STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salisbury Rehabilitation and Nursing Center	635 Statesville Boulevard Salisbury, NC 28144

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, observations, and staff, Resident, Pharmacy Consultant and Nurse Practitioner interviews, the facility failed to administer pain medication as ordered for 1 of 3 residents (Resident #2) reviewed for pain management. Findings included: Review of Resident #2's hospital record indicated she had a right ankle Computed Tomography (CT) Scan on 12/23/2024 which showed a new minimally displaced fracture involving the right ankle and a knee x-ray that showed a mildly displaced fracture involving the distal femur which forms the knee joint. The hospital record also indicated Resident #2 had surgical repair of the right ankle on 1/25/2025. Resident #2 was admitted to the facility on [DATE] with fractures to her left knee and right ankle. An admission Minimum Data Set assessment dated [DATE] indicated Resident #2 was cognitively intact and had moderate pain frequently. A Physician's Order dated 1/8/2025 at 8:00 pm indicated Resident #2 should receive Oxycodone Hydrochloride (a narcotic pain medication) 10 milligrams two times a day for pain beginning 1/8/2026 and would be discontinued on 1/10/2025. Resident #2's Medication Administration Record for 1/2025 indicated Resident #2 did not receive Oxycodone HCl 10 milligrams on 1/8/2025 at 8:00 pm or 1/9/2025 at 8:00 am. The Medication Administration Record for 1/2025 indicated Resident #2 received Acetaminophen 1000 milligrams as needed for pain on 1/9/2025 at 7:22 am and on 1/13/2025 at 10:45 am. Further review of Resident #2's Medication Administration Record for 1/2025 indicated she rated her pain at a 0 on a scale of 1 to 10 (with 1 being the least amount of pain and 10 being the worst amount of pain) on 1/8/2025 and 1/9/2025. On 1/29/2025 at 1:35 pm Resident #2 was interviewed and stated she was admitted on [DATE] and did not receive the narcotic pain medication she needed for pain from fractures in both legs until the next day. Resident #2 stated the nurses did give her Acetaminophen which did not relieve her pain, and she rated her pain at an 8 or 9 (on a scale of 1 to 10) from the time she was admitted until she received the ordered medication on the evening of 1/9/2025. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Aide #2 stated she worked 7:00 am to 3:00 pm shift on 1/8/2025 and was assigned to Resident #2 when she was admitted . Nurse Aide #2 stated Resident #2 did complain of pain when she arrived, and she notified the Unit Manager of Resident #2's pain in both legs. An interview was conducted with Unit Manager #1 on 1/29/2025 at 1:15 pm and she stated Resident #2 admitted around 3:00 pm on 1/8/2025 and when she came from the hospital, they did not send a prescription with her for the Oxycodone Hydrochloride (a narcotic pain medication). Unit Manager #1 stated she did get an order for Acetaminophen 1000 milligrams every 6 hours as needed for pain. Unit Manager #1 stated Resident #2 rated her pain at a 7 on a scale of 1 to 10 (one being the least amount of pain and 10 being the worst pain) and she gave her the Acetaminophen and she later rated her pain at a 3 about an hour later. During an interview with Nurse Aide #3 on 1/29/2025 at 2:15 pm she stated she worked on the 3:00 pm to 11:00 pm shift on 1/8/2025 and Resident #2 did not complain of pain to her during her shift. Nurse Aide #3 stated she checked on her every 2 hours and when she turned her call light on. Nurse Aide #3 stated Nurse #1 did give her pain medication that night, but she did not know what she was given. Nurse #1 was interviewed on 1/29/2025 at 2:05 pm and stated she cared for Resident #2 on 1/8/2025 on the 7:00 pm to 7:00 am shift and she gave her Acetaminophen that evening and checked on her an hour later and she said her pain was a 2 on a scale of 1 to 10. Nurse #1 stated she must have forgotten to document the Acetaminophen she gave Resident #2 on the Medication Administration Record. The Pharmacy Consultant was interviewed by phone on 1/30/2025 at 2:30 pm and stated Resident #2 would need narcotic pain medications as ordered for fractures in both legs. She stated the ordered narcotic would have been beneficial in managing Resident #2's pain. The Pharmacy Consultant stated the facility should have obtained a prescription, signed by the provider, and faxed it to the pharmacy and then the pharmacy would have released Resident #2's narcotic pain medication when she was admitted to the facility. The Director of Nursing was interviewed on 1/29/2025 at 3:53 pm and she stated Unit Manager #1 was not able to get a prescription for Resident #2's pain medication on the evening she was admitted to the facility. She stated Unit Manager #1 did get an order for Acetaminophen and Resident #2 was documented by Unit Manager #1 and Nurse #1 as not having pain during the evening or night. The Director of Nursing stated the on-call service the facility contracts will not give a prescription for a narcotic if the prescription is not sent from the hospital. The Director of Nursing stated when the prescription is faxed to the pharmacy the medication is released from the electronic back-up medication system. During an interview with the Administrator on 1/29/2025 at 4:01 pm he stated the nursing staff should have reached out to the Physician or Nurse Practitioner to obtain a prescription for Resident #2's ordered pain medications so the medication could be dispensed from the facility's back-up medication system to ensure Resident #2 was comfortable.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review and staff and Nurse Practitioner interviews, the facility failed to ensure a resident was transported to a scheduled urologist appointment on 1/2/2025 to have their suprapubic indwelling urinary catheter changed. The deficient practice occurred for 1 of 1 resident reviewed for medical related social services (Resident #3). Findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses of diabetes, obstructive uropathy and chronic kidney disease. Resident #3's quarterly Minimum Data Set assessment dated [DATE] indicated she was severely cognitively impaired and required an indwelling urinary catheter. A Visit Summary from the Urologist dated 12/2/2024 stated Resident #3 was scheduled for a 31-day suprapubic catheter change at the urologist's office on 1/2/2025. There was no evidence in the medical record that Resident #3 attended the urology appointment scheduled for 1/2/2025. During an interview with the Appointment Coordinator on 1/29/2025 at 3:40 pm he stated he called the Urology Clinic on 1/2/2025 to inquire about Resident #3's appointment to have her suprapubic catheter replaced and was told the appointment was cancelled but he stated they could not say who had cancelled the appointment. The Appointment Coordinator stated he had failed to reschedule Resident #3's appointment to have her suprapubic catheter changed. On 1/29/2025 at 3:48 pm the Urology Clinic's Scheduler was interviewed by phone, and she stated Resident #3's scheduled appointment on 1/2/2025 was not cancelled and the resident was not brought to the appointment. She stated no one had called to reschedule her appointment so her suprapubic catheter had not been changed within 31 days. An interview was conducted with the Director of Nursing on 1/29/2025 at 3:53 pm and she stated the Appointment Coordinator must not have ensured Resident #3's appointment for her suprapubic catheter change was put on the transportation schedule. She stated Resident #3 should have been taken to her appointment on 1/2/2025 and when it was missed it should have been rescheduled as soon as possible. The Director of Nursing stated Resident #3's suprapubic urinary catheter was not changed at the facility because it was supposed to be changed at the urologist's office. During an interview with the Administrator on 1/29/2025 at 4:01 pm he stated he thought on 1/2/2025 there was inclement weather, and they had cancelled all the scheduled appointments because of the weather. He stated he did not know why Resident #3's appointment had not been rescheduled, and it should have been rescheduled as soon as possible. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The weather conditions for the facility's geographical area where the facility was located were reviewed for 1/1/2024 and 1/2/2024, and historical weather conditions indicated there was no precipitation. The weather source was the Concord-[NAME] Airport Weather Conditions. During an interview by phone with Nurse #2 on 2/12/2025 at 2:41 pm she stated she cared for Resident #3 on the 7:00 pm to 7:00 am shift that began on 1/18/2025. Nurse #2 stated Resident #3 did not have any issues through the night. She stated she checked on Resident #3 throughout her shift and saw her around 6:30 am to 7:00 am that morning and she was responsive, and her urine was not dark and did not have a lot of sediment in it. On 2/12/2025 at 3:12 pm an interview was conducted by phone with Nurse Aide #4 and she stated she cared for Resident #3 on 1/19/2025 on 1/19/2025. Nurse Aide #4 stated she gave Resident #3 a bed bath the morning of 1/19/2025 and she was not having any problems with her breathing, she was not lethargic, and her urine was not cloudy. Nurse Aide #4 stated Resident #3 became lethargic after breakfast. She stated Nurse #1 checked on her and found her unresponsive and her blood pressure was low. An interview was conducted by phone with Nurse #1 was interviewed by phone on 2/12/2025 at 2:29 pm and stated she cared for Resident #3 on 1/19/2025 and sent her to the hospital after breakfast when Resident #3 became lethargic, pale, and clammy shortly after breakfast. Nurse #1 stated she did not notice any sediment in Resident #3's catheter bag and her urine was not dark when she sent her to the hospital, but her blood pressure was low, and her breathing was labored. Nurse #1 stated she called the Physician and obtained orders to send Resident #3 to the hospital. A review of Resident #3's vital signs on 1/19/2025 at 9:34 am revealed her blood pressure was 92/66, her pulse was 118 per minute, her respirations were 20 per minute, and her oxygen saturation level was 98%. On 1/19/2025 Resident #3 was admitted to the hospital and an Emergency Department to Hospital Physician's Note stated her urine was thick and cloudy with a lot of sediment. The Hospital Physician's Note further stated they were unable to determine when the catheter was last changed because they were unable to obtain the information from the facility. The Hospital Physician's Note also stated Resident #3 was admitted with sepsis due to left lower lobe pneumonia and urinary tract infection and her suprapubic urinary catheter was changed in the hospital on 1/19/2025. A Discharge Summary from the hospital dated 1/28/2025 indicated Resident #3's sepsis was resolved and she was transferred to another facility with plans for palliative care. Nurse Practitioner #1 was interviewed by phone on 1/30/2025 at 10:51 am and she stated Resident #3's missed appointment to have her suprapubic urinary catheter changed on 1/2/2025 did not cause her decline or diagnosis of sepsis (a serious condition resulting from infection when bacteria is present a person's blood) when she went to the hospital on 1/19/2025. She stated Resident #3 had been declining due to her history of diabetes and kidney failure. Nurse Practitioner #1 stated she spoke with Resident #3's Responsible Party about a month ago and he understood Resident #3 had less than 6 months to live but had declined hospice services at the facility. Multiple attempts to contact the Urologist for interview were unsuccessful.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review and staff, Nurse Practitioner, Pharmacy Consultant, and resident interviews, the facility failed to ensure 1 of 1 resident (Resident #2) had pain medication available that was ordered on admission to the facility. Findings included: Review of Resident #2's hospital record indicated she had a right ankle Computed Tomography (CT) Scan on 12/23/2024 which showed a new minimally displaced fracture involving the right ankle and a knee x-ray that showed a mildly displaced fracture involving the distal femur which forms the knee joint. The hospital record also indicated Resident #2 had surgical repair of the right ankle on 1/25/2025. Resident #2 was admitted to the facility on [DATE] with fractures of her left knee and right ankle. A Physician's Order dated 1/8/2025 at 8:00 pm indicated Resident #2 should receive Oxycodone Hydrochloride (a narcotic pain medication) 10 milligrams (mg) two times a day for pain beginning 1/8/2026 and would be discontinued on 1/10/2025. Resident #2's Medication Administration Record for 1/2025 indicated Resident #2 did not receive Oxycodone HCl 10 mg on 1/8/2025 at 8:00 pm or 1/9/2025 at 8:00 am. The Medication Administration Record for 1/2025 indicated Resident #2 received Acetaminophen 1000 mg needed for pain on 1/9/2025 at 7:22 am and on 1/13/2025 at 10:45 am. Further review of Resident #2's Medication Administration Record for 1/2025 indicated she rated her pain at a 0 on a scale of 1 to 10 (with 1 being the least amount of pain and 10 being the worst amount of pain). On 1/29/2025 at 1:35 pm Resident #2 was interviewed and stated she was admitted on [DATE] and did not receive the narcotic pain medication she needed for pain from fractures in both legs until the next evening. Resident #2 stated the nurses did give her Acetaminophen which did not relieve her pain, and she rated her pain at an 8 or 9 (on a scale of 1 to 10) from the time she was admitted until she received the ordered medication on the evening of 1/9/2025. On 1/29/2025 at 1:15 pm Unit Manager #1 was interviewed and stated she was assigned to Resident #2 on 1/8/2025 when she was admitted at approximately 3:00 pm. Unit Manager #1 stated Resident #2 came from the hospital without a prescription for her pain medication and she could not get her ordered pain medication from the electronic backup medication system until a prescription was faxed to the pharmacy. Unit Manager #1 stated the facilities on-call provider group will not give an order for a narcotic and she asked for Acetaminophen 500 mg two tablet every 6 hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Pharmacy Consultant on 1/30/2025 at 2:30 pm and she stated Resident #2 would need the narcotic pain medication that was ordered for her fractures, and the Acetaminophen would not have controlled her pain. The Pharmacy Consultant also stated the facility should have obtained a prescription and faxed it to the pharmacy and the pharmacy would have released the ordered narcotic pain medication from the facility's electronic emergency back-up medications. The Pharmacy Consultant stated the pharmacy cannot release narcotic medications until they have a prescription. On 1/29/2025 at 3:53 pm the Director of Nursing was interviewed and stated Unit Manager #1 was not able to get a written prescription of Resident #2 on 1/8/2025, when she was admitted , for Oxycodone 10 mg because the resident arrived after Nurse Practitioner #1 left for the day and the on-call provider started. The Director of Nursing stated their contracted on-call provider would not give orders for narcotic medications for a resident if the hospital failed to send a prescription with the resident. The Director of Nursing stated the pharmacy could not release the ordered narcotic pain medication from the electronic emergency back-up medications without the prescription. The Administrator was interviewed on 1/29/2025 at 4:01 pm and stated the nursing staff should have reached out to the physician or Nurse Practitioner and obtained a prescription for the ordered narcotic pain medication for Resident #2's ordered pain so that her pain medication could be released from the electronic back-up medications, when she was admitted to the facility to ensure her pain was controlled.