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	01/02/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to allow a resident who was assessed as safe to smoke without supervision the choice to smoke at preferred times for 1 of 3 residents reviewed for choices (Resident #50).The findings included:Resident #50 was admitted to the facility on [DATE].Review of Resident #50's admission Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and was coded for tobacco use.Review of Resident #50's care plan created on 08/16/25 revealed the resident preferred to smoke. The goal was Resident #50 would smoke safely through the review period. Interventions included Resident #50 could smoke unsupervised.Review of Resident #50's smoking assessments revealed a smoking assessment was completed on 10/08/25. The assessment further revealed Resident #50 was safe to smoke without supervision.An interview with Resident #50 on 12/17/25 at 1:00 PM revealed she was an independent smoker and was able to smoke anytime from 7:00 AM until 8:00 PM. Resident #50 further revealed she would like to be able to smoke after 8:00 PM, but nursing staff would lock the doors going to the smoking area and was unable to smoke. Resident #50 stated she had reported to staff she wanted to be able to smoke after 8:00 PM.An interview with Nurse Aide (NA) #3 on 12/17/25 at 1:15 PM revealed she worked both the 7:00 AM to 3:00 PM shift and 11:00 PM to 7:00 AM shift, and Resident #50 had complained that she was unable to go out after 8:00 PM and smoke. NA #3 further revealed she had been educated by department heads that no residents were allowed outside to smoke after 8:00 PM. NA #3 indicated Resident #50 was a safe independent smoker and had no prior incidents that she was aware of.An interview with the Director of Nursing (DON) on 12/23/25 at 11:38 AM revealed the owner of the building was uncomfortable with residents going outside to smoke after 8:00 PM due to the cold weather. The DON further revealed independent smokers should be allowed to go out to smoke when they preferred. An interview with the Administrator on 12/23/25 at 9:30 AM revealed supervised smokers stopped smoking at 8:00 PM due to lack of staff being available and concerns of cold temperatures. The Administrator stated he was unaware that independent smokers were not allowed outside after 8:00 PM to smoke. The Administrator indicated it must have been carried over by the previous administration, and it would be corrected immediately that independent smokers could smoke after 8:00 PM if they preferred.

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

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	01/02/2026

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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 0602 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 record review and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of narcotic medication for 2 of 3 residents reviewed for misappropriation of resident property (Resident #22 and #6). On 11/6/2025 the facility discovered Resident #22 had a medication card of 30 Oxycodone (a narcotic pain medication) 5 milligram tablets missing from the medication cart's locked narcotic box and on 11/10/2025 the facility discovered Resident #6 had a medication card of 28 Oxycodone 5 milligram tablets missing from the medication cart's locked narcotic box. Findings included:The facility's abuse policy which was revised on 10/20/2022 was reviewed and the policy stated misappropriation was the deliberate misplacement, exploitation or wrongful use of the resident's money or belongings. The abuse policy further stated the resident has the right to be free of misappropriation of their property.a. A review of Resident #22's electronic medical record (EMR) revealed his physician's orders included oxycodone 5 milligrams two times a day which was ordered on10/22/2025.A Packing Slip Proof of Delivery form from the facility's contracted pharmacy was provided for review by the facility. The form was not signed by a receiving nurse but indicated 2 medication cards of 30 tablets each of Oxycodone 5 milligrams was delivered to the facility on [DATE]. The packing slip was printed at the pharmacy on 10/22/2025 at 2:27 pm. Resident #22's Medication Administration Record for 10/2025 indicated he had not complained of pain when he was assessed each shift, and he received his Oxycodone 5 milligrams twice a day at 8:00 am and 8:00 pm. Resident #22's Medication Administration Record for 11/2025 indicated he had not had any pain, and he received his Oxycodone 5 milligrams twice a day at 8:00 am and 8:00 pm.Review of Resident #22's Medication Administration Record for 12/2025 revealed he did not complain of pain during his pain observations each shift, and he received the prescribed dose of Oxycodone 5 milligrams twice a day at 8:00 am and 8:00 pm.An interview was conducted with Medication Aide (MA) #1 on 12/18/2025 at 10:52 am, and she stated she arrived for her shift on 11/6/2025 at 2:00 pm and was counting the narcotics on the medication cart with Nurse #2 when she realized Resident #22 should have two medication cards of Oxycodone 5 milligrams because the cards were numbered 1 of 2 and 2 of 2, and Resident #22 only had (1) card which was numbered 1 of 2. MA #1 indicated she notified Director of Nursing (DON) #1 immediately of the discrepancy. Attempted three calls and a text message to Nurse #2 for an interview and left telephone voice messages but she did not return the telephone messages.During an interview with DON #1 on 12/17/2025 at 9:30 am she stated they discovered the missing Oxycodone 5 milligram Medication Card of 30 tablets when Medication Aide (MA) #1 reported to her by MA #1 that Resident #22 had 2 medication cards of 30 tablets of Oxycodone 5 milligrams and one of the cards was missing when she counted the cards with Nurse #2 on 11/6/2025 at the beginning of MA #1's 2:00 pm to 10:00 pm shift. b. A Physician's Order dated 10/2/2025 indicated Resident #6 should receive Oxycodone 5 milligrams every 6 hours as needed (PRN) for moderate pain.A Packing Slip Proof of Delivery form dated 10/2/2025 and timed at 5:00 pm indicated Resident #6 had 30 tablets of Oxycodone 5 milligrams delivered to the facility.On 11/13/2025 at 8:00 am Resident #6's Packing Slip Proof of Delivery indicated 30 tablets of Oxycodone 5 milligrams was delivered to the facility.Resident #6's Medication Administration Record for 12/2025 indicated she was not administered any doses of her PRN oxycodone 5 milligrams. On 12/18/2025 at 10:42 am Medication Aide (MA) #1 stated she had been assigned to Resident #6 on Monday, 11/3/2025, and was asked to count Resident #6's narcotics by the Hospice Nurse. She stated she remembered Resident #6 had 28 oxycodone 5 milligram tablets in the locked narcotic drawer of the medication cart. MA #1 stated Resident #6 had not been taking the oxycodone 5 milligram tables that were ordered as needed and she knew she would not have taken 28 tablets in just 5 days. She stated she notified DON #1 immediately.The Hospice Nurse was interviewed by telephone on 12/18/2025 at 2:41 pm and stated she visited Resident #6 on 11/10/2025 and counted Resident #6's oxycodone tablets with Medication Aide (MA) #1. The Hospice Nurse stated she had also visited Resident #6 on 11/5/2025 and she had 28 tablets but on 11/10/2025 she did not have any Oxycodone. The Hospice Nurse stated Resident #6 did not usually take the Oxycodone because she had an order for another narcotic pain medication (Morphine Sulfate) which was liquid and easier for her to swallow. The Hospice Nurse stated she and Medication Aide #1 reported Resident #6's missing Oxycodone to DON #1 immediately. DON #1 was interviewed on 12/18/2025 at 10:34 am and she stated the 28 tablets of missing oxycodone 5 milligrams for Resident #6 was discovered by MA #1 when she was counting Resident

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	345115	A. Building B. Wing	01/02/2026

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with staff, Nurse Practitioner, and the Psychiatric Nurse Practitioner, the facility failed to provide effective supervision for a resident who had cognitive impairment, alcohol induced dementia, and a court appointed Guardian. On 12/2/2024 Resident #120 told the Director of Nursing he was upset because he had been told by a staff member that he was going to be moved to the secured unit. Later that same day Resident #120 stacked patio furniture in the enclosed courtyard and then proceeded to climb onto an awning, then up to the roof of the facility. Resident #120 was observed by staff to be running around on the roof and sitting on the edge of the roof with his legs dangling over the edge of the roof. To ensure safe rescue of the resident, the local fire department was called, and the resident was assisted off of the roof by firemen and the firemen aided in returning the resident to the ground. The Guardian stated when she saw Resident #120 at the hospital on [DATE] he told her he was not attempting to harm himself; he was trying to leave the facility when he climbed up on the roof from the courtyard. There was a high likelihood of a serious adverse outcome including life threatening injuries or death when Resident #120 climbed up onto the roof and while he was on the roof on 12/2/2024. The deficient practice was identified for 1 of 7 residents reviewed for accidents (Resident #120).In addition, the facility failed to complete a smoking assessment on admission and quarterly to determine if a resident was safe to smoke independently or required supervision for 1 of 3 residents reviewed for smoking (Resident #50).Example #2 was cited at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy).Findings included: A Letter of Appointment Guardian of Person (entitle under laws of North Carolina to have custody, care, and control of Resident #120) was assigned to the Guardian and signed by Clerk of Superior Court on 8/31/2021. Resident #120 was admitted to the facility on [DATE] with diagnoses including depression, agitation, and alcohol induced dementia. Resident #120's care plan that was updated on 7/24/2024 indicated he was confused and unaware of safety needs. The care plan also stated Resident #120 was a safe smoker and was allowed to go to the courtyard and could smoke unsupervised. A Psychiatry Progress Note by the Psychiatric Nurse Practitioner dated 10/21/2024 indicated Resident #120 was assessed for psychiatric medication follow-up and his current psychiatric medications included: trazodone 50 milligrams once a day (an antidepressant medication) and sertraline (an antidepressant medication) 50 milligrams once a day. The progress note further indicated he had no suicidal or homicidal ideation, he was calm and cooperative during the assessment, and his depression and insomnia were stable. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #120 was moderately cognitively impaired and had no behaviors. Resident #120 required supervision with transfers and toileting, was independent with ambulating in the facility, and did not require a mobility aid. (continued on next page)

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	345115	A. Building B. Wing	01/02/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A progress note dated 12/2/2024 at 5:20 pm written by Nurse #4 indicated Resident #120 went outside to the courtyard and climbed a tree to get on the roof at 4:30 pm, after a staff member told him he was transferring to the locked dementia (secured) unit. The Fire Department responded and assisted Resident #120 off the roof. The progress note further stated Resident #120 was put on hourly checks beginning at 6:00 pm. During the survey multiple attempts were made to contact Nurse #4 without success. Nurse Aide #5 was interviewed on 12/18/2025 at 1:37 pm. She stated she was in the activities room that led out to the smoking area on 12/2/2024 and saw Resident #120 moving the furniture in the smoking area. Nurse Aide #5 stated Resident #120 stepped up on a chair, and then stepped up on a table, and then swung himself onto the awning over the smoking area. Nurse Aide #5 stated she yelled out for help and immediately ran out to the courtyard, but Resident #120 had climbed to the top of the smoking area awning and then to the roof before she could get to him. Nurse Aide #5 stated Resident #120 was running across the roof toward the front hall of the facility. She stated Resident #120 went around the roof to above where the 100-hall exit door was (which was on the opposite side of the facility from where he initially got on the roof) and was sitting on the roof with his feet dangling over the side. The nurse aide explained from her vantage point she was able to witness the resident at all times when she was out in the courtyard, and she did not lose sight of him. Nurse Aide #5 stated other staff arrived in the courtyard and she returned to her assignment since she was not assigned to Resident #120. During a phone interview with Resident #120's court appointed Guardian on 12/18/2025 at 8:50 am she explained Resident #120 had a history of wandering the facility, but he had not attempted to leave the facility before the incident on 12/2/2024. The Guardian stated she had not been notified about the 12/2/2024 roof incident until a conversation with the Social Worker on 12/11/25. The Guardian stated when she saw Resident #120 at the hospital on [DATE] he told her he was not attempting to harm himself; he was trying to leave the facility when he climbed up on the roof from the courtyard. The Guardian stated the facility had asked her for Resident #120 to be placed on the secured unit before the incident on 12/2/2024 but it was because he was pushing other residents in their wheelchairs, not because he had attempted to elope, and she had refused to have him moved to the secured unit. The Guardian also stated she was no longer assigned to Resident #120 since he had moved to a secured unit at a facility in another county. Nurse Practitioner (NP) #1's progress note dated 12/5/2024 and timed 9:44 pm indicated Resident #120 was evaluated after he had climbed onto the roof of the facility on 12/2/2024. The progress note indicated Resident #120 had a history of alcohol dependence with acute withdrawal, illicit drug use, major depressive disorder, dementia, and chronic insomnia; and was confused. The progress note also stated Resident #120 denied suicidal ideation, was feeling well, and had no intentions or desires to get back on the roof. Nurse Practitioner #1 indicated an electronic wander guard transmitter should be put into place for Resident #120. NP #1's progress note dated 12/10/2024 and timed 6:28 pm by Nurse Practitioner #1 indicated Resident #120 was seen for a routine monthly follow-up assessment. At the time of the assessment the resident was confused, with diagnoses of major depressive disorder, dementia, chronic encephalopathy, and insomnia. The progress note stated supportive measures and redirection of behaviors should continue as needed. (continued on next page)

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	345115	A. Building B. Wing	01/02/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	NP #1 was interviewed by phone on 12/18/2025 at 5:17 pm and stated she was present in the facility when Resident #2 had climbed onto the roof on 12/2/2024. NP #1 stated she saw Resident #120 on 12/2/2024 after the incident but did not document the visit until 12/5/2024 in a progress note. NP #1 stated she did not believe Resident #120 was suicidal and he stated he just wanted to leave the facility when she assessed him on 12/5/2024. She stated he had become agitated because he was told he was going to be moved to the secured unit. NP #1 stated Resident #120 was normally confused and would wander around the facility but had not tried to leave the facility until 12/2/2024. During a phone interview with the Psychiatric Nurse Practitioner on 12/29/2025 at 12:21 pm he stated he was not notified of the incident when Resident #120 climbed onto the roof of the facility on 12/2/2024. He stated he saw Resident #120 for depression and insomnia and reviewed his medications. The Psychiatric Nurse Practitioner stated when he assessed Resident #120 on 6/29/2024 and 7/16/2024 he was not suicidal but did have behaviors of wandering and definitely had cognitive impairment related to dementia. The Maintenance Director was interviewed on 12/18/2025 at 4:06 pm in conjunction with an observation made when he conducted measurements with a measuring tape. The Maintenance Director measured the distance from the ground to the top of the smoking area metal awning to be 96 inches (8 feet) and the distance from the top of the smoking area awning to the roof to be 60 inches (5 feet). The Maintenance Director stated he cut the tree limbs back around the smoking area awning and the roof after the 12/2/2024 incident when Resident #120 climbed up on the smoking area awning and then the roof. He explained it was reported to him that the resident had used the limbs to support himself as he had climbed. The Maintenance Director stated the top of the awning and roof were flat. Director of Nursing (DON) #2, the previous DON, who no longer worked for the facility, was interviewed by phone on 12/17/2025 at 3:27 pm. During the interview she stated she was present at the facility on 12/2/2024. She explained Resident #120 became upset because he told the DON he had been told by a staff member that he was going to be moved to the secured unit. DON #2 further stated Resident #2 climbed up on the awning over the smoking area in the courtyard and from there he climbed up on the roof of the facility. DON #2 stated the fire department was called and they removed him from the roof and he was on the roof for approximately 15 to 20 minutes. In a follow up phone interview on 12/19/2025 at 8:32 am DON #2 stated Resident #120 was not suicidal but tried to leave the facility when he climbed onto the roof on 12/2/2024. She stated Resident #120 was on every hour checks until Nurse Practitioner #1 saw him a few days after the 12/2/2024 incident and the resident stated had no intention of climbing on the roof again. On 12/19/2025 at 9:12 am Administrator #2, the former Administrator, was interviewed by phone and stated on 12/2/2024 Resident #120 had managed to stack furniture and used the limbs of a tree to climb up on the awning over the smoking area in the courtyard of the facility. Resident #120 then proceeded to climb up on the roof of the facility. The facility provided a statement that was undated and signed by the Social Worker that stated she met with Administrator #2, DON #2, and the Guardian on 12/1/2024, 12/2/2024 and 12/4/2024 and in the meetings they discussed moving Resident #120 to the secured dementia unit, but the Guardian had refused to move Resident #120. The Administrator was notified of the immediate jeopardy on 12/18/2025 at 4:15 PM. (continued on next page)

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	345115	A. Building B. Wing	01/02/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility provided the following corrective action plan: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #120 was a long-term resident who had documented cognitive impairment, agitation, impaired judgment, but no wandering behaviors prior to 12-2-2024. Resident#120 had a court-appointed guardian for the person. Resident#120 had a Brief Interview for Mental Status (BIMS) score of 9, indicating cognitive impairment on 10-22-2024 and was assessed as a safe smoker on 10-16-2024. Resident #120 had a documented history of mild agitation, impulsive behaviors, impaired decision-making and was care planned for those areas. Resident#120 was being seen by psychiatric services and was last seen on 10-21-2024 by a psychiatric Nurse Practitioner (NP). The notes from the psychiatric NP visit documented the resident's behaviors were stable and Resident#120 stated he got sad sometimes. Resident #120 was an active smoker, had been deemed a safe smoker, and did not require supervision. The smoking area was in the enclosed courtyard, and the resident was allowed to go out to the courtyard and smoke independently. Resident #120 ambulated independently without assistive device and gait was steady on even and uneven surfaces. He did not require supervision for ambulation due to gait. On 12-1-2024, the former Administrator and former Director of Nursing (DON) contacted Resident 120's court-appointed guardian to discuss concerns regarding Resident #120 including increased agitation and a decline in safety awareness all of which had been observed over several days prior to contacting the resident's guardian. During this call, the former Administrator and former DON reported Resident #120 had required frequent redirection, had been entering common areas without purpose, and had demonstrated poor judgment related to environmental safety including taking his roommate, who was not a smoker, out to the courtyard to smoke, and he became easily agitated with staff. The guardian was informed that the resident's behaviors appeared to be escalating and that additional supervision or a higher level of secured care might become necessary if the behaviors continued. No change in placement was approved by the guardian at the time of the call. In the days leading up to 12-2-2024, staff noted an increase in agitation and unsafe behaviors of Resident #120, which contributed to the escalation of behaviors, according to a note in the resident's chart dated 12-1-2024. The note documented the resident was trying to take his roommate outside to smoke. Resident #120's roommate was not a smoker. Resident#120 had been a safe smoker until 12-2-2024 when he was reassessed following his climbing onto the roof and his smoking status was changed to a supervised smoker. Resident#120 had made no prior attempts to elope and usually only went outside to smoke or to color. The reason for the resident's change in behavior was unknown. Resident#120 did not wear a wander guard up until the time of discharge. The former DON did attempt to place a wander guard on resident #120 on 12-2-2024 but according to an interview with the Assistant Director of Nursing (ADON) he would not wear the wander guard and ripped it off in seconds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 12-2-2024, at approximately 5:00 PM, while Nursing Assistant (NA) #1 was in the Activities room which exits to the courtyard, and has windows with a view of the courtyard, and she observed Resident # 120 in the enclosed courtyard appearing restless, agitated, repositioning and climbing on courtyard furniture near the wall of the facility. NA #1 ran out to the courtyard, and the resident was observed to have climbed up onto the roof using a table and the branch of a tree. NA#1 called for assistance from other staff verbally as she was running out of building into the courtyard. By the time NA #1 got outside to the enclosed courtyard she observed resident #120 standing on the roof above the courtyard area, near the awning on the south side of the facility. The resident was alternating standing and pacing on the roof, demonstrating poor safety awareness and an inability to recognize the risk of serious injury. When other staff arrived in courtyard NA #1 stated she immediately notified the Unit manager, who contacted the former Director of Nursing and Unit 2 charge nurse who called the Fire Department. Staff maintained continuous visual observation from the courtyard below and did not access the roof due to safety concerns. The Fire Department assisted the resident off the roof using appropriate safety equipment which included a ladder and physical assistance. Two firemen went up to the roof to assist the resident in safely getting down from the roof and the resident was cooperative with redirection once emergency personnel arrived. Resident#120 was verbal but cognitively impaired, and when the fireman asked him why he climbed onto the roof, he stated he was trying to get outside, but was unable to provide further explanation. Resident #120 was assessed immediately upon removal from the roof by the former Director of Nursing, with a full head-to-toe assessment completed at approximately 5:30 PM, and no injuries were identified. Due to the resident's cognitive impairment, agitation, and the behavior of him climbing up to the roof, enhanced supervision of Resident #120 was initiated on 12-2-2024, at approximately 6:00 PM, which included frequent NA visual checks every 15 min and a nurse check hourly. Staff were instructed by the former DON to place the resident on 1:1 during periods of agitation. Resident did not require 1:1 monitoring. Resident#120 was then restricted from going out to the courtyard unsupervised and was placed on the supervised smoking list. This enhanced supervision was implemented at 6:00pm on 12-2-2024 per the medical record and was conducted by licensed nursing staff and direct care staff. The enhanced supervision remained in place until further care planning decisions were made. The facility determined the resident accessed the roof by climbing onto movable courtyard furniture, possibly also holding onto a tree branch, and stepping onto an awning, which provided access to the roofline. On 12-2-2024, immediately following the roof access incident, the former Administrator and former DON notified Resident 120's guardian of the event in which the resident gained access to the roof from the enclosed courtyard. The guardian was informed the resident had climbed furniture, accessed an awning, and stood on the roof. The resident had created a high risk for serious injury or death to himself due to impaired judgment and lack of safety awareness. During this conversation, the facility requested permission to transfer the resident to a secured unit within the facility, due to the unsafe climbing behavior, repeated wandering, inability to recognize danger, and escalating agitation. The former DON and the former Administrator explained that until placement could occur, the resident had been placed on enhanced supervision, had restricted access to the courtyard, and had been closely monitored by nursing and direct care staff. The guardian declined placement in the secured unit, stating a preference for the resident to remain in the current unit and attempting to manage behaviors in the resident's current environment, meaning out on the regular floor and not in the secured unit. The resident continued with periods of wandering and attempting to go to the courtyard from 12-2-2024 through 12-4-2024 according to interviews with the Unit Manager and the ADON. (continued on next page)

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	01/02/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 12-2-2024, Resident #120 was relocated to a room closer to the nurses' station, which allowed for increased frequency of staff observation, quicker response to agitation, and earlier intervention when wandering behaviors were noted. The resident had exhibited no further behaviors at that time, but administration team felt continued close supervision was needed for the resident for safety due to the 12-2-2024 incident. At the time of incident on 12-2-2024 Resident #120 had shown a cognitive decline and agitation but had not exhibited wandering behavior, attempted to exit seek, or display at risk behavior until 12-2-2024. On 12-4-2024, the former Administrator and Director of Nursing contacted the court-appointed guardian again to provide an update regarding Resident 120's safety risks. The guardian was informed that despite enhanced supervision, the resident continued to exhibit wandering behaviors, agitation, poor safety awareness, and the facility remained concerned about its ability to safely meet the resident's needs in a non-secured setting. The request for secured unit placement was reiterated due to continued risk of serious harm; however, the guardian again declined the request, citing a preference for continued care in the current environment. The guardian was advised about the resident's care plan had been updated on 12-2-2024, to include increased supervision, identification of wandering risk, environmental safety controls, and behavioral monitoring interventions, which remained in place. On 12-11-2024 at approximately 6:30 AM Resident #120 was observed by former Nurse #1 pacing and exhibiting increased agitation up and down hallway and charted the observation. Nurse #1 followed the resident into the courtyard and observed the resident moving around tables. The resident would not say what he was doing when asked but the resident was easily redirected back into the facility by former Nurse #1 and returned to his room without incident. The nursing station was across from resident's room, and he was monitored closely by staff until Involuntary commitment paperwork was obtained for psychiatric and medical evaluation due to the increased agitation and noted hallucinations (hearing a television (TV) that was not there or on and yelling for it to be turned off). The resident was transported to the hospital by the local police department and was to have a psychiatric evaluation as part of an involuntary commitment (IVC) for his agitation. The resident was admitted to the hospital. The resident's guardian felt the resident would become increasingly agitated in secured unit and would not allow admission into the secured unit. The facility was unable to safely meet the residents' needs due to guardian's continued refusal of placement into the secured unit. The former Administrator informed the hospital Resident #120 could return but it would need to be on the secured unit for safety, the resident's guardian declined, and alternate placement was arranged by the hospital. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All Residents with cognitive deficits and physical capabilities have the potential to be affected. At the time of incident on 12-2-2024 all residents who had wandering behaviors resided on the secured unit. As of 5-1-2025 all newly admitted residents have been assessed for wandering on admission as part of the admission assessment. All residents will be assessed for wandering quarterly and with any significant change in condition. (continued on next page)

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	01/02/2026

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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	All residents were assessed for wandering, change in behavior, increased agitation, and subsequent elevation of problematic/inappropriate behaviors on 10-24-2025 by ADON, who was acting as the DON. Wander guard transmitters were placed on all residents who had the ability to wander by the Unit Manager and ADON, who was acting as the DON. Any residents who were identified with a change in behavior, increased agitation, and subsequent elevation of problematic/inappropriate behaviors were reviewed by the ADON, who was acting as the DON, and referrals were made to the resident's physician and psychiatric service as needed. There were no residents assessed being at risk for injury in need of 1:1 due to behaviors on 10-24-2025. The Interdisciplinary Team (IDT) which included the Former Administrator, ADON, acting as DON, Social Worker#1, Admissions Coordinator, Unit Manager #1, Unit manager #2 Maintenance Director and Activity Director met on 10-24-2025. During the meeting the IDT reviewed all residents in the facility to identify residents who had wandering or exit seeking behavior. As of 10-24-2025 all residents who had wandering behavior or exit seeking had wander guards. As of 10-24-2025 there have been 2 staff members who were in the dedicated role of wandering resident monitors on duty 24 hours a day, 7 days a week. The 2 assigned staff members monitor wandering residents and points of egress. This system will remain in place for safety as long as facility has wanderers who can access points of egress in the facility or until a safer alternative is identified. Hall monitors are on the facilities staffing template for staffing coordinator to schedule every shift in the same manner she schedules nurses and NAs. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. During an all staff meeting on 12-14-2024, staff received in-service training regarding the expectations of supervision of wandering residents by the former DON. The training included education regarding continuous observation of residents exhibiting unsafe behaviors, immediate escalation of concerns, and proactive identification of environmental risks. All staff were educated and acknowledged they attended and attested to understanding of expectations, by signing education attendance log. Staff were instructed to relocate any resident who was displaying exit seeking behavior or was wandering to the secure unit and notify the former DON. The former DON would then evaluate if long-term placement to the secured unit was needed. On 5-1-2025 all employees in the facility were re-hired by new ownership and have received training on dementia, as well as caring for wandering residents and residents with behavior by Human Resources and the DON. All employees had to complete training module on caring for residents with Dementia and behaviors to be eligible for rehire by new administration by 5-1-2025. All newly hired staff receive training on dementia, as well as caring for wandering residents and residents with behavior by ADON and HR Director. The training is repeated annually after hire. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 10-24-2025 to alter the process and prevent recurrence, the facility implemented changes to supervision, environmental monitoring, and risk identification practices. These actions included restricting unsupervised courtyard access for residents with wandering or unsafe behaviors, implementing designated staff monitoring of the courtyard during resident use, completing routine environmental rounds focused on elevated surfaces and climb risks, and incorporating behavioral escalation triggers into care planning. These actions were completed and fully implemented by 10-24-2025 by ADON, acting as interim DON and the Maintenance Director. All Staff were educated on the systematic change on 10-24-2025. Staff that were not available were educated prior to returning to work. All new hires will be educated during orientation. On 10-24-2025 to alter the process and prevent recurrence, the facility implemented changes to supervision, environmental monitoring, and risk identification practices. These actions included restricting unsupervised courtyard access for residents with wandering or unsafe behaviors, implementing designated staff monitoring of the courtyard during resident use, completing routine environmental rounds focused on elevated surfaces and climbing risks. These actions were completed and fully implemented, with education completed by 10-24-2025 by the ADON, acting as interim DON, and the Maintenance Director to all staff. Education Included that a nurse manager be notified immediately for any new agitation, pacing, wandering or exit seeking behavior, a wandering assessment to be completed and a wander guard placed on resident, Medical Director or provider to also be notified of change in behavior as well as the Residents Responsible party to also be notified of change in behavior and interventions. On 10-24-2025 all employees were educated by the ADON on facility processes for residents with Increased agitation, pacing, exit seeking or wandering behavior and a review of the education will continue annually. All new hires will be educated on facility processes for residents with wandering behavior as part of the orientation process. All residents will be assessed for wandering and exit seeking quarterly and with any significant change in condition. Two staff members have been put into place to monitor wandering and exit seeking residents. The 2 staff members have been in place 24 hours a day, 7 days a week, since 10-24-2025. The 2 assigned staff members monitor residents with exit seeking behaviors, agitation and wandering residents and points of egress. This system will remain in place for safety as long as facility has wanderers who can access points of egress in the facility or until a safer alternative is identified. The wandering resident monitors have been on the facilities staffing template for staffing coordinator to schedule every shift in the same manner she schedules nurses and NAs. Residents with new behaviors of wandering and exit seeking behaviors are discussed Monday thru Friday in Morning clinical meetings by the Administrator, the DON, the ADON, the unit managers, the Social Worker, and the Rehab Director. The DON has been tasked with being responsible for checking the charts to ensure a wandering assessment was completed, Medical Director and the resident's responsible party was notified, a wander guard was initiated, and the care plan was updated with resident specific interventions. A list of exit seeking wandering residents will be updated immediately when a resident becomes newly identified as being at risk for wandering and the list of exit seeking wandering residents will be reviewed weekly by DON and Social Worker for accuracy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Resident wandering assessments and nursing documentation will be audited by the DON and/or the ADON to identify residents who display an increase in agitated behaviors and/or exit seeking/wandering behavior. Audits will include that all residents with increased agitation, exit seeking, and wandering behaviors have wander guards in place and are care planned for appropriate interventions related to the identified behavior. Results of audits will be discussed weekly at the clinical At-Risk IDT Meeting. Audits were initiated on 10-24-2025 by the ADON, acting as the DON, and will continue weekly for 3 months, and then monthly for 3 months to ensure compliance. Results of audits will be presented monthly by the DON to the Quality Assurance and Performance Improvement (QAPI) Committee, consisting of the Director of Nursing, the Assistant Director of Nursing, the Administrator, the MDS Nurse, the Social Worker, Business Office Manager, Maintenance Director, Housekeeping Director, Dietary Manager, Admissions Coordinator, Activities Director, Rehab Director, Unit Manager, and Medical Director for discussion and revisions will be made as needed. The facility's QAPI team met on 10-24-2025 and reviewed interventions put into place to address wandering, elopement, change in behavior, increased agitation, and subsequent elevation of problematic/inappropriate behaviors. Alleged date of compliance: 10-25-25. The facility's corrective action plan was validated on-site on 12/23/25 by record reviews, observations, and staff interviews. Review of audits showed the facility completed new wandering/elopement assessments on all residents. Individual interviews of multiple current staff members working all reported to have completed dementia and behavior de-escalation training since new ownership on 5/1/25. Record review of the in-service documents dated 12/12/24 and 10/24/25 noted the ADON, the previous DON and the Staff Development Coordinator completed the in-person trainings. Signed staff rosters were reviewed with no issues or concerns. Interviews conducted with multiple staff members revealed they had received training about dementia, behaviors, and the elopement monitoring process, and were able to identify what processes to put into place in the event a resident begins showing increased agitation and wandering. Observations revealed two hall monitors on