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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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 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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 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.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 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 [NAME] 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 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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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.On [DATE] 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 [DATE] 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 [DATE] log:[DATE]: 7 PM 35 [DATE]: 7 AM 32 [DATE]: 7 AM 32 [DATE]: 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 [DATE]. On [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 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 [DATE] log:[DATE]: 8 AM 34 [DATE]: 7 AM 33 / 7PM 34 [DATE]: 7:20 AM 31 / 3:50 PM 30

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 refrigerator and freezer correctly.