STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	4748 Old Salisbury Road Lexington, NC 27295

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(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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 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 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.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 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, 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 [DATE]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was cognitively intact. 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 [DATE]. A quarterly MDS assessment dated [DATE] 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 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. The Administrator was interviewed on 8/28/25 at 8:58 AM and stated that she was aware a written grievance response was required

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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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).Findings included:Resident #55 was admitted on [DATE] with diagnoses including multiple fractures of the pelvis, glaucoma, and anxiety. Resident #55's admission Minimum Data Set (MDS) dated [DATE] 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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 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, 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). 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 [DATE], 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 [DATE] 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 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 [DATE] 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 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses including cerebral infarction, type 2 diabetes, and dysphagia (difficulty swallowing). A review of a quarterly Minimum Data Set, dated [DATE] 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: 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. 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 shift and night shift). An admission Minimum Data Set (MDS) assessment dated [DATE] 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 [DATE] 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 [DATE] 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 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 [DATE] 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 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.

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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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 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. 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 residents reviewed for immunization (Resident #63 and Resident #83).a. Resident #83 was admitted to the facility on [DATE]. Resident #83's quarterly Minimum Data Set (MDS) assessment dated [DATE] 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 [DATE]. Resident #63's admission Minimum Data Set (MDS) assessment dated [DATE] 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. 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.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE].Resident #83's quarterly Minimum Data Set (MDS) assessment dated [DATE] 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 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.