or Nurse Managers to ensure there is an appropriate diagnosis for the medication attached to the order. Audits will begin 1/13/26 for 12 weeks. Any variations will be addressed immediately by contacting physician, physician extender or pharmacist and corrected in the electronic medical record. The DHS and/or ADHS will review the pharmacist drug regimen review recommendation monthly, and the DHS and/or ADHS will ensure all recommendations are addressed and processed timely. This will include notification to physician and/or physician extender for any irregularities between medication regimen and diagnosis. Results of the audits including diagnosis, medication regimen and drug regimen reviews will be tracked and trended by the Quality Improvement Coordinator and reported in Quality Assurance Performance Improvement (QAPI) monthly for three months or until substantial compliance is maintained.	

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F0756 SS = D	Continued from page 29 The Consultant Pharmacist was interviewed by telephone on 12/10/25 at 3:52 pm. The Consultant Pharmacist discussed during her monthly medication reviews, she reviewed all the medications, ensured there was a diagnosis for the medication and that the stop dates, if needed, were correct. The Consultant Pharmacist confirmed Resident #2's PRN Haldol was written for 60 days. She explained she thought since the resident was on hospice, the diagnosis of dementia with agitation was ok. The Consultant Pharmacist stated the PRN Haldol should be written for 14 days and stated she did not question the order because the order came from the hospice Physician. The Assistant Director of Nursing (ADON) was interviewed on 12/11/25 at 3:01pm. The ADON confirmed she had entered the Haldol order into Resident #2's medical record on 11/3/25. She stated she wrote the reason for the Haldol was dementia with agitation because that was how hospice wanted the order written and she did not think she could question the hospice Physician. The ADON explained when she audited a resident's medical record and saw a medication had been entered with a wrong diagnosis, she would call the PA and have it changed. The ADON stated she audited resident medical records daily which included any new Physician orders for medications. During an interview with the Director of Nursing (DON) on 12/12/25 at 2:27 pm, the DON explained medication orders were only checked by the Consultant Pharmacist on a monthly basis. She confirmed she had not received any recommendations from the Consulting Pharmacist regarding Resident #2's PRN Haldol stop date or a need for Resident #2's indication for use to change. The DON also stated the facility had just learned from the PA on 12/10/25 that PRN antipsychotic medications needed a 14 day stop date. 2. Resident #1 was readmitted to the facility on 10/8/25 with multiple diagnoses that included unspecified dementia without behavioral or psychotic disturbances. There were no mental health diagnoses. A physician order dated 10/8/25 read; olanzapine (antipsychotic) 5 milligrams (mg) at bedtime for unspecified dementia without behavioral and/or psychotic disturbances. Review of Resident #1's Medication Administration Record for November and December 2025 revealed Resident #1 received olanzapine 5 mg daily at bedtime.	F0756	Continued from page 29 QAPI was completed on 1/21/26 with interdisciplinary team. Date of compliance:01/13/26	

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F0756 SS = D	Continued from page 30 A physician order dated 10/9/25 read; sertraline (antidepressant) 50 mg once a day for unspecified dementia without behavioral/mood/anxiety disturbances. Review of Resident #1's MAR for November and December 2025 revealed Resident #1 received sertraline daily at 9:00 am. The initial pharmacist Medication Regimen Review (MRR) dated 11/4/25 revealed Olanzapine 5 mg at bedtime for dementia with behaviors and sertraline 50 mg daily for dementia with behaviors. The pharmacist review did not have any documentation for recommendations or irregularities. The monthly pharmacist Medication Regimen Review (MRR) dated 12/5/25 revealed medical record was reviewed but did not document anything related to Resident #1's antipsychotic or antidepressant. The pharmacist review did not have any documentation for recommendations or irregularities. An interview occurred with the Physician Assistant (PA) on 12/10/25 at 3:15 pm. The PA confirmed there were no diagnosis of depression or psychosis currently for Resident #1. The PA stated she had seen these diagnoses in past medical records. She presented a record from a neurologist dated 8/26/25 where Resident #1 had been diagnosed with Alzheimer's dementia with mood disturbance. The PA stated she had obtained the documentation from an older medical record which was not part of Resident #1's current medical record. The PA stated Resident #1's mood disturbances were hallucinations/delusions which he was currently exhibiting by hollering out and being physically aggressive with staff. She also stated she was unaware Resident #1's antipsychotic and antidepressant were noted to be prescribed for his dementia without behaviors. A telephone interview occurred with the Consulting Pharmacist on 12/10/25 at 3:52 pm. The Consulting Pharmacist discussed when she performed her monthly reviews, she would review the resident's medical record, look at the medications, and ensured there was a diagnosis for the medication being given. She reviewed Resident #1's medications and diagnosis provided for the olanzapine and sertraline and stated the diagnoses were not appropriate for the medications provided. The Consultant Pharmacist explained in November 2025 a message was sent to the Physician to review the diagnosis for the sertraline but stated there was not a response provided. The Consultant	F0756		

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F0756 SS = D	Continued from page 31 Pharmacist reviewed Resident #1's November MRR during the interview and was unable to locate the notification to the physician about the diagnosis for sertraline. She stated the olanzapine diagnosis was going to be addressed in January 2026 but could not say why it had not been addressed with the monthly November or December 2025 reviews. The Consultant Pharmacist stated the diagnosis for the medications prescribed to Resident #1 should have been changed or brought to the Physicians' attention. The Assistant Director of Nursing (ADON) was interviewed on 12/11/25 at 2:48 pm. The ADON reviewed Resident #1's olanzapine and sertraline orders. She stated the diagnosis of unspecified dementia without behavioral or psychotic disturbances were written as the indication for the medications because Resident #1 did not have a mental health diagnosis available. The ADON stated she had not discussed the issue with the Physician or Physician Assistant. During an interview with the Director of Nursing (DON) on 12/12/25 at 2:27 pm, the DON explained medication orders were only checked by the Consultant Pharmacist monthly. She confirmed she had not received any recommendations from the Consulting Pharmacist regarding Resident #1's lack of diagnosis for the antidepressant and antipsychotic medications.	F0756		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F0842	Corrective action for the residents found to be affected by the deficient practice: The physician was contacted regarding Resident #34's Lidocaine patch orders to request clarification and discuss changes in patient needs. New orders were obtained from physician extender on 12/10/25 and 12/11/25 to clarify placement of the lidocaine patches and reduction of the dosage by the Assistant Director of Health Services (ADHS). Nurse #6 and Nurse #8 received education on 12/15/25 and 01/08/26 by the Director of Health Services (DHS) on how to give medications correctly and appropriate documentation to follow per the Medication Administration: General Guidelines policy with audit performed for correct procedures performed. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice.	01/13/2026

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F0842 SS = D	Continued from page 32 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F0842	Continued from page 32 Reports were pulled for all residents with Lidocaine orders on 01/07/26 by the ADHS to assess if clarification is needed on the orders to understand the directions clearly for application/administration. There were six residents who were reviewed and all were receiving the number of patches that were specified by the physician order. Systemic changes made to ensure that the deficient practice will not recur: Education will be provided to all licensed nurses by the DHS, ADHS, and/or Nurse Managers regarding appropriate documentation of following physician orders for the appropriate number of lidocaine patches as specified per order by 01/13/26. This includes following orders as written and calling the physician and/or physician extender for clarification when needed, and not making assumptions. This education follows the Medication Administration: General Guidelines policy for Prep. Nurses were further counseled that continued errors for this reason would result in disciplinary action. This education will be included in orientation for all new license nurse hires. This facility does not use any agency staff to cover clinical shifts. Education for licensed nurses on paid time off or Family Medical Leave Absent will be completed prior to their next shift by Clinical Competency Coordinator and/or nurse manager. Plans to monitor its performance to make sure that the solutions are sustained. There will be five random Medication Administration Observations of licensed nurses completed weekly for 12 weeks for verification of providing the accurate number of lidocaine patches that matches the physician order, and accuracy of the medication administration process by the DHS, ADHS, and/or Nurse Managers beginning 01/13/26 for 12 weeks. Any corrections needed will be addressed immediately The findings of the medication administration observations will be tracked and trended by the Quality Improvement Coordinator and reported in Quality Assurance Performance Improvement (QAPI) monthly for three months or until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary	

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F0842 SS = D	Continued from page 33 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and interviews, the facility failed to maintain an accurate medical record related to documentation of medication administration for 1 of 2 residents reviewed for accurate medical records (Resident #34). The findings included: Resident #34 was admitted to the facility on 07/16/2025 with diagnoses of pain in right hip and low back pain. A review of Resident #34's physician orders revealed an order dated 08/13/2025 for Lidocaine (an over-the-counter pain reliever) adhesive patch, medicated; 4%; amount: 4; apply to skin. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily. a. An observation and interview with Nurse #6 and Resident #34 on 12/10/25 at 12:00 pm revealed Nurse #6 had two lidocaine patches in her hand. Nurse #6 proceeded into Resident #34's room and when she returned from the room, she said that she had placed the two patches on Resident #34's low back and no patches were placed to Resident's bilateral hips. A review of Resident #34's Medication Administration Record (MAR) revealed that Nurse #6 had signed the MAR for the four lidocaine patches on 12/10/2025 for the 9:00 am administration time. The MAR specified for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily. A record review and interview with Nurse #6 on 12/11/2025 at 11:00 am revealed that she had only placed two lidocaine patches on Resident #34 for all of the dates she worked in November, which included November 2nd, 12th, 15th, 18th, 19th, 20th, 24th, 25th, 26th, 27th, and 29th of 2025. Nurse #6 said she had	F0842	Continued from page 33 team. Date of compliance: 01/13/26	

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F0842 SS = D	Continued from page 34 placed the two patches either on Resident #34's low back or on her hips, but never both. Nurse #6 confirmed the order had not been changed but said in her opinion the resident no longer needed to have four patches, so she did not apply her four patches. Nurse #6 acknowledged that this would have been incorrect documentation of the MAR. b. A review of Resident #34's MAR revealed Nurse #8 signed the MAR for the four Lidocaine patch administration on 12/11/2025. The MAR specified for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily. A record review and interview with Nurse #8 on 12/11/25 at 10:50 revealed she had never placed four patches on Resident #34 when she had provided her medications in the past. When reviewing the MARs for the dates that she worked in September, October, and November, she said that she had only ever placed one lidocaine patch on Resident #34 for those dates, which included September 7th, 9th, 15th, 16th, 21st, 24th, 25th, 29th, and 30th of 2025; October 2nd, 4th, 5th, 8th, 9th, 16th, 19th, 21st, 27th, and 30th, of 2025; and November 1st, 5th, 6th, 7th, 10th, 11th, 13th, 22nd, and 30th of 2025. Nurse #8 said that she understood that the order stated to place four lidocaine patches on Resident #34 and Nurse #8 could not say why she did not follow the order. Nurse #8 stated that she signed the MAR indicating the four patches were applied but she did not apply four patches which would have been inaccurate documentation. She said she would place one patch wherever Resident #34 indicated she wanted it. These locations included left or right lower back or left or right hip. During an interview on 12/11/2025 at 2:05 pm with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON said that the nurses providing the lidocaine patches to Resident #34 should have clarified the order if they were not providing what the order stated. She said if the order indicated they were to provide Resident #34 with four patches; the nurses should have been providing her with four patches. Both DON and ADON agreed this wound not have been accurate documentation of the MAR.	F0842		
F0847 SS = B	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements	F0847	Corrective action for the residents found to be affected by the deficient practice: Resident #66's responsible party was contacted by the admissions director on 12/16/2025 to follow up with her to ensure she understood the arbitration agreement	01/13/2026

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F0847 SS = B	Continued from page 35 If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident representatives and staff, the facility failed to	F0847	Continued from page 35 where she vocalized, she wanted to rescind her signature. Resident #1's representative did not check whether she accepted or declined the agreement. On 1/6/2026 Resident #1's representative was re-sent the arbitration agreement by the admissions director to check whether she accepts or declines the agreement and ensure she understands the arbitration agreement and it is explained to her with a follow up call. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit was conducted on 1/6/2026 to ensure any new residents or their responsible parties in the last 30 days were explained the arbitration agreement in a form and manner that he or she understands, including in a language the resident and his or her representative understands; The resident or his or her representative acknowledges that he or she understands the agreement. There have been no new admissions since 12/5/2025. Systemic changes made to ensure that the deficient practice will not recur: The admissions director was educated on 12/19/2025 and her back up, the business office manager, on 1/9/2026 by regional admissions director on the Admissions director's arbitration and Eventus compliance attestation policy. This policy requires the admissions directors to ensure that the Arbitration Agreement be verbally reviewed and explained with each new admission and/or the veteran's legal representative prior to or at the time of admission. Plans to monitor its performance to make sure that the solutions are sustained. The admissions director will notate the date and time each resident and/or residents responsible party received education on the arbitration agreement and had no questions about it. The administrator will follow up with phone calls eight business days from admission with the resident and/or responsible party to ensure their understanding of the arbitration agreement. Audits will begin 1/13/26 and be conducted weekly and continue for 12 weeks. Administrator will track and trend results monthly and present results to the Quality Assurance Performance improvement (QAPI) committee on a monthly for 3 months	

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F0847 SS = B	Continued from page 36 explain the arbitration agreement to a resident's representative prior to having them sign the agreement. This occurred for 2 of 5 residents reviewed for arbitration (Resident #1 and Resident #66). The findings included: A review of the facility's undated arbitration agreement read that the residents or resident representatives acknowledge they had read and understood the agreement and that it had been explained in plain language. a. Review of Resident #1's arbitration agreement dated 10/7/25 revealed neither box was checked indicating if the resident/resident Representative accepted or declined the agreement. The agreement was signed by Resident #1's Representative. Resident #1 was admitted to the facility on 10/8/25. Resident #1's Representative was interviewed by telephone on 12/11/25 at 5:00pm. The Representative discussed sitting next to the facility's Admission Coordinator during Resident #1's pre-admission meeting on 10/7/25. She stated the Admissions Coordinator did not explain any of the forms. The Representative explained that the Admissions Coordinator just pointed out where to sign. Resident #1's Representative stated she did not have the arbitration agreement explained to her. b. Resident #66 was admitted to the facility on 11/19/25. Review of the arbitration agreement for Resident #66 dated 11/19/25 revealed the form was signed by Resident #66's Representative through an electronic signing platform that indicated the representative read and understood the agreement and the agreement had been adequately explained. A telephone interview occurred with Resident #66's Representative on 12/11/25 at 4:00pm. The Representative explained the admission paperwork was sent to her by email with a note to sign the paperwork. She stated she lived in Alaska and had to figure out the paperwork on her own. The Representative stated she did not have any verbal communication with the Admissions Coordinator. Once the agreement was explained to the Representative by the surveyor, she asked the surveyor if the agreement could be rescinded. Education was provided by the surveyor on whom to contact to discuss the matter.	F0847	Continued from page 36 or until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	

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F0847 SS = B	Continued from page 37 During a telephone interview with the Admissions Coordinator on 12/12/25 at 9:18am, the Admissions Coordinator discussed that the facility was now using an electronic signing platform. She explained the forms were sent to the resident's representative by email. The Admissions Coordinator stated she did not explain any of the forms to the representatives but wrote in the email if they had questions, they could call her. She stated, with Resident #1's Representative, she sat next to the Representative and explained all the forms, including the arbitration agreement, and the Representative did not ask any questions. The Admissions Coordinator stated she never spoke with Resident #66's Representative. The Director of Nursing (DON) was interviewed on 12/12/25 at 2:40pm. The DON confirmed she knew what the arbitration agreement was and stated any form the resident or resident Representative did not understand should be explained to them prior to signing. The Administrator was interviewed on 12/12/25 at 2:56pm. The Administrator stated he had nothing to add.	F0847		
F0880 SS = J	Infection Prevention & Control 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;	F0880	Corrective action for the residents found to be affected by the deficient practice: On 12/9/2025 at 4:30pm Nurse #2 used an alcohol wipe when cleaning the glucometer for resident #26 instead of using an EPA-registered disinfectant wipe then completed the blood glucose check and returned to the cart and cleaned with an alcohol-based wipe again. On 12/9/2025 at 5:15pm Nurse #3 failed to disinfect the glucometer prior to use for resident #37 then returned the cart and used the proper EPA-registered disinfectant wipe after being stopped by the surveyor. On 12/9/2025 at 8:30pm Regional Nurse Consultant educated the Director of Health services, Nurse #2, and Nurse #3 on Infection Control and Glucometer Cleaning and Disinfecting policy and then did a return demonstration for competency of glucometer cleaning and disinfecting. For Nurse #2 and Nurse #3 this was their first resident to have their blood sugars checked for the med pass. The facility identified nine residents that have the	01/13/2026

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F0880 SS = J	Continued from page 38 §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. (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:	F0880	Continued from page 38 potential to be affected by the use of communal blood glucose meters. The glucose meters have the potential of being contaminated with blood and must be cleaned and disinfected before and after each use with an approved EPA-registered disinfectant in accordance with the manufacturer's instructions to disinfect a shared glucometer due to the high likelihood to expose residents to the spread of blood borne infections. Corrective action for other residents having the potential to be affected by the same deficient practice. A root cause analysis was completed, and the facility came to the conclusion that the wrong disinfectant was used due to time pressure and lack of knowledge. Facility also failed to monitor compliance of glucometer cleaning and disinfecting. On 12/9/2025 at 7:45pm the facility removed and discarded the prior glucometers that were being utilized for multi resident use. On 12/9/25 at 7:45pm the facility placed individual glucometers in a zipped plastic bag with resident's name identifier on the bag, these zip lock bags prevent the possibility of cross contamination between glucometers. The glucometers are removed from the zipped plastic bag prior to entering the resident room and then cleaned, disinfected and air-dried per the EPA-registered disinfectant wipe manufacturer's recommendation, the blood glucose monitor is used to check the resident's blood glucose, cleaned, disinfected, air-dried and then replaced in the zipped plastic bag. The glucometers are stored in each resident's respective medication cart. On 12/9/2025 the residents' names were applied to the individual glucometer. When residents are discharged from the facility the glucometer is disinfected with the EPA-registered disinfectant wipe and stored in medication room. This process was changed to reduce the risk of blood borne pathogen transmission. Systemic changes made to ensure that the deficient practice will not recur: On 12/9/2025 all new admissions and residents with new glucometer testing orders will be given a new glucometer by the nurse receiving the order and/or admitting nurse. The new glucometers are stored in central supply. The nurse and/or admitting nurse will label the glucometer and baggy with resident's name and it will be placed in their respective medication cart	

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F0880 SS = J	Continued from page 39 Based on observation, record review, and interviews with staff and the Physician's Assistant (PA), facility staff used a shared blood glucose meter located in the medication cart without cleaning and disinfecting it before and after each use. This occurred while there were two residents identified with a known bloodborne pathogen in the facility with 1 of the 2 residents requiring blood glucose monitoring. Shared blood glucose meters can be contaminated with blood and must be disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer's instructions to disinfect a shared blood glucose meter has a high likelihood of exposing residents to the spread of blood borne infections. This deficient practice affected 2 of 2 residents who were observed to have their blood glucose checked (Resident #26 and #37) and involved 2 of 2 nurses observed performing blood glucose checks (Nurse #2 and the Assistant Director of Nurses [ADON]). Immediate jeopardy began on 12/09/2025 when Nurse #2 was observed to use a shared blood glucose monitor for Resident #26 without disinfecting the meter. Immediate jeopardy was removed on 12/11/2025 when the facility implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity level D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective to correct the deficient practice. Findings included: The facility's policy and procedure titled "Infection Control: Glucometer (blood glucose meter) Cleaning and Disinfecting" dated 09/01/2019 stated under "E. Cleaning and Disinfection" Step 1. Clean and disinfect glucose meter before and after each resident use. Step 4. Clean and disinfect the meter by using the EPA approved germicidal and disinfectant wipes. Wipe all external areas of the meter including both front and back surfaces until visibly clean. Step 5. Ensure that the surface of the meter remains wet at room temperature for the contact time listed on the wipe's directions for use. Allow to air dry. The manufacturer's instructions for cleaning and disinfecting the blood glucose meter used at the facility were summarized in the manufacturer's Blood Glucose Monitoring System User's Guide revised 07/2016. The instruction on page 46 titled, "Cleaning and Disinfecting Procedures for the Meter" stated, "The	F0880	Continued from page 39 for the hall or unit the resident is assigned. The Administrator of the facility notified the Director of Health Services and Assistant Director of Nursing to begin education to all Licensed Nurses on the specific resident use of glucometers, storage, cleaning, and disinfecting using proper EPA-disinfecting wipe on 12/9/2025 at 8:30pm. This education included the cleaning, disinfecting, and storage of individual glucometers. All Licensed Nurses who have not received the education by 12/10/2025 will be removed from the schedule until the education has been completed as well as return demonstration. The education related to cleaning, disinfecting, and storage of individual glucometers will be added to the general orientation of newly hired Licensed Nurses. The Administrator and/or Director of Health Services are responsible for ensuring all Licensed Nurses are educated by 12/10/2025. Licensed nurses who are scheduled to work will receive the in-person education and complete return demonstration of cleaning and disinfecting glucometers; Licensed Nurses who are not scheduled to work will receive over the phone education with return demonstration to be demonstrated upon return to work with the Director of Health Services prior to next scheduled shift. Nurses who were on PTO or LOA will be expected to receive the training that includes a return demonstration of cleaning and disinfecting a glucometer using the proper EPA-disinfecting wipe immediately upon their return before being assigned to patient care. The Administrator and/or Director of Health Services maintains the employee roster of those who have been educated and who require review. The Nursing Facility does not utilize medication aides and/or Agency Nurses. The facility contacted the local health department regarding the infection control breach on 12/10/2025 at 11:00am. The medical director was notified on 12/10/2025. Alleged date of immediate jeopardy removal: 12/11/2025 Plans to monitor its performance to make sure that the solutions are sustained. Daily random audits of 2 glucometer cleaning and disinfection procedure checks will occur for 2 weeks, then weekly random audits of 5 glucometer cleaning and disinfection procedure checks will occur for 2 weeks including occasional weekends, then weekly random audits of 3 glucometer cleaning and disinfection	

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F0880 SS = J	Continued from page 40 Meter should be cleaned and disinfected between each patient. The manufacturer listed several products approved for use. Important Safety Instructions included: The blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. The manufacturer's user's guide Revised 07/2016, for the blood glucose meter listed the disinfectant wipes used at the facility as one of the EPA-registered wipes recommended to clean and disinfect the blood glucose meter. Specific instructions for use: Contact time for a disinfectant is the amount of time a surface must remain wet with the product to achieve disinfection. Special instructions for cleaning and decontamination against human immunodeficiency virus (HIV), hepatitis B and hepatitis C indicated, "Allow surfaces to remain wet for one minute, let air dry. For all other organisms, see directions for contact time." A continuous observation and interview from 4:30 pm to 4:53 pm occurred on 12/09/2025 in the 2C hallway. The observation revealed Nurse #2 removed a blood glucose meter from his medication cart. He wiped it down with an alcohol pad and then took it into Resident #26's room and advised he was going to check Resident #26's blood sugar. He held the blood glucose meter (with the test strip already in the machine) to the resident's finger obtaining his blood sugar. Nurse #2 was observed walking out of the resident's room and placed the blood glucose meter on top of the medication cart. The blood glucose meter was observed to not be labeled with a resident's name. At 4:40pm, Nurse #2 was observed to wipe the blood glucose meter with an alcohol wipe and place the blood glucose meter in the drawer of the medication cart without disinfecting it per the disinfectant wipe's instructions, despite there being a container of disinfecting wipes present on his medication cart. Nurse #2 was observed for another ten minutes with no other residents receiving blood sugar checks. Nurse #2 stated that he did not have any other blood sugars to check until bedtime. He explained that he was trained to clean and disinfect the blood glucose meter using alcohol. When asked about the facility policy regarding disinfection, Nurse #2 responded that it also recommended using alcohol. He confirmed that the manufacturer likewise recommended alcohol for disinfecting the blood glucose meter. A continuous observation of the Assistant Director of Nursing, working on 1B Hallway, on 12/09/2025 from 5:15 pm until 5:30 pm revealed she took an unlabeled blood glucose meter out of her medication cart. The ADON did	F0880	Continued from page 40 procedure checks will occur for 8 weeks including occasional weekends. The glucometer cleaning and disinfection procedure audits will be completed by the DHS and/or ADHS beginning 1/13/26 and continue for 12 weeks. The glucometer cleaning audits will be tracked and trended by Quality Improvement Coordinator and present to Quality Assurance Performance Improvement (QAPI) monthly x 3 months or until substantial compliance is maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 1/13/2026	

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F0880 SS = J	Continued from page 41 not clean or disinfect the blood glucose meter. She proceeded to enter Resident #37's room. ADON told Resident #37 that she was going to do his blood sugar and proceeded to clean Resident #37's finger with an alcohol pad in preparation. She took the lid off the lancet and at this time surveyor asked her to step out of the room for a moment. The ADON confirmed that she did not clean and disinfect the blood glucose meter before entering the room to perform the finger stick, stating, "I didn't because the nurse who worked before me would have." She explained that the facility policy required the meter to be cleaned after each use. When asked about the manufacturer's recommendation for disinfecting the meter, the ADON responded, "It says after each use." She admitted that she was unaware the blood glucose meter should be cleaned both before and after each use. She proceeded to disinfect the blood glucose meter with a designated disinfecting wipe and noted out loud that it needed a 1-minute dry time. She allowed it to dry for 1 minute and then put on fresh gloves before entering Resident #37's room again and explained what she was going to do and then completed the blood glucose check for resident #37. The ADON then exited the room and cleaned the blood glucose meter with a designated disinfecting wipe and allowed it to dry for 1 minute before placing it back into her medication cart. The blood glucose meter was stored open in a drawer of the cart. The ADON stated that no residents had their own blood glucose meters for use. No other blood glucose meters were noted on the medication cart. When asked if she had received training on blood glucose meter use and disinfection, she said she had and most recently received training in September 2025 when she attended the annual skills fair. She said that she did not remember that the blood glucose meter needed to be cleaned and disinfected before and after each use. The DON was requested to provide the Diagnosis Report for its current residents. The Diagnosis Report dated 12/09/2025 indicated there were two residents identified as having at least one bloodborne pathogen, which in both cases included hepatitis C. Upon review of those two residents, it was discovered that one of the residents required blood sugar monitoring (Resident #37). On 12/09/2025 at 5:48 pm interview with the RN Clinical Competency Coordinator revealed she provided education on using the blood glucose meters for Nurse #2 and the ADON at the Registered Nurse/Licensed Practical Nurse Skills Fair which was held on 09/16/2025. The RN Clinical Competency Coordinator stated that both nurses would have been educated and were required to perform a	F0880		

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F0880 SS = J	Continued from page 42 return competency. On 12/09/2025 at 6:02 pm, Director of Nursing (DON) was interviewed. The Director of Nursing explained that the way to disinfect the blood glucose meter was to wipe it down before and after each use and allow it to dry for the designated time. She stated that nurses receive training upon hire and annually. She added that staff recently attended a skills fair in September 2025, where they received training on cleaning and disinfecting blood glucose meters. The DON confirmed that staff performance was monitored occasionally during on-site visits conducted by the contract pharmacy. She noted that the pharmacy did not report any instances of staff failing to disinfect the meters. When asked where she believed the process broke down, the DON stated that there was a time when using alcohol to clean the meters was considered acceptable, and the current challenge was correcting that outdated practice among nursing staff. At 3:15 p.m. on December 10, 2025, the Physician's Assistant (PA) was interviewed. The PA stated that using individual blood glucose meters would reduce the likelihood of spreading communicable diseases. When asked whether using shared blood glucose meters could increase the risk of disease transmission, the PA confirmed that there was a risk, especially if the meters were not properly cleaned. The Administrator was informed of the immediate jeopardy on 12/09/2025 at 6:51pm. The facility provided a credible allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On 12/9/2025 at 4:30pm Nurse #2 used an alcohol wipe when cleaning the blood glucose meter for resident #26 instead of using an EPA-registered disinfectant wipe then completed the blood glucose check and returned to the cart and cleaned with an alcohol-based wipe again. On 12/9/2025 at 5:15pm the ADON failed to disinfect the blood glucose meter prior to use for resident #37 then	F0880		

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F0880 SS = J	Continued from page 43 returned the cart and used the proper EPA-registered disinfectant wipe after being stopped by the surveyor. On 12/9/2025 at 8:30pm Regional Nurse Consultant educated the Director of Health services, Nurse #2, and ADON on Infection Control and Blood glucose meter Cleaning and Disinfecting policy and then did a return demonstration for competency of blood glucose meter cleaning and disinfecting. For Nurse #2 and ADON this was their first resident to have their blood sugars checked for the med pass. The facility identified 9 residents that have the potential to be affected by the use of communal blood glucose meters. The glucose meters have the potential of being contaminated with blood and must be cleaned and disinfected before and after each use with an approved EPA-registered disinfectant in accordance with the manufacturer's instructions to disinfect a shared blood glucose meter due to the high likelihood of exposing residents to the spread of blood borne infections. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. A root cause analysis was completed, and the facility came to the conclusion that the wrong disinfectant was used due to time pressure and lack of knowledge. Facility also failed to monitor compliance of blood glucose meter cleaning and disinfecting. On 12/9/2025 at 7:45pm the facility removed and discarded the prior blood glucose meters that were being utilized for multi resident use. On 12/9/25 at 7:45pm the facility placed individual blood glucose meters in a zipped plastic bag with resident's name identifier on the bag, these zip lock bags prevent the possibility of cross contamination between blood glucose meters. The blood glucose meters are removed from the zipped plastic bag prior to entering the resident room and then cleaned, disinfected and air-dried per the EPA-registered	F0880		

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F0880 SS = J	Continued from page 44 disinfectant wipe manufacturer's recommendation, the blood glucose monitor is used to check the resident's blood glucose, cleaned, disinfected, air-dried and then replaced in the zipped plastic bag. The blood glucose meters are stored in each resident's respective medication cart. On 12/9/2025 the residents' names were applied to the individual blood glucose meter. When residents are discharged from the facility the blood glucose meter is disinfected with the EPA-registered disinfectant wipe and store in medication room. This process was changed to reduce the risk of blood borne pathogen transmission. On 12/9/2025 all new admissions and residents with new blood glucose meter testing orders will be given a new blood glucose meter by the nurse receiving the order and/or admitting nurse. The new blood glucose meters are stored in central supply. The nurse and/or admitting nurse will label the blood glucose meter and baggy with resident's name and it will be placed in their respective medication cart for the hall or unit the resident is assigned. The Administrator of the facility notified the Director of Health Services and Assistant Director of Nursing to begin education to all Licensed Nurses on the specific resident use of blood glucose meters, storage, cleaning, and disinfecting using proper EPA-disinfecting wipe on 12/9/2025 at 8:30pm. This education included the cleaning, disinfecting, and storage of individual blood glucose meters. All Licensed Nurses who have not received the education by 12/10/2025 will be removed from the schedule until the education has been completed. The education related to cleaning, disinfecting, and storage of individual blood glucose meters will be added to the general orientation of newly hired Licensed Nurses. The Administrator and/or Director of Health Services is responsible for ensuring all Licensed Nurses are educated by 12/10/2025. Licensed nurses who are scheduled to work will receive the in-person education and complete return demonstration of cleaning and disinfecting blood glucose meters; Licensed Nurses who are not scheduled to work will receive over the phone education with return demonstration review by Director of Health Services prior to next scheduled shift. The Administrator and/or Director of Health Services maintains the employee roster of those who have been educated and who require review. On 12/9/2025 The Facility Administrator directed the Director of Health Services to begin education to	F0880		

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F0880 SS = J	Continued from page 45 Licensed Nursed on the Blood Glucose policy. All Nurses who have not been educated by 12/10/2025 will be removed from the schedule until the education is completed. This education related to the revised blood glucose monitoring will be added to the general orientation of all newly hired nurses which includes blood glucose meter cleaning and disinfection procedures. The Administrator and/or Director of Health Services is responsible for ensuring all Licensed Nurses are educated by 12/10/2025. Licensed nurses who are scheduled to work will receive in-person education; Licensed Nurses who are not scheduled to work will receive verbal education over the phone with review of education by the Nurse Manager and/or Administrator upon next scheduled shift. The Administrator and/or Director of Health Services maintains the employee roster of those who have been educated and who require review. The Nursing Facility does not utilize medication aides and/or Agency Nurses. The facility contacted the local health department regarding the infection control breach on 12/10/2025 at 11:00am. The Medical Director was notified on 12/10/2025. Alleged date of immediate jeopardy removal: 12/11/2025 The facility's credible allegation of immediate jeopardy removal was validated on 12/12/2025. The validation was evidenced by observations and/or interviews conducted on each hallway regarding the required infection control practices for the disinfection of blood glucose meters. Record reviews of training, and audits were reviewed. All medication carts were observed to contain individual labeled blood glucose monitors. All the nursing staff who were interviewed reported they had received the required in-service training prior to beginning their shift. They were able to verbally demonstrate knowledge of the blood glucose meter infection control policy and procedure, nurse on all shifts were interviewed. Review of training records titled “Inservice Education Program Summary Record” dated 12/09/2025 and 12/10/2025, for “Blood glucose meter Cleaning and	F0880		

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F0880 SS = J	Continued from page 46 Disinfecting" indicated that each nurse reviewed the policy and then performed a cleaning blood glucose meter skills checklist competency. The in-service training also included a review of the facility policy, as well as completing a return demonstration of the procedures for blood glucose meter disinfection. The education stressed the importance of using individually assigned blood glucose meters for each resident requiring blood glucose monitoring and storing these blood glucose meters in an individual, re-sealable plastic bag with the resident's name. Nurses were observed conducting blood glucose checks and subsequent blood glucose meter disinfection completed the task without difficulty. The nursing practices observed included the handling and storage of blood glucose meters to protect the meters from potential cross-contamination via contact with other meters or surfaces. Interview and observation on 12/10/2025 4:05 am with Nurse #11 revealed that she had received the in-service training on the blood glucose meter the night before when she came on shift, on 12/09/2025 at 10:00 pm from the DON and ADON. Nurse #11 demonstrated disinfecting a blood glucose monitor with disinfecting wipe, allowed it to air dry for one minute and then placed it back into an individually labeled bag for storage. She then placed the bagged blood glucose monitor back into the cart with the other individually labeled monitors. Observation and interview on 12/12/2025 at 10:15 am with Nurse #9 revealed he had received blood glucose training on 12/10/2025 and he verbalized the start to finish process he was trained to disinfect the blood glucose monitors. He then opened his medication cart and revealed that each resident who required blood glucose monitoring had their own machine which was stored in individually labeled bags. Observation and interview on 12/12/2025 at 10:25 am with Nurse #10 revealed she had received blood glucose training on 12/10/2025 and she verbalized the start to finish process she was trained to disinfect the blood glucose monitors. She then opened her medication cart and revealed that the single resident who required blood glucose monitoring on that hall, had their own machine which was stored in individually labeled bag. Interview on 12/12/2025 at 10:30 am with Nurse #12 revealed she had received blood glucose training on 12/12/2025 prior to her shift and she verbalized the start to finish process she was trained to disinfect the blood glucose monitors.	F0880		

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F0880 SS = J	Continued from page 47 Interview on 12/12/2025 at 10:48 am with Nurse #13 revealed he had received blood glucose training on 12/10/2025 and he verbalized the start to finish process he was trained to disinfect the blood glucose monitors. A list of facility licensed nursing staff was reconciled with the acknowledgement of the training. There were no concerns identified during either the interviews or observations or record review. The immediate jeopardy removal date of 12/11/25 was validated.	F0880		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must	F0883	Corrective action for the residents found to be affected by the deficient practice: Resident #20 had their vaccine education information corrected by the Infection Preventionist (IP) on 12/12/25 to demonstrate that the Vaccine Information Sheet (VIS) was covered with the patient prior to the immunization. Resident #72 that did not have the appropriate signatures for the vaccine consent was corrected and new signature by the IP and the resident on 12/12/25 where a verbal consent was required and obtained and then documented correctly along with the education provided from the VIS. Education was provided by the Director of Health Services on 01/08/26 to the IP and Nurse #13 on the proper process to follow for obtaining consents when a resident is unable to sign and the appropriate documentation to use regarding coverage of the information on the vaccine VIS. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents are who are offered in house vaccines have the potential to be affected by the alleged deficient practice. Audit completed on all vaccine consents from Influenza season 2025-2026 were reviewed by the IP for appropriate signatures and appropriate documentation of the education provided from the immunization Vaccine Information Sheets on 01/08/26. There were eighty consents reviewed by the IP with fourteen consents were noted without a signed vaccine information statement	01/13/2026

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F0883 SS = D	Continued from page 48 develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to (1) document that education of the influenza vaccine was provided for Resident #20 and (2) failed to obtain Resident #72's signature on the influenza vaccine consent/refusal form prior to administering the influenza vaccine. This occurred for 2 of 5 residents reviewed for immunizations. Findings included: 1. Resident #20 was re-admitted to the facility on 7/24/25. Review of the facility's document titled, "Resident Influenza (Flu) Vaccine Consent/Refusal Form," revealed Resident #20 consented to receive the influenza vaccine and signed the form on 6/12/25. A Vaccine Information Statement (VIS) form for the influenza vaccine was not attached to the consent form. The significant change Minimum Data Set (MDS) assessment dated 6/13/25 indicated Resident #20 was cognitively intact.	F0883	Continued from page 48 and two with incomplete documentation of verification of signature. All corrections will be completed by 1/12/26. Systemic changes made to ensure that the deficient practice will not recur: Education was provided by the Director of Health Services (DHS)on 01/08/26 to the IP and Senior Care Partner Register Nurse on the proper process to follow for obtaining consents when a resident is unable to sign and the appropriate documentation to use regarding coverage of the information on the vaccine VIS. This education will be added to orientation for infection preventionist and/or senior care partners register nurse. Plans to monitor its performance to make sure that the solutions are sustained. Beginning 01/13/26, The IP or Clinical Competency Coordinator will perform weekly audits for influenza vaccines provided in the facility to ensure appropriate consents were obtained and documented as well as appropriate documentation noted on the education provided from the VIS for each vaccine provided. Audits will begin 01/13/26 and continue weekly for 12 weeks through 04/13/26 or until 100% compliance is maintained. Any areas of concern will be corrected immediately. The audits for vaccine information sheets and proper signature will be tracked and trended by Quality Improvement Coordinator and presented in the monthly Quality Assurance Performance Improvement (QAPI) meeting for 3 months or until substantial compliance maintained. QAPI was completed on 1/9/26 with interdisciplinary team. Date of compliance: 01/13/26	

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F0883 SS = D	Continued from page 49 Review of Resident #20's electronic medical record (EMR) revealed Resident #20 received the influenza vaccine at the facility on 11/4/25. The vaccine education section did not indicate education was or was not provided to Resident #20 or Resident #20's Representative. The facility was unable to provide written documentation that Resident #20 or Resident #20's Representative had received education prior to consenting to the influenza vaccine. During an interview with the Infection Preventionist on 12/11/25 at 2:16 PM, Resident #20's signed vaccination consent form was reviewed. It was noted the form did not have a signed VIS attached to the vaccine consent form. She stated obtaining a signature on the VIS form was most important when a resident or resident representative refuses a vaccine because there would be documentation that they were educated on the risks of refusing the vaccine. The Infection Preventionist stated the VIS forms did not have to be provided or signed for a resident to receive a vaccine. She was unable to locate this information within the Influenza Vaccine policy. Further discussion revealed the Infection Preventionist did not always bring a VIS form when she met with a resident or resident representative to discuss vaccination. She stated a resident or resident representative did not have to sign the Vaccine Information Sheet if they accepted the vaccine and Resident #20 did not sign the form because he accepted the vaccine. The Infection Preventionist stated vaccine education was documented in the resident's EMR. She reviewed Resident #20's EMR and noted the EMR did not indicate education for the influenza vaccine was or was not provided to Resident #20 or Resident #20's representative. The Infection Preventionist confirmed she was responsible for the immunization program for the facility and responsible for obtaining the resident or resident representative's signature for the vaccination consent and VIS forms. An interview with the Director of Nursing (DON) and Administrator was conducted on 12/12/25 at 11:45 AM. Resident #20's influenza vaccine consent form was reviewed, and the missing VIS form was noted. The DON stated providing the Vaccination Information Statement form was not required when a resident or resident representative refused a vaccination. The Administrator stated education was documented in the EMR. Page three of the "Influenza (Flu) Vaccinations for Health Care Center Residents" policy was reviewed. Item #3 stated "Prior to administering the vaccine, the resident or legal representative will be provided the vaccine	F0883		

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F0883 SS = D	Continued from page 50 information statement (VIS). Item #3 further stated education regarding the benefits and side effects of the influenza vaccine "shall be documented in the resident's record." Item #5 stated the resident or legal representative may refuse vaccination and the reason for the refusal "should be documented in the resident's medical record or Electronic Health Record (EHR)." The DON stated the VIS form did not need to be provided to a resident or resident representative when a vaccine was refused because Item #3 began with "Prior to administering the vaccine…" The DON and the Administrator reviewed Resident #20's EMR and were unable to give a reason for why the Vaccination Information Statement was not provided to Resident #20 and why vaccine education was not documented in Resident #20's EMR. 2. Resident #72 was admitted on 3/24/25. The quarterly Minimum Data Set (MDS) assessment dated 7/8/25 indicated Resident #72 had moderate cognitive impairment. The MDS indicated Resident #72's hearing and vision were adequate, speech was clear, was able to understand, and was able to be understood. The MDS further indicated Resident #72 had no functional impairment to upper and lower extremities with range of motion and had the ability to use suitable utensils to bring food to his mouth. The facility document titled "Resident Influenza (Flu) Vaccine Consent/Refusal Form" for Resident #72 revealed the form was marked for consenting to receive the influenza vaccine. The consent form did not have Resident #72's signature or a signature for Resident #72's Representative. The vaccine consent form dated 7/24/25 was witnessed by the Infection Preventionist and Nurse #18. The vaccine consent further revealed the influenza vaccine was administered on 10/24/25 by Nurse #13. An influenza VIS form was attached to the consent form with two witness signatures dated 7/24/25. The VIS form did not have Resident #72's signature or a signature for Resident #72's Representative. During an interview with the Infection Preventionist on 12/11/25 at 2:16 PM, Resident #72's influenza vaccine consent form was reviewed. She noted the resident/resident representative signature line was blank but there were two witness signatures dated 7/24/25. She also noted the attached influenza VIS did not have a signature for Resident #72 or a signature for Resident #72's Representative. The Infection Preventionist's signature was one of the two witness signatures on both forms. She stated her signature represented she witnessed Resident #72's verbal consent	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0883 SS = D	Continued from page 51 to receive the vaccine. The Infection Preventionist stated she did not think about documenting verbal consent was obtained from Resident #72 on the vaccine consent form. The Infection Preventionist indicated she and Nurse #18 had taken the forms into Resident #72's room and explained the vaccine to him on 7/24/25. The vaccine was administered by Nurse #13 on 10/24/25. The Infection Preventionist confirmed she was responsible for the immunization program for the facility and obtaining the resident or resident representative's signature for the vaccination consent and VIS forms. During an interview on 12/11/2025 at 2:34 PM, Nurse #13 confirmed she reviewed vaccination consent forms prior to administering vaccines. Upon review, Nurse #13 noticed the resident/resident representative signature line was blank on Resident #72's influenza vaccine form. She stated she likely noticed Resident #72's name was written on a line and did not review the form for Resident #72's signature. Nurse #13 confirmed she administered the influenza vaccine to Resident #72 on 10/24/25. An interview with the Director of Nursing (DON) and Administrator was conducted on 12/12/25 11:45 AM. Resident #72's influenza vaccine consent and influenza VIS forms were reviewed by the DON and the Administrator. The DON noticed Resident #72's missing signature on both forms. The DON stated Resident #72 likely refused to sign the forms but gave verbal consent to receive the influenza vaccine. She stated she did not know why the consent form did not state Resident #72 gave verbal consent with witness signatures. The DON and the Administrator were made aware the Infection Preventionist did not document she obtained telephone consent from resident representatives who lived out of state. The DON stated policy did not state documenting verbal consent or telephone consent was required.	F0883		