STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	**4748 Old Salisbury Road , Lexington, North Carolina, 27295**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/25/25 through 8/28/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D4463-H1.	E0000		09/19/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/25/25 through 8/28/25. Event ID# 1D4463-H1. The following intakes were investigated 745038, 745019, 745003, 745031, 745020, 745035, 2571121, 745037, 745034, 745027, 745005, 745015, and 745006. 15 of the 47 complaint allegations resulted in deficiency.	F0000		09/19/2025
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, 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.	F0550	F0550-Resident Rights/Exercise of Right Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 08/26/25, facility failed to provide cueing assistance during meals as specified in the residents #90 care plan. Once identified a certified nursing assistant assisted resident with meal. No negative outcomes for resident #90. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/15/25, the director of nursing/designee to audit all of the residents requiring assistance and/or cues with meals. Observations of dining room staff and residents seating were observed. Any discrepancies corrected immediately.	09/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0550 SS = D	Continued from page 1 §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 observations, record review, and resident and staff interviews, the facility failed to provide cueing assistance during a meal as specified in the resident's plan of care. Resident #90 was seated at a table in the main dining room with her meal tray in front of her not eating while other residents at other tables were eating their lunch. This deficient practice affected 1 of 8 residents reviewed for dignity. The findings included: Resident #90 was admitted to the facility on 2/10/21 with diagnoses that included Alzheimer's disease, dementia, dysphagia (difficulty swallowing), and memory deficit following other cerebrovascular disease. Review of a quarterly Minimum Data Set (MDS) dated 5/22/25 assessed Resident #90 to be severely cognitively impaired without behaviors. She was assessed as requiring set-up or clean-up assistance with eating. According to the active care plan for Resident #90 dated 6/28/25, the resident had an ADL (activities of daily living) self-care performance deficit related to Alzheimer's. An approach read Resident #90 needed set-up and cueing assistance with meals. On 8/25/25 at 12:15 PM an observation was conducted in the main dining room during lunch. Resident #90 was noted to be sitting by herself in a wheelchair at a	F0550	Continued from page 1 Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Director of nursing/designee educated 100% nursing staff on assisting residents that require cueing at meals. Staff must be seated near resident and remain attentive. Education completed on 09/18/.25. The nursing home administrator/designee will assign and educate members of the interdisciplinary team on dining room management. Education completed on 9/18/25 New hires will be educated during onboarding/orientation. Agency staff will receive this same education prior to working their next scheduled shift. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Starting 9/22/25 the director of nursing/designee will observe meals to include meals on all shifts 5 times a week for 12 weeks to ensure that residents requiring cueing consistently receive the appropriate level of care. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 9/23/25	

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F0550 SS = D	Continued from page 2 table in the main dining room while four other residents were seated at a table to her right eating their meal. Resident #90 had a tray of food set up sitting on the table in front of her that was untouched. The resident did not attempt to eat during the observation. Nurse Aide (NA) 6 and NA #7 were observed seated at a table at the back of the dining room. Each NA had one resident sitting beside each of them assisting those residents with eating. Neither NA was observed assisting Resident #90. NA #6 and NA #7 were interviewed on 8/25/25 at 12:38 PM. NA #6 stated there were usually only 2 staff members in the dining room at mealtimes. NA #6 and NA #7 stated Resident #90 only occasionally needed cueing and assistance with her meals. On 8/26/25 a continuous observation from 12:30 PM to 1:17 PM was conducted in the main dining room during lunch. Resident #90 was noted to be sitting by herself at a table in the dining room with a tray of food set up sitting on the table in front of her, and it was untouched. The resident did not attempt to feed herself during the observation. There were three residents eating lunch at a table to Resident #90's right side. NA #3 and NA #4 were observed sitting at a table in the back of the dining room assisting two residents with eating. Each NA was assisting one resident with an empty seat on the other side of the NA. At 12:33 PM on 8/26/25 an interview was conducted with NA #4 and NA #3. NA #4 stated if more than one resident needed assistance with eating then she could have one resident sit at her right side and one resident sit at her left side to assist both during mealtimes. She stated Resident #90 only occasionally needed assistance with meals and would sometimes feed herself if her tray was set up in front of her. NA #3 agreed that NA staff could assist two residents during mealtimes. NA #4 and #3 were not aware Resident #90's care plan specified she required cueing with her meals. At 1:17 PM NA #4 completed assisting the resident she had been helping and then approached Resident #90 and began assisting her with eating her meal. The Director of Nursing (DON) was interviewed on 8/28/25 at 11:20 AM and stated if a resident needed cues to eat, they should be placed closer to the NAs in the dining room who were there to assist residents with eating. She stated a resident should not have to wait to eat their meals while others were assisted.	F0550		
F0583 SS = D	Personal Privacy/Confidentiality of Records	F0583	F0583-Personal privacy/confidentiality of records	09/22/2025

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F0583 SS = D	Continued from page 3 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to protect residents' private healthcare information by leaving confidential medication information unattended, visible, and accessible to others on the computer screen for 1 of 5 medication carts observed (100 hall medication cart). Findings included: A continuous observation of the upper 100-hall	F0583	Continued from page 3 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/26/25, it was identified the facility failed to protect residents private healthcare information by leaving confidential medication information unattended, visible, and accessible to others on the computer screen on 100 hall medication cart. This was immediately corrected by closing computer screen and providing 1:1 education to the nurse of providing confidential records. No negative outcomes. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents in building have the potential to be affected. On 09/17/25, Director of nursing/designee audited 100% of medication carts in building to ensure confidential medical information was not left unattended, visible, or accessible to others and that computer screens were closed or signed off to maintain confidentiality. Deficiencies were corrected immediately. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The director of nursing/designee educated all licensed nursing staff and medication aides on ensuring computer screens are closed or signed off to protect resident's confidential medical information when unattended. Educated completed on 08/26/25 During routine rounding clinical leadership will ensure all computer screens are closed or signed off while unattended to protect resident's confidential medical information. New hires will be educated during on boarding process. Agency staff will receive the same education prior to working their next schedules shift. Education of all current agency nurses completed on 09/19/25 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 09/22/25, director of nursing/designee to conduct audit 2 medication carts a week for 12 weeks to	

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F0583 SS = D	Continued from page 4 medication cart occurred on 8/26/25 from 2:28 PM until 2:33 PM. The medication cart was in the hallway unattended and was observed to have the computer screen opened which showed multiple residents' personal identifying information such as resident name, diagnoses, medications, date of birth, and room number. The medication cart was observed for five minutes, and during that time one Nurse Aide and the Wound Nurse walked past the cart. Nurse #3 was interviewed on 8/26/25 at 2:33 PM. She confirmed she was responsible for the 100-hall medication cart. Nurse #3 stated she should have locked the computer screen before leaving the cart. The nurse further stated, "I'm so far behind giving medications that I just ran down the hall to give the medications." Nurse #3 explained she did not normally leave a computer screen unlocked, and she should have locked it before walking away. The Director of Nursing (DON) was interviewed on 8/28/25 at 11:20 AM and stated all computer screens should remain locked to protect the residents' privacy when a medication cart is unattended. She stated Nurse #3 was educated regarding patient privacy and sent home on 8/25/25 after leaving the screen open. On 8/28/25 at 2:25 PM the Administrator was interviewed and indicated residents' private information should have been secured.	F0583	Continued from page 4 computer screens are closed so no confidential resident information is visible/accessible. Finding from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 9/23/25	
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical	F0584	F584 – Safe/Clean/Comfortable/Homelike Environment Address how corrective action will be accomplished for those residents found to have been affected by the defective practice: An initial observation completed on 8-25-25, facility identified deficient practice with maintenance, environment and cleanliness in room 207. On 8-26-25, observation was conducted the wall was behind Resident #83 headboard and under the PTAC unit were repaired. On 8-27-25, observation was conducted and room was cleaned and odor free. Address how the facility will identify other residents having the potential to be affected by the same	09/22/2025

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F0584 SS = D	Continued from page 5 layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure a resident room was in good repair and failed to maintain a clean and sanitary conditions in a resident room. The deficient practice was evidenced for 2 of 8 residents (Resident #67 and Resident #83) observed for a safe, clean and homelike environment on 1 of 4 resident halls (200 hall). a. An initial observation was completed on 08/25/25 at 10:33 AM of Resident #67 and Resident #83's room. The observation revealed a hole in the wall at the corner of Resident #83's headboard that measured approximately 11.5-inch x 8 inches with sheetrock exposed. On the wall to the left side of Resident # 83's bed paint was peeling off the wall between the bottom of the window frame and the packaged terminal air conditioner (PTAC) unit. The area of peeling paint extended was the length of the PTAC unit.	F0584	Continued from page 5 deficient practice: All residents have the potential to be effective by the deficient practice. On 9-12-25, the Director of Maintenance/Concierge team conducted a facility wide environment inspection of the floors, walls, and cleanliness of resident's rooms. Any areas noted will being brought to the attention to housekeeping or maintenance for immediate attention. Two rooms will be aesthetically corrected weekly until all identified areas are fixed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not repeat. On 9-12-25, The Administrator/designee educated all management team on identifying environmental/cleanliness of resident's rooms. During routine rounds the Concierge team/Clinical Leadership will observe for compliance. All new hires will be educated during On Boarding/Orientation. Administrator/Director of nursing/designee educated all nurses and certified nursing assistance to report environmental/cleanliness of rooms and any damaged areas including furniture and or equipment immediately to management and complete a maintenance request form. Completed on 9/22/25. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9-22-25, the Administrator/Designee will do facility rounds 5 days a week, for 12 weeks to ensure areas of environment concerns are identified and handled appropriately. Results of the audits will be reviewed by the Quality Assurance Performance Improvement for 3 months and the plan of correction will be revised as needed. Alleged Compliance Date: 9/23/25	

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F0584 SS = D	Continued from page 6 During subsequent observations on 08/25/25 at 12:35 PM and 08/25/25 at 3:00 PM the room was still in need of wall repairs. An interview and observation were conducted on 08/25/25 at 3:00 PM with the Maintenance Director. The Maintenance Director observed the peeling paint above the PTAC unit and the hole at the headboard and stated he had not been made aware of the damaged areas. He measured the area of peeling paint above the PTAC unit which measured 42 inches x 4 3/4 inches and the area behind the headboard which measured 11-inch x 9 inches. He stated the areas should have been reported to maintenance for repairs. He explained that when staff notice repairs need to be done on equipment, furniture, and/or walls they would fill out a maintenance slip and put it in the maintenance book so it can be addressed. Another observation was conducted on 08/26/25 at 10:21 AM of Resident #67 and Resident #83's room. The wall behind Resident #83's headboard and under his PTAC unit were repaired. b. An initial observation completed on 08/25/25 at 10:33 AM of Resident #67 and Resident #83's room revealed the strong odor of urine throughout the room, an empty urinal on the floor between the bathroom door and Resident #67's bed, a sock, pillowcase, and box of tissues were under Resident #67's bed. Resident # 67's bedside table had an empty cup lying over on its side with a sticky substance from the edge of the cup across the table measuring approximately 6 inches X 3 inches and food crumbs were scattered on the table. A spoon and fork were on top of Resident #67's mattress. There was also food crumbs scattered on the floor throughout the room. Another observation was conducted on 08/26/25 at 10:21 AM of Resident #67 and Resident #83's room. The strong odor of urine was still throughout the room, a sock, pillow case, and a box of tissues were still under Resident #67's bed. Resident # 67's bedside table still had a sticky substance from the edge of the cup across the table measuring approximately 6 inches X 3 inches and food crumbs were scattered on the table. A follow-up observation was conducted on 08/27/25 at 9:40 AM of Resident #67 and Resident #83's room. Room was now clean, no smell of urine was present, no trash, a box of tissues, clothes or food crumbs were on floor. An interview was conducted on 08/26/25 at 3:10 PM with Housekeeper #1. She stated she was the only one cleaning rooms on 08/25/25 and 08/26/25 and she was	F0584		

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F0584 SS = D	Continued from page 7 doing the best she could. She indicated she could not recall if she had cleaned Resident #67 and Resident 83's room. An interview and observation were conducted on 08/27/25 at 2:56 PM with the Environmental Services Director. He stated the housekeeper for Resident #67 and Resident #83's room called out on Monday (08/25/25), Tuesday (08/26/25), and Wednesday (08/27/25) and he had only one person available to clean resident rooms. He explained that he had hired one new housekeeper and a different housekeeper quit on 08/25/25, and another one quit on 08/26/25. He indicated he didn't know what to do but continue to try and hire more staff. He stated normally when he had a call out, he would pull his floor tech to assist where he was needed but with the number of staff that have quit, he needed him in laundry and on the floor cleaning rooms. Monday and Tuesday the floor tech helped with the laundry and with cleaning rooms. The Environmental Services Director then stated the staff that were available would work together and do the best they could. He indicated he did not notify management or corporate for assistance because he didn't think it would change anything. An interview was conducted on 08/28/25 at 2:45 PM with the Administrator. She stated she expected any room that needed repairs to be reported to the Maintenance Director so the repairs would be addressed and that resident rooms should be kept in good repair and clean. She indicated she was unaware some rooms had been missed during cleaning due to environmental service department call outs.	F0584		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance	F0585	F585 Resident/Family/Group Response Address how corrective action will be accomplished for those residents found to have been affected by the defective practice: On 8-25-25, it was identified that the facility failed to provide a written grievance response summary to Resident #9, #70, and #91. Copies of the written grievance were mailed to the Resident's Responsible Party. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All resident /resident representative have the potential to be effective by the deficient practice. On	09/19/2025

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F0585 SS = D	Continued from page 8 with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;	F0585	Continued from page 8 9-15-25, the Administrator/Social Services Director completed a 30 day look back on all grievances. Any grievance that did not have a written response have been corrected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9-10-25, the Administrator/Designee, educated the Department Heads on the policy on completing the grievance procedure and the written resolution for each grievance emphasizing the importance of timely written responses. Address what measures will be put into place or systemic changes made: Beginning 9-15-25, the Social Service Director or designee will audit the grievances weekly for 12 weeks to verify that all grievances include a written resolution. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed. Alleged Compliance date: 9/23/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	**4748 Old Salisbury Road , Lexington, North Carolina, 27295**

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F0585 SS = D	Continued from page 9 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Resident Representative (RR) and staff interviews, the facility failed to provide a written grievance response summary for 3 of 3 residents reviewed for grievances (Residents #9, #70 and #91). The findings included: A review of the facility grievance policy, dated 8/2018, included, in part, “The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident’s grievance was resolved or will be resolved, if applicable. A copy of the written grievance decision will be provided to the resident, upon request”. The policy did not address how grievance resolutions would be handled by anyone else that filed a grievance concern, such as the RR. 1. Resident #9 was originally admitted to the facility on 7/1/24. A quarterly Minimum Data Set (MDS) assessment dated 7/15/25 indicated she was cognitively intact.	F0585		

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F0585 SS = D	Continued from page 10 A review of the facility grievance logs from August 2024 to August 2025 revealed a concern form had been initiated on 7/15/25 by Resident #9's RR, regarding negative staff interaction with Resident #9. The concern form indicated a telephone notification was completed with the RR on 7/30/25 by the Social Worker. The form indicated a written response was not provided to the family member and was signed and dated by the Administrator on 7/30/25. On 8/27/25 at 10:24 AM, a phone interview was completed with Resident #9's RR who completed the grievance form on 7/15/25. She stated that she had never received nor been offered a written resolution of grievances from the facility, just that the Social Worker called her or would speak to her when she visited Resident #9. An interview occurred with the Social Worker on 8/27/25 at 1:04 PM, who stated that she maintained the facility grievance log. She stated when a grievance resolution was received, she normally provided the resolution either via a phone call or face to face to the RR or resident, if it had not already been provided by another member of management. She stated that she was unaware a written response was required for grievances. The Administrator was interviewed on 8/28/25 at 8:58 AM and stated that she was aware a written grievance response was required and was not aware this was not being offered and provided to RR's when a grievance concern had been resolved. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries. 2. Resident #70 was admitted to the facility on 3/18/20. A quarterly MDS assessment dated 6/20/25 indicated she had moderately impaired cognition. A review of the facility grievance logs from August 2024 to August 2025 revealed six concern forms were initiated by Resident #70's RR: - On 12/30/24 a concern form was initiated regarding staff concerns. The form indicated the Administrator spoke one-to-one with Resident #70's RR on 12/30/24 and	F0585		

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F0585 SS = D	Continued from page 11 a written response was not provided. The form was signed and dated by the Administrator on 12/30/24. - On 4/1/25 a concern form was initiated regarding laundry. The form indicated the Unit Manager spoke one-to-one with Resident #70's RR on 4/1/25, a written response was not provided to the RR and was signed and dated by the Administrator on 4/1/25. - On 6/25/25 a concern form was initiated regarding laundry. The form indicated the Social Worker spoke via phone to the RR regarding the resolution on 6/25/25, a written response was not provided to the RR, and the form was signed and dated by the Administrator on 6/25/25. - On 6/25/25 another concern form was initiated regarding care concerns. The form indicated the Social Worker spoke one-to-one with the RR on 6/25/25, a written response was not provided to the RR, and the form was signed and dated by the Administrator on 6/25/25. - On 6/25/25 a third concern form was initiated regarding staff communication for the care of Resident #70. The form indicated the Social Worker spoke one-to-one with Resident #70's RR on 6/26/25, a written response was not provided to the RR and was signed and dated by the Administrator on 6/26/25. - On 6/26/25 a concern form was initiated regarding the cleanliness of Resident #70's bathroom. The form indicated the Social Worker spoke one-to-one with Resident #70's RR on 6/26/25, a written response was not provided to the RR and was signed and dated by the Administrator on 6/26/25. A phone interview was completed with Resident #70's RR on 8/28/25 at 9:47 AM. She stated that she had never been provided or offered a written summary of her grievance concerns from the facility, just that they would either call her or speak to her face to face regarding the grievance resolution. An interview occurred with the Social Worker on 8/27/25 at 1:04 PM, who stated that she maintained the facility grievance log. She stated when a grievance resolution was received, she normally provided the resolution either via a phone call or face to face to the RR or resident, if it had not already been provided by another member of management. She stated that she was unaware a written response was required for grievances.	F0585		

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F0585 SS = D	Continued from page 12 The Administrator was interviewed on 8/28/25 at 8:58 AM and stated that she was aware a written grievance response was required and was not aware this was not being offered and provided to RR's when a grievance concern had been resolved. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries. 3. Resident #91 was admitted to the facility on 6/18/24. An annual MDS assessment dated 6/17/25 indicated she was cognitively intact. A review of the facility grievance logs from August 2024 to August 2025 revealed a concern form was initiated by Resident #91's RR on 5/14/25 regarding care concerns and the functionality of the call light. The form indicated the Administrator spoke one-to-one with Resident #91's RR on 5/14/25 and a written response was not provided to the RR. A phone interview was completed with Resident #91's RR on 8/28/25 at 9:51 AM. He stated that he had never been provided with or offered a written summary of grievance concerns from the facility, just that they would either call him or speak to him face to face regarding the grievance resolution. An interview occurred with the Social Worker on 8/27/25 at 1:04 PM, who stated that she maintained the facility grievance log. She stated when a grievance resolution was received, she normally provided the resolution either via a phone call or face to face to the RR or resident, if it had not already been provided by another member of management. She stated that she was unaware a written response was required for grievances. The Administrator was interviewed on 8/28/25 at 8:58 AM and stated that she was aware a written grievance response was required and was not aware this was not being offered and provided to RR's when a grievance concern had been resolved. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance	F0585		

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F0585 SS = D	Continued from page 13 response summaries.	F0585		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, family member and staff interviews, the facility failed to protect a resident's right to be free from staff to resident abuse when Nurse Aide (NA) #1 slapped Resident #74's hand when she became combative after removing her from another resident's room. This was for 1 of 1 resident reviewed for employee to resident abuse (Resident #74). The findings included: Resident #74 was admitted to the facility on 8/27/21 with diagnoses that included dementia with behavioral disturbances, osteoporosis, and major depressive disorder. Resident #74 resided on the Lillian's Way Hall. An annual Minimum Data Set (MDS) assessment dated 5/7/2025 prior to the incident and the most recent on 8/7/2025 indicated that Resident #74 had severely impaired cognition with behavioral symptoms. She had limited range of motion to extremities and utilized a wheelchair for mobility. Resident #74 was coded as weighing 115 pounds and was 63 inches tall on 5/7/2025. Resident #74's care plans on 5/7/2025 prior to the	F0600	F0600-Free from Abuse and Neglect 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/29/2025 Resident #74 was observed going into another resident's room when NA #1 pulled her out. Resident #74 was trying to hit NA #1, NA #1 then slapped the resident's hand. NA #1 was immediately removed from the building. Resident was placed at nursing station with NA #2 and floor nurse to provide psychosocial support and any immediate needs. The Medical Director was notified, family was notified, the DON was notified, investigation initiated, and the police were called to the facility. Adult protective services were notified. Resident #74 was immediately evaluated with head-to-toe assessment, no negative findings. Abuse coordinator did the initial (6/29/25) and 5 day (7/1/25) report as required. To prevent abuse from happening to resident #74 the staff will initiate interventions to deescalate behaviors such as re-approach or one on one. To protect all residents from future abuse NA#1 was immediately terminated. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by deficient practice. On 06/29/2025 DON/designee interviewed capable resident for any concerns of neglect/abuse: no negative findings (BIMS: 13 or above- Intact mental status). DON/designee performed skin checks on incapable residents (BIMS: below 13-moderate/severe impairment) for any signs of neglect/abuse: no negative findings. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 06/29/2025 DON/designee provided education to all staff about abuse policy. DON/designee provided education to all staff on identifying and reporting any suspicions, allegations, or witnessed abuse, as well as signs of staff burnout. Staff instructed if any identification of staff with increased agitation or change of behavior to offer a break and inform management to assess for possible change of assignment. DON/designee will complete education to employees that are on vacation prior to returning to work. DON/designee will complete education to all new hire employees during on boarding/orientation. All education was completed on 06/30/2025. ADHOC QAPI completed on 06/30/2025 *On 9/18/25 100% of staff educated on abuse policy,	09/19/2025

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F0600 SS = D	Continued from page 14 incident and the last reviewed on 8/19/2025 included the following problem areas: Resident had impaired cognitive function and thought processes related to Alzheimer'sResident had physical behavioral symptoms towards others (physical aggression, verbal aggression, refusing medications, refusal of care, easily agitated, and may attempt to get up without assistance). The interventions included intervene as necessary to protect the rights and safety of others including approach and speak to resident in a calm manner, divert attention when appropriate, and remove from situation and take to alternate location as appropriate. The interventions also included if resident becomes combative with care, leave resident safely and reattempt care at a later time. A review of the facility initial allegation report, investigation and statements revealed on 6/29/25 Resident #74 was in a separate resident's room when Nurse Aide (NA) #1 went to wheel Resident #74 out of the room. Resident #74 became combative, and NA #1 smacked her right hand causing a reddened area to appear on the top of posterior right hand. The incident was witnessed by NA #2 who was sitting at the nurse's station. NA #1 was initially suspended and then her employment was terminated. All staff received education on abuse. On 08/28/2025 at 11:13 AM phone call was placed to NA #1. NA #1 was not reachable. Message was left with no response call back. On 8/26/25 at 5:22 PM, an interview occurred with NA #2 who witnessed the events on 6/29/25. She explained that she was sitting at the nurse's desk at Lillian's Way Hall and could see NA #1 wheeling Resident #74 out of another resident's room and up to the nursing station. NA #2 saw Resident #74 start to fling her arms up in the air and hitting NA #1 in the process. NA #2 saw NA #1 smack Resident #74's hand down. NA #2 told NA #1 that she would need to report the incident to the Director of Nursing (DON). On 8/26/25 at 6:10 PM, an interview occurred with Nurse #1. She explained that she received a call on 6/29/25 from the DON about the incident and was asked to go over and start a reportable. Nurse #1 reported that NA #1 admitted the incident to her. Nurse #1 stated that NA #1 reported not smacking the resident out of malice but due to reflex because Resident #74 was swinging her arms around and hit NA #1. Nurse #1 reported that NA#1	F0600	Continued from page 14 behavioral intervention in dementia residents and staff with increased agitation and burnout. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. To ensure sustained compliance and prevent recurrence, the DON/designee immediately (06/29/2025) implemented monitoring and will maintain ongoing compliance by auditing five residents weekly for twelve weeks to ensure no concerns with care/abuse. DON/designee will monitor and maintain ongoing compliance by auditing five staff members weekly for twelve weeks on abuse/neglect using questionnaires on types of abuse, when and who to report abuse to, first steps to take if suspected and/or actual abuse witnessed and caring for dementia/combative behaviors. DON/designee to monitor and maintain ongoing compliance by auditing five staff members weekly for twelve weeks to include all shifts, while giving care to observe any signs of burnout and offer breaks when needed. The results of the audit will be reported monthly in QAPI x3 months for review and revision as needed by the Director of nursing. Alleged compliance date: 9/23/2025	

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F0600 SS = D	Continued from page 15 was immediately terminated and not allowed to return into the building. Nurse #1 reported that she has not seen NA #1 back at the facility since the incident occurred. On 08/28/2025 at 1:44 PM, an interview occurred with Nurse #2. She stated that she was not present on the evening of the incident but did work with Resident #74 on the next day, 6/30/25. Nurse #2 stated that she did not recall any redness on Resident #74's hand. Nurse #2 reported that she also did a skin assessment for Resident #74 on 7/1/25 and no redness was seen on resident's skin on that date. Nurse #2 stated that she had no concerns on that day regarding Resident #74's skin. On 8/25/25 at 10:15 AM, Resident #74 was observed sitting up in her bed with cookies in front of her. She was unable to recall the events of 6/29/25. On 8/25/25 at 12:40 PM, an interview occurred with a family member who was called about the incident after it happened. The family member reported that she has had good communication and rapport with staff during Resident #74's stay at the facility and staff treat Resident #74 well and she was satisfied with the care that she received. The family member indicated she was made aware of the incident that happened between Resident #74 and NA #1 a couple of months ago right after it happened and she was satisfied with the facilities response to the incident. Family member reported no additional concerns. On 8/28/2025 at 1:59 PM, an additional interview occurred with a family member. Family member reported that initially she was concerned when they called but once facility staff explained in detail what happened then she felt better. The family member reported that she felt like the facility handled the situation appropriately by terminating the employee and making a report to the authorities. The family member stated she was not nervous about Resident #74's care at the facility and felt that staff provided good care to Resident #74. On 8/27/25 at 8:07 AM, an interview occurred with DON. The DON reported that the NA #1 called her crying and stated that she had to tell her something she had done. The DON indicated that per NA #1's statement, Resident	F0600		

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F0600 SS = D	Continued from page 16 #74 was going into another resident's room and NA #1 went to get her out. NA #1 reported that Resident #74 was fighting her, and she smacked her on the hand. DON reported that NA #1 was a good NA and had never done anything like that before. The DON stated she explained to NA #1 that it was not acceptable and that NA #1 was not to go back into the building. DON reported that she called Nurse #1 on duty and asked her to go and take NA #1's statement in person so that it could be reported and Nurse #1 also called the family to notify them regarding the incident. the interview further revealed Nurse #1 also did a head to toe of the resident and did a complete sweep of the unit to check the other residents. DON reported that there were no other concerns reported. On 8/28/2025 at 11:42 AM, an interview occurred with the Administrator. The Administrator reported she was notified by NA #2 who witnessed the situation regarding the allegation of abuse. The Administrator stated that this was reported immediately, and NA #1 was removed from the facility. The Administrator revealed that NA#1 was immediately suspended and then her employment was terminated. The Administrator reported that the police department was notified, and an investigation was initiated. The Administrator stated she was able to view video footage at the time that revealed that Resident #74 had just been taken to the nurse's station when she became combative towards NA #1 which is when NA #1 was then seen smacking the resident's hand down. The Administrator stated that NA #1 was a good employee, however, they do not tolerate any type of abuse towards a resident. The Administrator reported that there have been no further staff to resident abuse concerns since this incident on 6/29/25.	F0600		
F0646 SS = D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, the facility failed to notify the State Mental Health Authority after a resident diagnosed with a serious mental illness experienced a change in condition. This	F0646	F0646-MD/ID Significant Change Notification Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 08/27/25, it was identified the facility failed to notify the State Mental Health Authority after resident #91 experienced a change in condition needing an updated PASSR. On 8/27/25, resident #91 PASRR was submitted to State Mental Health Authority for change of condition. On 9/3/25 PASSR returned at a level 2. No negative effects resulted from the PASRR not being applied for when resident experienced significant change of condition.	09/19/2025

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F0646 SS = D	Continued from page 17 deficient practice affected 1 of 1 resident reviewed for (PASRR) Preadmission Screening and Resident Review (Resident #91). Findings included: Resident #91 was admitted to the facility on 6/18/24 with diagnoses that included bipolar disorder, in partial remission and generalized anxiety disorder. Resident #91had a level I PASRR dated 5/23/24, which stated no further screening was required unless a significant change occurred to suggest a diagnosis of mental illness or a change in treatment needs for those conditions. Record review of the psychiatric follow-up evaluation dated 12/10/24 revealed on 12/5/24 Resident #91's Depakote dose was increased to 500 milligrams by mouth three times a day for treatment of bipolar disorder to assist with mood. According to the psychiatric evaluation, the Lexapro Resident #91 was previously prescribed was also restarted at 5 milligrams by mouth at bedtime due to the resident's increasing anxiety. The evaluation further indicated Resident #91 had behaviors of refusing showers and yelling out. On 8/27/25 at 9:24 AM the Social Worker was interviewed and confirmed she was responsible for ensuring residents with a newly diagnosed mental illness or change in condition were referred for a level II PASRR evaluation. She stated a level II PASRR screening request should have been sent at the time Resident #91 had a change in treatment for her bipolar disorder, but she must have overlooked it. The Director of Nursing was interviewed on 8/28/25 at 11:20 AM and stated residents with mental illness needed their level II PASRR determinations completed on time. On 8/28/25 at 2:25 PM the Administrator was interviewed and stated the residents with a mental health disorder had to have their PASRRs done correctly and on time.	F0646	Continued from page 17 Address how the facility will identify 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. On 09/03/25, all residents with significate change in condition in status were audited. Any deficits found were corrected immediately. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Administrator/Designee educated the social worker on reviewing change of condition in status requiring reporting the State Mental Health Authority. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning on 09/22/25 Social worker/designee will audit all new residents with PASRR, current residents with significant change of condition during clinical meeting weekly for 12 weeks. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months Administrator/designee will audit 3 residents per week for 12 weeks to determine if level 2 PASRR was applied for if needed. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 09/23/25	
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth	F0656	F0656-Develop/Implement Comprehensive Care Plan Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 08/25/25 the facility failed to develop a comprehensive person-centered care plan for resident	09/24/2025

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F0656 SS = D	Continued from page 18 at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive person-centered care plan for 1 of 26 residents reviewed for comprehensive care plans (Resident #55).	F0656	Continued from page 18 #55. On 08/27/25 residents comprehensive care plan was completed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by deficient practice. On 09/18/25 Director of nursing/designee completed a 30 day look back on all care plans and any discrepancies identified were corrected immediately. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: On 09/18/25 Administrator/designee educated Minimum Data Set nurses on requirements for development Implementation Comprehensive Care Plans. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning on 09/22/25 Administrator/designee will audit residents care plans 3 times a week for 12 weeks to ensure comprehensive care plans complete. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months Alleged Compliance Date: 09/23/25	

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F0656 SS = D	Continued from page 19 Findings included: Resident #55 was admitted on 7/26/25 with diagnoses including multiple fractures of the pelvis, glaucoma, and anxiety. Resident #55's Admission Minimum Data Set (MDS) dated 7/30/25 indicated she was cognitively intact. The Care Area Assessment (CAA) Summary indicated eight areas of concern which were triggered from the MDS and identified for care planning. These included: Visual Function, Activities of Daily Living Function, Urinary Incontinence, Falls, Dental Care, Pressure Ulcer, Psychotropic Drug Use, and Pain. Four Care Plans were observed in Resident #55's record and included Social Services discharge planning and Advanced Directives both dated 7/26/25, Activities dated 7/28/25, and Nutritional Status dated 8/2/25. On 8/28/25 at 8:48 AM an interview with MDS Nurse #2 was conducted. MDS nurse #2 explained she was responsible for the short-term care residents' assessments and care plans. MDS nurse #2 stated she became aware last evening she had forgotten to complete Resident #55's care plans. On 8/28/25 at 2:46 PM an interview was conducted with the Director of Nursing (DON). She stated comprehensive care plans should be completed on time.	F0656		
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 record review, resident, Medical Director and staff interviews, the facility failed to initiate physician orders on admission for the care of a surgical wound for 1 of 2 residents reviewed for quality of care (Resident #100).	F0658	F0658-Services Provided Meet Professional Standards Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/28/25, it was identified the facility failed to initiate physicians orders on admission for the care of a surgical wound for resident #100. Resident no longer resides in facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/17/25 Director of nursing/designee did a 14 day look back of all surgical admissions to include	09/22/2025

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F0658 SS = D	Continued from page 20 The findings included: Review of the hospital records dated 8/7/24 through 8/9/24 revealed Resident #100 had a total left knee replacement and was admitted to the orthopedic unit for continued care. The hospital discharge summary dated 8/9/24, included the following wound management orders: - Leave the Aquacel dressing (a type of dressing used for wounds to include surgical wounds) in place for seven days after surgery. On postoperative day seven, remove the Aquacel dressing and apply a dry dressing daily if needed. - If you have a Zipline dressing (a non-invasive skin closure device designed for surgical incisions): the Zipline dressing is adhesive and may be peeled off 14 days after surgery. Once removed, dressings or steri-strips are not needed. Resident #100 was admitted to the facility on 8/9/24 Her diagnoses included aftercare following joint replacement surgery, diabetes type 2 and primary osteoarthritis of the left knee. The admission skin assessment completed by Nurse #9 and dated 8/9/24 indicated Resident #100 had bruising present to her bilateral upper extremities, left hand, left thigh and a surgical incision to the left knee with Aquacel dressing in place. The skin assessment did not indicate if Resident #100 had surgical clips or a Zipline dressing. A review of the August 2024 physician orders did not include the removal of the Aquacel dressing seven days postoperatively or the removal of the Zipline dressing/surgical clips 14 days postoperatively. A review of the August 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no orders for the removal of the Aquacel dressing seven days postoperatively or the removal of the Zipline dressing/surgical clips 14 days postoperatively. A physician progress note dated 8/12/24 indicated that Resident #100 had recently underwent an elective left total knee replacement and on postoperative day seven	F0658	Continued from page 20 discharge summaries to ensure all treatment orders are in place on admission. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The regional director of clinical services educated Director of nursing, assistant director of nursing, unit manager on ensuring discharge summaries are reviewed for surgical residents to ensure all treatment orders are identified and transcribed. Education completed on 9/17/25. Director of nursing/designee educated all licensed nursing staff on ensuring discharge summaries are reviewed for surgical residents to ensure all treatment orders are identified and transcribed. Education completed on 09/22/25 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, Director of nursing/designee will audit all surgical admissions 5 times week for 12 weeks to ensure that all treatment orders are identified and accurately transcribed. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 09/23/25	

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F0658 SS = D	Continued from page 21 the Aquacel dressing could be removed and replaced with a clean dry dressing. The physician's assessment indicated a surgical incision was covered with Aquacel dressing and scant bloody drainage to the left knee. There was no increased redness or warmth. The Medicare 5-day Minimum Data Set (MDS) assessment dated 8/15/24 indicated Resident #100 was cognitively intact and was coded with a surgical wound. A review of Resident #100's medical record did not indicate that the Aquacel dressing or Zipline dressing was removed during her stay at the facility from 8/9/24 through 8/20/24. Resident #100 was discharged home on 8/20/24. A review of the discharge nursing note did not indicate if any type of surgical wound care was completed. The discharge instructions did not include any type of surgical wound care that would be needed at home. Attempts were made to reach Nurse #9 during the survey with no success. She was the nurse assigned to Resident #100 on 8/9/24, 8/19/24 and 8/20/24. A phone interview occurred with Resident #100 on 8/26/25 at 4:34 PM, who stated she had a Zipline dressing present after her left knee surgery. She recalled the area was covered with a waterproof dressing when she was admitted to the facility. She stated she was told by the surgeon and facility physician that the dressing would be removed seven days after her surgery and could be covered with a dry dressing if needed. Resident #100 stated the outer dressing was to be removed on postoperative day 7 and the Zipline dressing would have been removed on postoperative day 14. She stated she had constantly asked nursing staff about removing the dressing but received no response. Resident #100 added that someone (unable to recall who) removed the outer dressing on 8/19/24 at the facility but she never had the Zipline dressing removed until she got home. Resident #100 stated that her home health therapist removed the Zipline dressing a day or so after her return home. She stated it caused no harm but was uncomfortable. On 8/27/25 at 2:43 PM, an interview occurred with the Director of Nursing (DON). She stated she had been in	F0658		

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F0658 SS = D	Continued from page 22 that position since April 2025 and was unfamiliar with Resident #100 and was unable to speak to the protocol that was in place in August 2024 for ensuring all discharge orders were present for new admissions. She was able to review Resident #100's medical record and confirmed there were no orders to remove the Aquacel dressing on postoperative day seven or the Zipline dressing/surgical clips on day 14 postoperatively. She stated the admitting nurse should have either transcribed the surgical wound orders from the discharge summary or reached out to the orthopedic provider if there was a question. A phone interview was completed with the previous DON #1 on 8/28/25 at 11:13 AM. She was the DON during August 2024. At first, she stated she couldn't recall what the procedure was for new admissions with surgical wounds in order to ensure all the orders were captured. She later stated that the physician or his Nurse Practitioner would have approved the discharge summary prior to the resident's admission but was unable to recall if this did or did not occur for Resident #100 saying, "I can't confirm what happened during that time". The previous DON #1 was unable to recall Resident #100. The Medical Director was interviewed on 8/28/25 at 12:07 PM. He reviewed Resident #100's medical record and stated that the hospital discharge summary indicated when to remove the Aquacel dressing and Zipline dressing/surgical clips. The Medical Director indicated that Resident #100 should have had the Aquacel dressing removed on 8/14/24 and the Zipline dressing would have been removed on 8/20/24. He added that the Aquacel dressing has a bactericidal (anti-infectant) property that would have posed no harm to Resident #100 if the dressing had stayed on longer than ordered, however the surgical wound management should have been transcribed on admission from the hospital discharge summary and indicated on the August 2024 MAR/TAR for nursing staff to have addressed. The Administrator was interviewed on 8/28/25 at 12:36 PM and stated that it was her expectation for admission orders to be transcribed completely and correctly.	F0658		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition	F0693	Tag F693 – Tube Feeding Management 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	09/22/2025

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F0693 SS = D	Continued from page 23 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to ensure the enteral tube feed (a method of supplying nutrition through a feeding tube that goes directly into the stomach or small intestine) was infusing per the active physician's order for Resident #78. In addition, the facility failed to store a plastic enteral feeding syringe with the plunger separated from the barrel of the syringe which had the potential for bacterial growth and contamination. The deficient practice affected 1 of 1 resident reviewed for enteral feeding management (Resident #78). The findings included: A. Resident #78 was admitted to the facility on 2/22/25 with diagnoses including cerebral infarction, type 2 diabetes, and dysphagia (difficulty swallowing). A review of a quarterly Minimum Data Set dated 7/21/25 indicated Resident #78 was severely cognitively impaired. She was coded as having a feeding tube. A review of Resident #3's physician orders included the following active order for August 25, 2025, that read:	F0693	Continued from page 23 On 8/25/25, then facility failed to ensure the eternal tube feed was infusing per the active physician's orders for resident #78. In addition, the facility failed to store a plastic enteral feeding syringe with the plunger separated from the barrel of the syringe which had the potential for bacterial growth and contamination. The attending physician was notified, orders were clarified and corrected in electronic health record, residents representative notified. Resident #78 with no negative outcomes. The feeding syringe was replaced with a brand new one. No negative outcomes from syringe. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/15/25, an audit was conducted by the director of nursing/designee of all residents with feeding tubes to ensure orders were in place and syringe storage was audited. Any discrepancies identified were corrected immediately. On 08/25/25 1:1 Education given to nurse #4 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The Director of nursing/Designee provided education to all licensed nursing staff on following physician orders for tube feedings. Educated completed 09/15/25 DON/Designee also educated licensed staff on proper tube feeding management, including correct syringe storage and cleaning practices. Education completed 09/15/25 New hires will be educated during on boarding process. Agency staff will receive this same education prior to working their next scheduled shift. 4. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, director of nursing/designee will observe tube feeding being administered to ensure orders are being followed and observation to ensure proper storage and cleaning practices for syringes 4 times weekly for 12 weeks. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three	

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F0693 SS = D	Continued from page 24 Enteral feeding: tube feeding continuous; Special Instructions: Tube feeding continuous: Formula Isosource 1.5 calorie at 50 ml/hr (milliliters per hour) x 20 hours to allow for ADL (activities of daily living) care. On at 2 PM, off at 10 AM. Record total amount every shift. During an observation of Resident #78 on 8/25/25 at 10:45 AM, her tube feeding was infusing at a rate of 50 ml/hr. A second observation of Resident #78 was conducted on 8/25/25 at 12:56 PM, and the tube feeding was again infusing at a rate of 50 ml/hr. On 8/25/25 at 1:15 PM Nurse #4 was interviewed and verified the tube feeding order for Resident #78 was to begin at 2:00 PM and turned off at 10:00 AM. She stated 8/25/25 was her first day working at the facility, and she was unaware the tube feeding should have been turned off at 10:00 AM. Nurse #4 indicated the Assistant Director of Nursing (ADON) hung the bag for her at 8:00 AM, and she didn't know why the tube feeding was still infusing. The Assistant Director of Nursing was interviewed on 8/25/25 at 3:13 PM and stated she had assisted Nurse #4 by hanging the tube feeding bag for Resident #78 around 8:00 AM that morning because the nurse was busy sending another resident out of the facility. The ADON indicated 8/25/25 was Nurse #4's first day working at the facility, and she had been educated how to look up orders in the facility's computer charting system that morning. She stated Nurse #4 had not worked with the facility's charting program before, and she may have missed seeing the order. B. On 8/28/25 at 10:38 AM a plastic syringe used to provide medications and flush the feeding tube for Resident #78 was observed in a plastic bag hanging from the feeding pump pole. The plunger was in the barrel of the syringe and droplets of a clear liquid were noted in the tip of the syringe. Nurse #5 was interviewed on 8/28/25 at 10:40 AM and explained that she had provided Resident #78 with her medications and water flush via the feeding tube that morning. She stated that she was aware the plunger should be removed from the barrel of the syringe and stored separately, and she was on her way to find a new syringe because she stored it incorrectly.	F0693	Continued from page 24 months. Alleged Compliance Date: 09/23/25	

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F0693 SS = D	Continued from page 25 The Director of Nursing was interviewed on 8/28/25 at 11:20 AM and stated the Medication Aide usually administered medications for the residents on the 100 hall, but they were not allowed to assess tube feedings. She stated the oncoming nurse for 8/25/25 was an agency nurse whose first day was Monday so she may not have known she was responsible for residents with feeding tubes even though the previous shift's nurse should have given her a verbal report and written report sheet about the resident. She further stated the plunger for the enteral feeding syringe should have been removed from the barrel and stored separately due to the potential for bacterial growth in the syringe tip.	F0693		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff and Medical Director interviews, the facility failed to have oxygen in use signage on the door (Resident #10) and failed to administer oxygen at the prescribed rate for 2 of 3 residents reviewed for respiratory care (Resident #56 and Resident #10). The findings included: 1. a. Resident #10 was admitted to the facility on 05/21/25 with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and mucopurulent (thick sticky substance that is both mucus and pus) chronic bronchitis. A review of the active physician orders revealed an order dated 05/21/25 for oxygen (O2) via nasal cannula (NC) continuously at 2 liters per minute (L/min), special instructions; check concentrator to ensure functioning and appropriate setting every shift (day	F0695	F0695-Respiratory/Tracheostomy Care and Suctioning 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/28/25, it was identified the facility failed to have oxygen in use signage on the door for resident #10 and failed to administer oxygen at the prescribed rate for resident #10 and resident #56. No smoking oxygen in use sign promptly added to room door. The resident's oxygen concentrator was quickly adjusted to the correct setting. Physician immediately notified. The residents were monitored for any adverse effects. Resident's responsible party contacted, no negative outcomes occurred. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving oxygen had the potential to be affected by deficient practice. On 9/16/25, Director of nursing/designee audited 100% residents on oxygen to ensure concentrator flow rates matched physician orders and oxygen added to doors and front entrance. Deficiencies found were immediately corrected. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The director of nursing/designee educated all license nursing staff on verifying physician orders and following them to ensure oxygen is set on correct	09/19/2025

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F0695 SS = D	Continued from page 26 shift and night shift). An admission Minimum Data Set (MDS) assessment dated 05/27/25 indicated Resident # 10 was cognitively intact. She experienced shortness of breath or trouble breathing when lying flat, and she received oxygen therapy. A review of Resident #10's active care plan, last reviewed 08/27/25, included a focus area that read Resident #10 had altered respiratory status related to mucopurulent chronic bronchitis, chronic hypoxic respiratory failure, and history of pulmonary embolism. One of the interventions was for staff to administer oxygen at 2 L/min via nasal cannula. A review of the Medication Administration Record (MAR) revealed oxygen was signed off as being administered at 2 L/min and the staff had checked the oxygen settings to be correct on 08/25/25 and 08/26/25. On 08/25/25 at 10:46 AM an observation was made of Resident #10 while she was lying in bed. The oxygen regulator on the concentrator was set at 3.5 L/min when viewed horizontally, at eye level. On 08/26/25 at 11:26 AM an observation was made of Resident #10 while she was lying in bed. The oxygen regulator on the concentrator was set at 3.5 liters per minute when viewed horizontally, at eye level. An interview was conducted on 08/26/25 at 11:28 AM with Medication Aide #1 who stated she checked Resident #10's vital signs and oxygen level that morning during the medication pass. Medication Aide #1 then verified Resident #10's order was for oxygen at 2 L/min and that the concentrator read 3.5 L/min when viewed horizontally, at eye level. Medication Aide #1 stated, "I didn't fully check her concentrator and wasn't aware it was on 3.5 L/min." She further stated she should have checked the flow rate on the concentrator at eye level. An interview was conducted on 08/26/25 at 12:24 PM with Nurse #3. She stated she believed there was an order to change Resident #10's oxygen order from 2 L/min to 3.5 L/min, but she needed to confirm that with the provider. She further indicated she had not checked the oxygen concentrator during the morning shift. An interview was conducted on 08/26/25 at 12:30 PM with the Medical Director. He stated he had not ordered Resident #10's oxygen to be increased because her oxygen saturation level had remained above 90% during	F0695	Continued from page 26 setting according to physicians orders and oxygen sign outside of residents door. Education completed on 9/18/25 New hires will be educated during onboarding/orientation. Agency staff will receive this same education prior to working their next schedules shift. 4. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, Director of nursing/designee will audit 5 residents a week for 8 weeks on oxygen to verify accurate settings on concentrator and oxygen signs on the doors. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 9/23/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0695 SS = D	Continued from page 27 assessments. He then stated he expected the staff to follow Resident #10's oxygen order. b. On 08/25/25 at 10:46 AM an observation was made of Resident #10 with oxygen in use. There was no "oxygen in use" signage on her room door. On 08/26/25 at 11:26 AM an observation was made of Resident #10 with oxygen in use. There was no "oxygen in use" signage on her room door. On 08/28/25 at 10:44 AM an observation was made of Resident #10 with oxygen in use. There was no "oxygen in use" signage on her room door. An interview was conducted on 08/28/25 at 11:20 AM with the Director of Nursing (DON). She stated Medication Aides were not allowed to perform assessments, and the concentrator evaluation was supposed to have been done by the nurse. She further stated she was not aware the facility needed oxygen in use signs on the resident's doorways since the facility was a non-smoking facility. 2. Resident #56 was admitted to the facility on 10/29/22 with diagnoses that included shortness of breath and atherosclerotic heart disease of native coronary artery (a condition where the coronary arteries (the blood vessels that supply the heart with oxygen) become narrowed or blocked due to the buildup of plaque (fatty deposits), leading to chest pain and can cause shortness of breath. A review of the active physician orders for Resident #56 revealed an order dated 04/11/24, for oxygen (O2) at 2 liters per minute (2L/min) via nasal cannula (NC) to keep O2 Saturation at 92% or above. A quarterly Minimum Data Set (MDS) assessment dated 07/11/25 indicated Resident #56's cognition was moderately impaired. She was coded as receiving oxygen therapy and shortness of breath or trouble breathing when lying flat. A review of Resident #56's active care plan, last revised on 07/16/25 included a focus area that read Resident #56 required oxygen therapy related to shortness of breath while lying flat. One of the approaches was to provide oxygen as ordered. Resident #56's Medication Administration Record (MAR) revealed oxygen was signed off as being administered at 2L/min from 08/25/25 and 08/26/25 by Nurse #8. On 08/25/25 at 11:52 AM an observation was made of	F0695		

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F0695 SS = D	Continued from page 28 Resident #56 while she was lying in bed with eyes closed. The oxygen regulator on the concentrator read 6L/min when viewed horizontally, at eye level. On 08/25/25 at 3:22 PM an observation was made of Resident #56 while she was lying in bed. The oxygen regulator on the concentrator continued to read 6L/min when viewed horizontally, at eye level. On 08/26/25 at 10:18 AM an observation was made of Resident #56's oxygen regulator on the concentrator continued to read 6 L/min when viewed horizontally, at eye level. An observation and interview were conducted on 08/26/25 at 11:16 AM with Nurse #8. She verified she was Resident #56's nurse yesterday (8/25/25) and today (8/26/25). She then observed and verified the oxygen level for Resident #56 read 6L/min when viewed horizontally, at eye level. Nurse #8 stated the current oxygen order was for 2L/min via NC. She indicated she did not look at the oxygen yesterday or today although she signed the medication administration record (MAR) as being done. An interview was conducted on 08/26/25 at 12:30 PM with the Medical Director. He explained that he would have expected Resident #56 to have been seen for an acute visit if someone had turned her oxygen up to 6L/min. He reviewed Resident #56's notes and did not see any respiratory concerns documented. He stated he was not aware of Resident #56's oxygen levels dropping and that he expected nurses to follow the active oxygen orders and monitor oxygen saturations every shift. An interview was conducted on 08/28/25 at 10:15 AM with the Director of Nursing (DON). She stated she was unaware that Resident #56's oxygen was turned up to 6L/min. She explained nurses are to follow orders for oxygen and to check oxygen concentrators every shift.	F0695		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757	F757-Drug Regimen is Free from Unnecessary Drugs 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/26/25, the facility failed to discontinue a scheduled acetaminophen order when a new order for scheduled Hydrocodone-acetaminophen was received for resident #70. The acetaminophen was discontinued on when identified on 06/09/25. The family was contacted, medical director notified, hospice provider also	09/22/2025

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F0757 SS = D	Continued from page 29 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Medical Director and staff interviews, the facility failed to discontinue a scheduled acetaminophen (used to relieve mild to moderate pain) order when a new order for scheduled Hydrocodone-acetaminophen (used to relieve moderate to severe pain) was received. This was for 1 of 6 residents reviewed for unnecessary medications (Resident #70). The findings included: Resident #70 was admitted to the facility on 3/18/20 with diagnoses that included right hip pain, low back pain and compression fracture of the thoracic spine. A hospice note dated 6/5/25 indicated an order was provided to Nurse #2 to discontinue Resident #70's scheduled acetaminophen 500 milligrams (mg) and as needed Tramadol (25 mg- used to relieve moderate to severe pain) and begin Hydrocodone-acetaminophen 5-325 mg one tablet by mouth twice a day for pain. Another hospice note dated 6/9/25 read that Resident #70's family member was concerned that Resident #70 was still receiving scheduled acetaminophen along with the new order for Hydrocodone-acetaminophen. The hospice nurse stated that she went to the facility and reviewed the Medication Administration Record (MAR) which indicated Resident #70 had received both acetaminophen	F0757	Continued from page 29 notified. The resident was assessed no negative outcomes. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/17/25, the director of nursing/designee completed an audit of 14 day lookback on hospice resident's progress notes and all other residents receiving acetaminophen to ensure orders have been addressed. Discrepancies found were immediately corrected. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The Director of nursing/designee provided 1:1 education to nurse #2 that if prn and scheduled medications are on the medical record to ask for clarification and discontinue the orders per physician's request. Education completed on 9/16/25. The Director of nursing/designee educated all licensed nurses on receiving telephone orders and reviewing the MAR to identify PRN and scheduled medication and clarifying which specific order and caring them out as the physician requests. Education completed 9/17/25. New hires will be educated during onboarding/orientation. Agency staff will receive this same education prior to working their next scheduled shift. 4. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, the director of nursing/designee will review hospice residents progress notes 5 times a week for 12 weeks to ensure any new orders are identified immediately and all other orders will be reviewed 5 times a week in clinical meeting for 12 weeks. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 09/23/25	

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F0757 SS = D	Continued from page 30 500mg twice a day along with Hydrocodone-acetaminophen 5-325 mg twice a day from the 6/5/25 evening dose to the 6/9/25 morning dose. No ill effects were noted, and the resident did not receive the maximum dose of acetaminophen in 24 hours. The hospice nurse wrote that Nurse #2 discontinued the routine acetaminophen order, and the Medical Director was notified. The June 2025 physician orders were reviewed and revealed the following: - Tramadol 25 mg every eight hours as needed was discontinued on 6/5/25 as ordered. - A new order for Hydrocodone-acetaminophen 5-325 mg one tablet by mouth twice a day was ordered on 6/5/25. - The order for acetaminophen 500mg one tablet by mouth twice a day was not discontinued until 6/9/25. A review of the June 2025 MAR indicated that Resident #70 received acetaminophen 500mg twice a day and Hydrocodone-acetaminophen 5-325 mg twice a day as follows: - The evening dose on 6/5/25. - Both morning and evening doses on 6/6/25. - Both morning and evening doses on 6/7/25. - Both morning and evening doses on 6/8/25. The June 2025 MAR indicated that the morning dose of acetaminophen on 6/9/25 was not administered. A quarterly Minimum Data Set (MDS) assessment dated 6/20/25 indicated Resident #70 had moderately impaired cognition. An interview occurred with Nurse #2 on 8/28/25 at 9:17 AM. She was the nurse assigned to Resident #70 on 6/5/25 and 6/9/25. She reviewed Resident #70's medical record and was unable to state why she failed to discontinue the routine acetaminophen order when she received the new order for Hydrocodone-acetaminophen, only to say it was an oversight. Nurse #2 stated when she spoke with the hospice nurse on 6/9/25, the error was identified, the routine acetaminophen order was discontinued, and the Director of Nursing (DON) and	F0757		

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F0757 SS = D	Continued from page 31 Medical Director were notified. The DON was interviewed on 8/28/25 at 9:25 AM and recalled being made aware of Resident #70 receiving both routine orders of acetaminophen and Hydrocodone-acetaminophen. She stated this error occurred because the routine order for acetaminophen was not discontinued as ordered on 6/5/25. The DON further added that the Medical Director was notified at the time the error was identified. She stated she expected physician orders to be correct and that orders to be followed when discontinuing medications. An interview occurred with the Medical Director on 8/28/25 at 12:07 PM. He reviewed Resident #70's medical record and stated that he would not consider Resident #70 receiving seven doses of acetaminophen 500 mg twice a day along with Hydrocodone-acetaminophen 5-325mg twice a day a significant medication error as the amount of acetaminophen did not reach the toxicity point of 3000 mg per day. He added that the nurse should have discontinued the routine order of acetaminophen on 6/5/25 as ordered. The Administrator was interviewed on 8/28/25 at 12:36 PM and stated that she would expect orders to be followed and the routine dose of acetaminophen twice a day should have been discontinued on 6/5/25.	F0757		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	F0761-Label/Store drugs and Biologicals Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/26/25, the facility failed to mark medication with opened-on or discard-by dates on medication carts #1, #4 and #5. Unlabeled medications eye drops, lidocaine and sterile water were immediately discarded. The facility also failed to maintain medication refrigerators temperatures within the recommend range. Refrigerators replaced on Granny's place and Lillian's. No negative outcomes Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/17/25, Director of nursing/designee conducted a 100% audit of all medication carts to ensure any medications requiring dates were labeled. All	09/19/2025

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F0761 SS = E	Continued from page 32 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to mark medications with opened-on or discard-by dates and failed to maintain medication refrigerator temperatures within the recommended range. This was for 5 of 6 areas reviewed for medication storage (Medication Carts #1, #4 and #5, and medication storage room refrigerators for Granny's Place and Lillian's). Findings included: 1. On 8/28/25 at 11:40 AM Medication Cart #1 was reviewed with Nurse #5. Four dropper bottles of ophthalmic solution were discovered with no opened-on or discard-by dates: 2 bottles- dorzolamide-timolol 2%/0.5% ophthalmic solution 10 milliliters (ml). 1 bottle- netarsudil ophthalmic solution 0.02% % 2.5 ml. 1 bottle- latanoprost 0.005% ophthalmic solution 2.5 ml. On 8/28/25 at 11:45 AM during the medication cart review, Nurse #5 stated that two of the eye drop bottles had been sent with the resident from the hospital and they all should have had opened-on dates. On 8/28/25 at 12:20 PM during an interview with the Assistant Director of Nursing (ADON) she stated the eye drops should have been marked when they were opened. 2. On 8/28/25 at 12:30 PM Medication Cart #4 was reviewed with Nurse #6. One dropper bottle of latanoprost 0.005% ophthalmic solution 2.5 ml was discovered with no opened-on or discard-by date.	F0761	Continued from page 32 refrigerator temperature were immediately audited to ensure temperatures were in recommend range. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The director of nursing/designee educated all licensed nurses and medication aides on policy for medication storage to include storage of eye drops along with opened dates and discard dates. Completed on 09/17/25 The director of nursing/designee completed 1:1 education on 08/28/25 for the nurses on carts #1, #4 and #5. The director of nursing/designee educated all licensed nurses on refrigerator temperatures and procedure to follow if out of range. New hires will be educated during onboarding/orientation. Agency staff will receive the same education prior to working their next schedule shift. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, director of nursing/designee will audit 2 medication carts a week for 12 weeks to ensure medications requiring dates are correctly labeled. Beginning 9/22/25, director of nursing/designee to audit refrigerator logs 5x a week to make sure that temperatures are documented with actions if corrections needed for 12 weeks. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 9/23/25	

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F0761 SS = E	Continued from page 33 On 8/28/25 at 12:35 PM during the medication cart review, Nurse #6 verified the dropper bottle had been opened. During an interview with Nurse #6 she stated the bottle should have an opened-on date. 3. The Medication Room for Granny's Place was reviewed 8/28/25 at 12:40 PM with Nurse #7. The current temperature of the refrigerator was observed at 40°F (degrees Fahrenheit). The “Temperature Log for Refrigerator- Fahrenheit” instructions (version 8/21) included: “Take action if temp is out of range -too warm (above 46°F) or too cold (below 36°F).” 1. “Label exposed vaccine “do not use,” and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s)”. 2. “Record the out-of-range temps and the room temp in the “Action” area on the bottom of the log”. 3. “Notify your vaccine coordinator or call the immunization program at your state or local health department for guidance”. 4. “Document the action taken on the attached “Vaccine Storage Troubleshooting Record”. The refrigerator temperature logs were reviewed and revealed the following low temperatures documented and initialed by staff on the August 2025 log: 8/25/25: 7 PM 35° 8/26/25: 7 AM 32 ° 8/27/25: 7 AM 32° 8/28/25: 7 AM 34° There was no documentation of the action taken on the temperature log. Medications were observed in the refrigerator in the refrigerator in the medication room for Granny’s Place on 8/28/25.	F0761		

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F0761 SS = E	Continued from page 34 On 8/28/25 at 12:50 PM an interview with Nurse #7 was conducted during the observation. She stated this morning she had checked and adjusted the refrigerator temperature and notified the Infection Control nurse about the concern. She explained she was going to check the temperature again later and if it was still low, she was going to contact maintenance. An interview with the Infection Control Nurse was conducted on 8/28/25 at 1:23 PM. She explained she had spoken with Nurse #7 about the refrigerator temperature this morning and Nurse #7 had turned the temperature up. She stated she had not told maintenance about the refrigerator temperatures yet. 4. On 8/28/25 at 1:43 PM Medication Cart #5 was reviewed with Nurse #2. Five items were discovered without opened-on or discard-by dates: 1 bottle- 20 ml sterile water for injection was without an opened-on date. 1 vial- Lidocaine hydrochloride 1% 10mg/ml (milligram/ml) 5 ml without an opened-on date. 3 bottles- Latanoprost 0.005% 2.5 ml ophthalmic solution; 1 noted as filled on 6/2/25 with no opened-on date, 1 noted as opened on 4/26, and 1 noted as opened 4/23. Manufacturer instructions to discard 6 weeks after opening. On 8/28/25 at 1:45 PM during the medication cart review, Nurse #2 stated items should be marked when opened and the eye drops should have been discarded when they expired. 5. The Medication Room for Lillian's was reviewed on 8/28/25 at 1:50 PM with Nurse #2. The current temperature of the refrigerator was observed at 38°F. The “Temperature Log for Refrigerator- Fahrenheit” instructions (version 8/13) included: “Take action if temp is out of range -too warm (above 46°F) (degrees Fahrenheit) or too cold (below 35°F)”. 1. “Label exposed vaccine “do not use,” and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s)”. 2. “Record the out-of-range temps and the room temp in	F0761		

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F0761 SS = E	Continued from page 35 the “Action” area on the bottom of the log”. 3. “Notify your vaccine coordinator, or all the immunization program at your state or local health department for guidance”. 4. “Document the action taken on the attached “Vaccine Storage Troubleshooting Record”. The refrigerator temperature logs were reviewed and revealed the following low temperatures documented and initialed by staff on the August 2025 log: 8/2/25: 8 AM 34° 8/3/25: 7 AM 33°/ 7PM 34° 8/4/25: 7:20 AM 31°/ 3:50 PM 30° 8/5/25: 8 AM 32 °/5 PM 33 ° 8/6/25: 8 AM 34 °/5 PM 32 ° 8/7/25: 9 AM 34 °/6 PM 33 ° 8/8/25: 8 AM 33 °/5 PM 34 ° 8/9/25: 7 AM 34°/ 7 PM 33° 8/10/25: 7 AM 32°/ 7 PM 33° 8/11/25: 7:50 AM 34°/ 4:15 PM 32° 8/13/25: 7 PM 34° 8/14/25: 7 AM 32 °/ 7PM 33° 8/15/25: 7 AM 34°/ 7 PM 33° 8/16/25: 7 AM 34°/ 7 PM 34° 8/17/25: 7 AM 32°/ 7 PM 31° 8/18/25: 7:20 AM 33°/6:50 PM 32° 8/19/25: 7:05 AM 34°/ 6:00 PM 34° 8/20/25: 9 AM 34°/ 5 PM 33° 8/21/25: 9 AM 32°/ 5 PM 32° 8/22/25: 76:55 AM 33°/ 5:20 PM 32°	F0761		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	**4748 Old Salisbury Road , Lexington, North Carolina, 27295**

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F0761 SS = E	Continued from page 36 8/23/25: 7 AM 32°/ 7 PM 31° 8/24/25: 7 AM 33°/ 7 PM 34° 8/25/25: 7 AM 32°/ 6:30 PM 34° There was no documentation of the action taken on the temperature log. Medications were observed in the refrigerator in the refrigerator in the medication room for Lillian's on 8/28/25. On 8/28/25 at 2:00 PM an interview with Nurse #2 was conducted during the medication room observation. She stated she had checked the refrigerator temperature at the beginning of the shift and adjusted it and would check the temperature again later and make sure it was in range. An interview was conducted on 8/28/25 at 2:46 PM with the Director of Nursing (DON). She stated she expected the nurses to mark medications when they're opened and discard them when they expired. She stated she would expect the nurse to adjust the temperature of the refrigerator if it were out of range and then notify the nurse manager of the concern.	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F0812	F812 Food Procurement and Storage 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/25/25, the Food Service Manager, discarded the unwrapped /undated food from the refrigerator and freezer that was brought to the attention of the survey team 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/25/25, to protect residents in similar situations, the Food Service Manager Immediately performed an audit of refrigerators and stock rooms in the kitchen and nourishment room to ensure there were no expired, unlabeled, or inappropriately stored food items. No negative findings.	09/22/2025

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F0812 SS = E	Continued from page 37 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to label, date, and seal food items left open to air and stored for use in 1 of 1 walk-in refrigerator and failed to label and remove expired food items stored for use 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents. The findings included: Accompanied by the Dietary Manager, an observation was made of the walk-in refrigerator on 8/25/25 at 9:32 AM. The following items were stored in the refrigerator: -One undated box of turkey sausage that was open and partially used with the remaining contents unwrapped and exposed to air. -One undated package of Danishes open and partially used with the remaining contents unwrapped and exposed to air. An observation of the walk-in freezer revealed the following stored item: -One large plastic, zippered storage bag containing unlabeled and uncooked ground meat dated 7/7/25. The Dietary Manager was interviewed on 8/25/25 during the kitchen tour at 9:32 AM. He stated food should be wrapped once it's opened and labeled with the contents and date it was opened. He indicated food should be used or discarded within seven days after opening. The Dietary Manager stated he did not work over the past weekend, and he did not have an opportunity to check the refrigerator and freezer Monday morning due to printing meal tickets for the breakfast service. On 8/25/25 at 12:35 PM the Administrator was interviewed and stated foods should be labeled with their contents and opened dates and stored in the	F0812	Continued from page 37 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: On 9/12/25, the Regional Register Dietician and the Food Service Director educated kitchen staff on policies and procedures for labeling opened food items, discarding expired food items, and storing items appropriately per food category. New hires will be educated upon hire. 4. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/7/25, the Food Service Manager or designee will audit refrigerators and food storage areas 5 times weekly for 12 weeks to ensure there are no unlabeled or expired food items and all food items are stored appropriately. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed. Alleged Compliance Date: 9/23/25	

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F0812 SS = E	Continued from page 38 refrigerator and freezer correctly.	F0812		
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; (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	F0842	F0842-Resident Records-Identifiable information Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/28/25, it was identified the facility failed to maintain an accurate medication administration record for the documentation of supplemental oxygen for resident #10 and resident #56. Physician immediately notified. The residents were monitored for any adverse effects. Resident's responsible party contacted. No negative outcomes occurred. 1:1 education immediately given to nurses caring for residents #10 and resident #56 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Director of nursing/designee audited 100% observation of residents on oxygen to ensure concentrator ordered rate, physician orders and medication administration record are accurately documented. Deficiencies found were immediately corrected. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The director of nursing/designee educated all licensed nursing staff on ensuring concentrators are set as prescribed and documented in electronic health record. Education completed on 09/18/25 New hires will be educated during onboarding/orientation. Agency staff will received the same education prior to working their next scheduled shift. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, director of nursing/designee will audit 5 residents a week for 8 weeks ensuring concentrators are set as prescribed and documented in electronic health record.	09/19/2025

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F0842 SS = D	Continued from page 39 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 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 observation, record review and staff interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for the documentation of supplemental oxygen for 2 of 3 residents reviewed for medical record accuracy (Resident #10 and Resident #56). 1. A review of the active physician orders for Resident #56 revealed an order dated 04/11/24, for oxygen (O2) at 2 liters per minute (L/min) via nasal cannula (NC) to keep O2 Saturation at 92% or above, every shift, day shift 7:00 AM-7:00 PM, evening shift 7:00 PM-7:00 AM.	F0842	Continued from page 39 Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 9/23/25	

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F0842 SS = D	Continued from page 40 Review of Resident #56's August 2025 Medication Administration Record (MAR) revealed oxygen was signed off as being administered on day shift at 2L/min on 08/25/25 and 08/26/25 by Nurse #8. Night shift was signed off as being administered by Med Aide #2. Phone interviews were attempted with Med Aide #2 however she was unable to be reached for interview. A review of the staff schedule indicated Nurse #8 was assigned to Resident #58 on during day shift on 08/25/25 and 08/26/25. An interview was conducted on 08/26/25 at 11:16 AM with Nurse #8. She verified she was Resident #56's nurse yesterday (8/25/25) and today (8/26/25). Nurse #8 stated the current oxygen order was for 2L/min via NC. She indicated she did not look at the oxygen concentrator to verify the amount being administered yesterday or today although she signed the medication administration record (MAR) as being done. An interview was conducted on 08/28/25 at 10:15 AM with the Director of Nursing (DON). She explained nurses were to follow orders for oxygen and sign the medication administration record after verifying the amount was correct. She indicated the oxygen flow records were to be complete and accurate. 2. A review of the active physician orders for Resident #10 revealed an order dated 5/21/25 for oxygen (O2) via nasal cannula (NC) continuously at 2 liters per minute (L/min), special instructions; check concentrator to ensure functioning and appropriate setting every shift (day shift and night shift). A review of the Medication Administration Record (MAR) revealed oxygen was signed off as being administered at 2 L/min and the staff had checked the oxygen settings to be correct on 8/25/25 by Nurse #4 and 8/26/25 by Medication Aide (MA) #4. On 8/25/25 at 10:46 AM an observation was made of Resident #10 while she was lying in bed. The oxygen regulator on the concentrator was set at 3.5 L/min when viewed horizontally, at eye level. On 8/28/25 at 11:26 AM an observation was made of Resident #10 while she was lying in bed. The oxygen regulator on the concentrator was set at 3.5 L/min when viewed horizontally, at eye level.	F0842		

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F0842 SS = D	Continued from page 41 An interview was conducted on 8/28/25 at 11:28 AM with Medication Aide #4 who stated she checked Resident #10's vital signs and oxygen level the morning of 8/28/25 during the medication pass. MA #1 then verified Resident #10's order was for oxygen at 2 L/min and the concentrator read 3.5 L/min when viewed horizontally, at eye level. MA #1 stated, "I didn't fully check her concentrator and was not aware it was on 3.5 L/min". She further stated she should have checked the flow rate on the concentrator at eye level. An interview was conducted on 8/26/25 at 11:28 AM with Nurse #3 who indicated she had not checked Resident #10's oxygen concentrator that morning. Nurse #4 was unable to be reached by phone for an interview after multiple attempts. An interview was conducted on 08/28/25 at 10:15 AM with the Director of Nursing (DON) who stated Medication Aides were not allowed to perform assessments, and the concentrator evaluation was supposed to have been done by the nurse to ensure the oxygen rate was set correctly. She explained nurses were to follow orders for oxygen and sign the medication administration record after verifying the amount was correct. She indicated the oxygen flow records were to be complete and accurate.	F0842		
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	F0883	Tag F0883 –Influenza and Pneumococcal Immunizations 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/28/25, the facility failed to educate and offer the pneumococcal and influenza immunizations on admission to resident #83. Facility also failed to maintain a resident's medical record of acceptance, refusals, or contraindications for the pneumococcal immunization as well as education regarding risk and benefits of refusing the immunization for resident #63. Resident's charts were updated with current vaccination information immediately along with education regarding risk and benefits of vaccinations. No negative outcomes. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	09/19/2025

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F0883 SS = D	Continued from page 42 (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 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 educate and offer the pneumococcal (pneumonia) and influenza (flu) immunizations on admission (Resident #83) and failed to maintain a resident's medical record of refusal for the pneumococcal (pneumonia) immunization as well as education regarding risk and benefits of refusing the immunization (Resident #63). This occurred for 2 of 5	F0883	Continued from page 42 On 9/17/25, Director of nursing/Designee 100% audit of all current residents was completed to ensure documentation of pneumococcal and influenza vaccine status were present to include: Date each vaccine was offered, whether accepted or declined, education on risk and benefits. Any discrepancies found were corrected immediately. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Director of nursing educated 1:1 Assistant director of nursing on offering vaccines to residents on admission, providing resident/family education about vaccines including risks and benefits, and documenting acceptance/refusals. Education complete on 9/18/25 Director of nursing/designee educated all licensed nursing staff on offering vaccines to residents on admission, providing resident/family education about vaccines including risks and benefits and to notify director of nursing/assistant director of nursing if interested. Education complete on 9/16/25 New hires will be educated during on boarding process. Agency staff will receive tis same education prior to working their next scheduled shift. 4. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, the Director of nursing/Designee will audit new admissions 5 times a week for 12 weeks to verify that vaccines were offered or declined, education provided and documentation complete. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 9/23/25	

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F0883 SS = D	Continued from page 43 residents reviewed for immunization (Resident #63 and Resident #83). a. Resident #83 was admitted to the facility on 11/13/24. Resident #83's quarterly Minimum Data Set (MDS) assessment dated 07/31/25 indicated his cognition was severely impaired and the pneumococcal and influenza immunizations were not offered. Resident #83's immunization record revealed no documentation that he had been offered, given, or refused the pneumococcal or influenza immunizations. An interview was conducted on 08/28/25 at 11:40 AM with the Assistant Director of Nursing (ADON). She stated handled the immunizations for residents and staff. She verified that Resident #83 did not have any immunizations listed in his electronic medical record (EMR) nor did he have a consent or refusal form signed and uploaded into his EMR. She stated she was not sure why or how this may have occurred. She indicated influenza immunizations would be coming up, but she was unsure of a date at this time. b. Resident #63 was admitted to the facility on 06/26/25. Resident #63's admission Minimum Data Set (MDS) assessment dated 07/02/25 indicated his cognition was moderately impaired. Pneumococcal immunization was offered and declined. A review of Resident #63's medical record revealed that he or his responsible party had been offered and refused the pneumococcal immunization. Further review revealed no refusal form or nursing note revealing refusal was on file and there was no education noted regarding the risk and benefits of refusing the pneumococcal immunization present in Resident #63's medical record. An interview was conducted on 08/28/25 at 11:40 AM with the Assistant Director of Nursing (ADON). She stated handled the immunizations for residents and staff. She verified that Resident #63 refused the pneumonia immunization, but she did not see his signed refusal form. She indicated she was on vacation when Resident #63 was admitted, and she would look to see if another staff member had completed the refusal but had not uploaded it yet. The ADON did not provide any additional information during the survey period.	F0883		

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F0883 SS = D	Continued from page 44 An interview was conducted on 08/28/25 at 2:45 PM with the Administrator. She indicated that immunizations should be discussed and offered on admission to the facility. If the resident refused, consented to, and/or had some or all immunizations that information should be obtained and entered into the resident's medical record.	F0883		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F0887	Tag F0887 –COVID-19 Immunization 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/28/25, the facility failed to educate and offer resident #83 the COVID-19 vaccine on admission and failed to maintain a residents record of refusal, acceptance, or if contraindicated for the Covid-19 vaccine. Residents chart was updated with current vaccination information immediately. No negative outcomes. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/17/25, Director of nursing/Designee 100% audit of all current residents was completed to ensure documentation of COVID-19 vaccine status was present, including: Date each vaccine was offered, Whether accepted or declined, education on risk and benefits . Any discrepancies found were corrected immediately. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Director of nursing educated 1:1 Assistant director of nursing on offering vaccines to residents on admission, providing resident/family education about vaccines including risks and benefits, and documenting acceptance/refusals. Education complete on 9/18/25 Director of nursing/designee educated all licensed nursing staff on offering vaccines to residents on admission, providing resident/family education about vaccines including risks and benefits and to notify director of nursing/assistant director of nursing if interested. Education complete on 9/16/25 New hires will be educated during on boarding process. Agency staff will receive tis same education prior to working their next scheduled shift.	09/19/2025

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F0887 SS = D	Continued from page 45 (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to educate and offer Resident #83 the COVID-19 vaccine on admission and failed to maintain a resident's record of refusal, acceptance, or if contraindicated for the COVID-19 vaccine for 1 of 5 residents reviewed for COVID-19 vaccination status (Resident #83). Resident #83 was admitted to the facility on 11/13/24. Resident #83's quarterly Minimum Data Set (MDS) assessment dated 07/31/25 indicated his COVID-19 vaccination was not up to date. Review of Resident #83's medical records revealed no documentation that the COVID-19 vaccine was offered, contraindicated, administered, or refused. No documentation that the COVID-19 vaccine education was provided, and no documentation of previous COVID-19 vaccines received. An interview was conducted on 08/28/25 at 11:40 AM with the Assistant Director of Nursing (ADON). She stated she was the ADON and oversaw the immunizations for residents and staff. She indicated that vaccines should be discussed and offered on admission to the facility by the admitting nurse. If the resident has had some or all vaccines that information should be obtained and entered into the resident's medical record. She verified that Resident #83 did not have the Covid-19	F0887	Continued from page 45 4. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Beginning 9/22/25, the Director of nursing/Designee will audit new admissions 5 times a week for 12 weeks to verify that vaccines were offered or declined, education provided and documentation complete. Findings from these audits will be reviewed in QAPI meetings and revised as needed for a minimum of three months. Alleged Compliance Date: 9/23/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	**4748 Old Salisbury Road , Lexington, North Carolina, 27295**

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F0887 SS = D	Continued from page 46 vaccine noted in his electronic medical record (EMR) nor did he have the Covid-19 consult/refusal signed and uploaded. An interview was conducted on 08/28/25 at 2:45 PM with the Administrator. She indicated all residents should have a consent/refusal form, education, and administration details filled out and filed in the resident's chart.	F0887		