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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and staff and resident interviews, the facility failed to place survey results in a location readily accessible to residents and visitors and available to review without asking.The findings included:A Resident Council group meeting was conducted on 12/15/25 at 3:00 PM. During the meeting, Resident #13, Resident #18, Resident #25, Resident #30, and Resident #99 indicated they did not know where the survey results were located. An observation conducted on 12/18/25 at 12:20 PM revealed a sign was located on the receptionist desk that stated, Survey Binder Is Located at Front Desk. The survey results book was located behind the reception desk in the lobby area near the facility entrance. The area where the survey results book was located was in a small room that was restricted by walls and a desk that was closed off to residents and visitors. The survey results book was observed to be visible behind Receptionist #1 but was not in reach from the front of the desk. An interview with Receptionist #1 on 12/18/25 at 1:35 PM revealed she had worked in the facility for three years and the survey results book had always been located behind the desk. Receptionist #1 stated the location of the survey results book was considered a restricted area that visitors and residents were not allowed to access. Receptionist #1 indicated residents or visitors would have to ask to be able to review the survey book results. Receptionist #1 revealed she worked Monday through Friday from 8:00 AM until 2:00 PM and she was educated to allow residents or visitors to review the survey results book if they had asked.An interview with Receptionist #2 on 12/18/25 at 2:20 PM revealed she had worked in the facility for a year, and the survey results book had always been behind the receptionist desk. Receptionist #2 indicated visitors and residents were not allowed in the area behind the desk and would have to request to see the survey results notebook. Receptionist #2 indicated she worked Monday through Friday and every other weekend from 2:00 PM until 8:00 PM. An interview with the Assistant Director of Nursing (ADON) on 12/18/25 at 4:30 PM revealed she had not noticed the survey results book had not been in a public area and was aware it needed to always be available to residents and visitors. The ADON indicated she understood that residents or visitors should not have to ask to see survey results.An interview with the Administrator on 12/18/25 at 6:00 PM revealed the survey results book had previously been placed in front of the receptionist desk, but residents had taken the book and misplaced it. The Administrator indicated he had tried to prevent the survey results book from going missing. The Administrator indicated he decided to move the survey results book to the current location a couple weeks ago. The Administrator stated he was aware the survey results book needed to always be available for residents and visitors. The interview further revealed the Administrator understood that residents or visitors should not have to ask to see the survey results.

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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. **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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 #6's narcotics with the Hospice Nurse. She stated MA #1 notified her immediately of the missing narcotic medication. DON #1 stated neither MA #1 nor Nurse #2 were suspended during the investigation and neither were asked to provide a drug test. DON #1 stated the facility did not drug test staff unless they showed signs of impairment due to drug use.The Pharmacist, from the facility's contracted dispensing pharmacy, was interviewed by telephone on 12/18/2025 at 12:10 pm and she stated the pharmacy did not receive communication that either Resident #22 or Resident #6 had narcotic medications that were missing. The Pharmacist stated the facility would be responsible for investigating and reporting missing medication to the authorities.DON #1 was interviewed on 12/18/2025 at 10:34 am and she stated she began an investigation and submitted a 24 hour report for the 30 tablets of oxycodone to the state agency, police and adult protective service, did an audit of all other resident's narcotic medication cards; educated the nurses and medication aide on counting of narcotics at the beginning of each shift and counting the number of narcotic medication cards in the cart; and she initiated a new policy that she and the Assistant Director of Nursing (ADON) were the only staff that could remove narcotics that were to be returned to the pharmacy. DON #1stated she had a locked safe installed in her office closet and the closet had a lock for holding medications that should be returned to the pharmacy. DON #1 stated the staff had not been counting the number of cards when they did a narcotic count and when she reviewed the form where the cards should be counted when completing the narcotic count there were days that the count of how many cards should be in the cart had not been done. DON #1 stated she could not determine who had taken the narcotic medication cards that belonged to Resident #22 and Resident #6. DON #1 stated she began a plan of correction for the misappropriation of narcotic medications after Resident #22's narcotics were reported missing and Resident #6's narcotics were reported during the investigation.Administrator #1 was interviewed on 12/19/2025 at 12:57 pm and stated the nursing staff should have counted the narcotics following the facility's policy and ensured there was no missing narcotic medications.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews with the facility staff, rehabilitation (rehab) therapy staff, and Medical Director, the facility failed to identify a reclining Broda wheelchair (a specialized type of seating that allows for tilt-in-space positioning) as a restraint that was reclined in a position that prohibited the resident from rising independently and without medical justification for its use in this manner. This occurred for 1 of 3 residents (Resident #119) reviewed for restraints. The findings included: Resident #119 was initially admitted to the facility on [DATE]. She was discharged home with a family member on 11/12/25. The resident had a second admission to the facility on [DATE]. Her cumulative diagnoses included emphysema, a history of a cerebral infarction (a type of stroke) and repeated falls. Resident #119's electronic medical record (EMR) included a Nursing re-admission Assessment Tool completed by Nurse #3 and dated 12/13/25. This document contained information on the resident's mental and physical health. The resident was described as cognitively impaired, oriented to person only, and confused. The re-admission Assessment Tool also included a Device Assessment and Restraint Identification. These sections were not completed on the document. Resident #119's EMR did not include a physician order for the use of any device that would restrict the resident's movements. There was no documentation identified in Resident #119's medical record regarding the identification, assessment, or use of a restraint for this resident. An observation was conducted on 12/15/25 at 12:20 PM of Resident #119 as she was sitting near the 100 Hall Nursing Station in a reclining Broda wheelchair with the back of the chair reclined approximately 130 degrees. The resident appeared to be trying to sit up or stand up by pulling her upper body forward and away from the back of the chair. Another observation was made on 12/15/25 at 12:52 PM of Resident #119 as she was sitting in the reclining Broda wheelchair in her room. The back of the chair remained reclined at an angle of approximately 130 degrees. The resident was not leaning forward in the chair at the time of this observation. An observation was made on 12/16/25 at 10:28 AM as the resident was sitting in a reclined Broda wheelchair watching a television in her room. The back of the reclining chair was reclined slightly at approximately 110 degrees. Resident #119 appeared to be comfortable in the chair and was not attempting to sit up further or get up out of the chair. A second observation was conducted on 12/16/25 at 12:07 PM as the resident sat in her room with her lunch meal tray placed on a bedside tray table in front of her. The reclined Broda wheelchair she was sitting in remained slightly reclined with the back of the chair reclined approximately 110 degrees. The resident appeared to be content as she began to feed herself. A third observation was conducted on 12/16/25 at 3:59 PM as Resident #119 was sitting in a reclined Broda wheelchair in a common hallway of the facility. The chair back was reclined back approximately 130 degrees. The resident was observed to be grabbing the hallway's handrail and appeared to be trying to sit upright as she leaned forward. The resident was being supervised by staff member at the time of this observation. An observation was conducted on 12/17/25 at 11:45 AM as Resident #119 was observed to sitting in a Broda wheelchair at a table with three other residents in the dining room. The back of the chair was slightly reclined (approximately 110 degrees). The resident appeared comfortable at the time of the observation. An interview was conducted on 12/17/25 at 1:25 PM with the facility's Rehabilitation (Rehab) Therapy Manager. During the interview, the Manager was asked who was responsible for deciding what type of wheelchair would be used for a newly admitted resident. He stated that the Rehabilitation Therapy Department would evaluate a resident to help determine the type of wheelchair for a resident. When asked, the Manager stated a specific form was not used to document that a wheelchair assessment was completed for a resident. On (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/17/25 at 1:27 PM, an observation was conducted of Resident #119 as she was sitting in a reclined Broda wheelchair in her room with the television on. The back of the chair was observed to be reclined at approximately 130 degrees. The resident appeared to be attempting to raise her upper body from the back of the chair by placing her hands on the arm rests of the chair and pulling herself forward. Two nurse aides (NAs) were in the hallway in front of Resident #119's room at the time of the observation made on 12/17/25 at 1:27 PM. NA #1 identified herself as being assigned to care for Resident #119. NA #2 was assigned to another area but stated she was familiar with the resident. An interview was conducted with NA #1 and NA #2. When the NAs were asked why the resident's chair was reclined back as far as it was (approximately 130 degrees), NA #1 stated, She's a high risk for falls. When asked if reclining the back of the wheelchair that far was intended to prevent her from falling, they both agreed that it was. The NAs added that when Resident #119 was in an activity with someone close by, the back of the wheelchair could be reclined less. An interview was conducted on 12/17/25 at 4:10 PM with the second shift nurse (Nurse #2) assigned to Resident #119's hall. At that time, Nurse #2 reported that during the resident's first admission to the facility, she was in the same type of reclined wheelchair. She stated the resident had a history of multiple falls and seemed to do better with a roommate (which she had during this admission) and/or when there were people around her like when she was in an activity or in the dining room. The nurse was then asked if the resident would be able to get out of the wheelchair if the back of the chair was up and in a normal sitting position. The nurse stated, Yes, that's how she falls. An interview was conducted on 12/18/25 at 9:35 AM with the facility's Rehab Therapy Manager. Resident #119 was in the Rehab Therapy Department participating in therapy at the time of the interview. The back of the resident's reclining Broda wheelchair was observed to be upright while she was engaged in her therapeutic exercise. During the discussion of the resident's positioning in her reclining wheelchair, the Manager demonstrated the possible positions of the reclining back by using levers placed on the back of the chair (not accessible to the resident). As the Manager adjusted the reclining wheelchair's positions, he estimated the angles to range from 90 degrees (upright), 110 degrees, 130 degrees, and then a fully reclined position (not observed in use for this resident). He reported the 130-degree reclined position and fully reclined position were not typically used unless the resident wanted to rest. When informed of both the observations made of Resident #119 and staff interviews conducted, the Manager reported he would not want to use the reclining wheelchair at an angle greater than 110 degrees due to it becoming a restraint. He explained further by stating, For us, our thing is what device and seating system allows the greatest mobility and tolerance so they can increase strength, endurance and transition potentially to another device or seating system. He reported the reclining Broda wheelchair needed to be used as intended or they would need to remove it. He added, We've got to in-service on the correct way to use the chair. A follow-up telephone interview was conducted on 12/22/25 at 11:17 AM with the Rehab Therapy Manager. At that time, information was requested on the manufacturer's specifications for the precise measurement of the positioning angles achieved when the back of Resident #119's wheelchair was reclined. This information was not found on the manufacturer's website nor was it available from the Rehab Therapy Department as of 12/23/25. An interview was conducted on 12/18/25 at 11:15 AM with the facility's Director of Nursing (DON) #1. During the interview, the DON reported she understood how a reclined wheelchair (at 130 degrees) would be considered a restraint. She stated, The Broda chair is never to be used as a restraint. The DON agreed with the Rehab Therapy Manager that the facility needed to work on communication between the Therapy Department and nursing staff to be sure all staff knew how to adjust the reclining wheelchair appropriately for the resident. The DON stated (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was certain the Rehab Therapy Manager never intended the reclining Broda wheelchair to be used as a restraint. A telephone interview was conducted on 12/22/25 at 10:45 AM with the facility's Medical Director. During the interview, the concern related to the observations of Resident #119 sitting in a wheelchair reclined at approximately 130 degrees was discussed. When asked, the MD stated he was not aware of any medical symptoms that may warrant the use of a 130-degree reclined wheelchair for this resident. He added that he certainly did not recommend restricting a resident's movements or restraining a resident and would suggest staff attempt other measures such as re-direction be utilized instead.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a 5-day investigation report to the State Agency for Resident #22 and Resident #6 for misappropriation of narcotic medication. In addition, the facility failed to report Resident #6's missing narcotics to Adult Protective Services or submit an initial allegation report to the State Agency. The deficient practice occurred for 2 of 3 residents reviewed for abuse, neglect, and misappropriation (Resident #22 and Resident #6). Findings included:The facility's Abuse Policy dated 10/20/2022 stated the facility would report allegations of misappropriation to the State Agency, Adult Protective Services, and Law Enforcement agencies within 24 hours if the event that caused the suspicion did not result in bodily harm. The facility's Diversion of Medications Policy dated 5/2022 indicated the facility would report to any agencies required by state regulation.1. Resident #22 was admitted to the facility on [DATE] with diagnoses of immobility and contractures.A review of Resident #22's physician's orders indicated he should receive oxycodone (a narcotic pain medication) 5 milligrams two times a day which was ordered on 10/22/2025.A Packing Slip Proof of Delivery form provided by the facility from the facility's contracted pharmacy was provided for review. The form was not signed by the receiving nurse but indicated Resident #22 had 2 medication cards of 30 tablets each of Oxycodone 5 milligrams delivered to the facility on [DATE]. The packing slip was printed at the pharmacy when the medications cards were transported to the facility on [DATE] at 2:27 pm.During an interview with Medication Aide (MA) #1 on 12/18/2025 at 10:52 am 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 had two medication cards of Oxycodone 5 milligrams because the cards were numbered 1 of 2 and 2 of 2, but Resident #22 only had (1) card and it was numbered 1 of 2. Medication Aide #1 stated she reported the missing narcotic medication card to DON #1 immediately on 11/6/2025.An interview was conducted with DON #1 on 12/17/2025 at 9:30 am and she stated they discovered Resident #22 had a card of 30 tablets of oxycodone 5 milligrams tablets missing on 11/6/2025 when MA #2 realized the card was missing from the locked narcotic drawer on the medication cart. DON #1 stated she completed a 24-hour report to the State Agency and sent it in on 11/7/2025. DON #1 stated she had also reported the 30 missing oxycodone 5 milligrams tablets to the police department, but they did not open a police report, Adult Protective Services, and to the facility's contracted pharmacist. DON #1 stated she had not reported the 30 missing oxycodone 5 milligrams to the Drug Enforcement Administration (DEA) because she had only been at the facility for a week and thought the contracted pharmacist would notify the DEA. DON #1 stated she thought she had sent the 5-day investigation report to the state agency but was unable to provide a copy of the report or the validation it was faxed to the State Agency, and the report was not received by the State Agency.2. Resident #6 was admitted to the facility on [DATE] with diagnoses of osteoporosis and chronic pain.A Physician's Order dated 9/16/2025 indicated Resident #6 received hospice services.On 10/2/2025 a Physician's Order stated Resident #6 should receive Oxycodone 5 milligrams every 6 hours as needed for moderate pain.A Packing Slip Proof of Delivery form indicated Resident #6 had 30 Oxycodone 5 milligrams tablets on 10/2/2025 at 5 pm.A Physician's Order dated 10/15/2025 indicated Resident #6 should receive Morphine Sulfate (a narcotic pain medication) 20 milligrams/milliliters at 0.5 milliliters by mouth four times a day. A Packing Slip Proof of Delivery form indicated Resident #6 had 30 Oxycodone 5 milligrams tablets on 11/13/2025 at 8 am.On 12/18/2025 at 10:42 am MA #1 stated she was assigned to Resident #6 on 11/10/2025 and was asked to count Resident #6's narcotics by the Hospice Nurse that was visiting. She stated she remembered Resident #6 had 28 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxycodone 5 milligram tablets in the locked narcotic drawer of the medication cart on the when she worked on 11/3/2025, but the oxycodone was not in the locked narcotics box on the medication cart. MA #1 stated Resident #6 had not been taking the oxycodone 5 milligrams tablets because they were as needed and she was also receiving Morphine Sulfate (a narcotic pain medication) and it relieved her pain. MA #1 stated she notified DON #1 immediately of the missing narcotics. DON #1 was interviewed on 12/18/2025 at 10:34 am and she stated MA #1 and the Hospice Nurse discovered a medication card with 28 tablets of Oxycodone was missing from the locked narcotics drawer of the medication cart on 11/10/2025 and they notified her immediately. DON #1 stated she had not initiated a 24-hour report or 5- day report to the State Agency for the 28 tablets of oxycodone, and she did not report to the police, Adult Protective Services, or DEA that the 28 tablets of oxycodone were missing. DON #1 stated she thought that she did not need to report Resident #6's missing oxycodone since she had already investigated Resident #22's missing oxycodone. Administrator #1 was interviewed on 12/19/2025 at 12:57 pm and he stated DON #1 should have ensured the State Agency, Adult Protective Service, and Drug Enforcement Agency were notified of the missing narcotics that belonged to Resident #22 and Resident #6.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Nurse Practitioner, and Guardian interviews, the facility failed to allow 1 of 3 residents reviewed for discharge to return to the facility after transfer to the hospital (Resident #120). Findings included:Resident #120 was admitted to the facility on [DATE] with diagnoses of alcohol abuse and dementia.A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #120 was severely cognitively impaired.A discharge return anticipated Minimum Data Set assessment was dated 12/11/2024.On 12/11/2024 at 1:59 pm the Social Worker's Note indicated the Guardian was notified of Resident #120 being issued a 30-day discharge notice for behaviors the facility was unable to manage and the facility was going to proceed with involuntary committal as they were no longer able to keep Resident #120 safe.A Progress Note dated 12/11/2024 at 7:15 pm written by Nurse #7 indicated Resident #120 was transferred to the hospital for evaluation after aggressive behavior and extreme exit seeking. The progress note further stated Resident #120 was transferred with two police officers and was calm at the time of discharge.A Nursing Home Notice of Transfer/Discharge signed by Administrator #2 dated 12/11/2024 indicated Resident #120 was transferred to the hospital due to the safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident. The notice further stated the Guardian was notified of the transfer to the hospital.The Social Worker was interviewed on 12/17/2025 at 3:46 pm and she stated the Guardian was contacted on 12/11/2024 and told the facility could no longer handle Resident #120's behaviors and he was sent to the hospital for evaluation after he attempted to get on the facility's roof a second time on 12/11/2024. The Social Worker stated Resident #120 had climbed onto the roof of the facility on 12/2/2024.A telephone interview was conducted with the Guardian on 12/18/2025 at 9:10 am and she stated it was reported to her on 12/11/2024 Resident #120 was sent to the hospital because he was suicidal by the Social Worker. The Guardian stated she had not been made aware of Resident #120 climbing on the roof on 12/2/2024. She stated she had been notified Resident #120 was pushing other residents in their wheelchairs before 12/2/2025, and the facility wanted to move him to the secured dementia unit and she had refused. The Guardian stated on 12/11/2024 she was told he had attempted to jump off the roof of the facility by the Social Worker. The Guardian stated when she spoke with Resident #120 at the hospital, he stated he was not suicidal he just wanted to leave the facility. The Guardian stated she was also told during the conversation with the Social Worker the facility refused to accept him back to the facility on the grounds that they were unable to keep him from harming himself. Nurse #7 was interviewed by phone on 12/22/2025 at 1:02 pm she stated she had not worked on 12/2/2024 when Resident #120 had climbed on the roof of the facility but had heard about the incident. Nurse #7 stated she did not remember if Resident #120 was on 1-hour checks, or if he had an electronic wander guard transmitter on when he was found in the courtyard stacking lawn furniture to attempt to get up on the roof on the morning of 12/11/2024. Nurse #7 stated Resident #7 had always walked around the facility but had never attempted to leave until 12/2/2024 when he was told he was being moved to the secured dementia unit that was locked. She stated he became more agitated, and she was afraid he would hurt someone after the 12/2/2024 incident but he was not suicidal. Nurse #7 stated Resident #120 needed a one-to-one sitter or to go to the secured dementia unit, but the facility did not have someone to sit with him one-to-one. A Hospital Discharge Summary Note dated 1/16/2024 indicated Resident #120 was presented to the hospital from the facility on 12/11/2024 with aggressiveness towards staff and had climbed up on the facility's roof. Resident #120 was transported by the police to the hospital with an involuntary committal order. The discharge summary further stated (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #120 was medically stable and behavioral health evaluated him on 12/11/2024 and he had not met the criteria for inpatient psychological services in the emergency department and after 7 days in the emergency department he was admitted to an inpatient room until placement could be found in a secured dementia unit. The note further indicated Resident #120's hospitalization had been prolonged due to his original facility declining his return. The hospital case management had secured placement for Resident #120 at another facility with a secured dementia unit on and he was discharged to that facility on 1/16/2025.On 12/19/2025 at 8:32 am Director of Nursing (DON) #2, who was the previous DON, stated when Resident #120 climbed on the roof of the facility on 12/2/2024 he was upset because he thought he was going to be moved to the 300-hall secured dementia unit, but there was not a plan to move him to the secured dementia unit. DON #2 stated he was not suicidal but was exit seeking. She stated no matter how much they reassured him he was afraid the facility was going to place him in the secured dementia unit. She stated he attempted to climb on the roof again on 12/11/2024 and they sent him to the hospital for evaluation and refused to take him back because he would not agree to placement on the secured dementia unit or wear an electronic wander guard bracelet. DON #2 stated he got more aggressive between 12/2/2024 and 12/11/2024 and the Guardian told them to send him to the hospital for evaluation. DON #2 stated before 12/2/2024 he was very mild mannered and he was not suicidal.On 12/19/2025 at 9:12 am Administrator #2, who was the facility's previous administrator, stated he did not refuse to take Resident #120 back from the hospital. Administrator #2 stated the Social Worker, DON #2, and he met with the Guardian to come up with a safe plan for Resident #120 before he was sent out on 12/11/2024 but the Guardian refused to allow him to be moved to the 300-hall dementia unit and the Guardian stated she felt it would be better for him to be moved to another facility. Administrator #2 stated the Guardian also suggested Resident #120 be sent to the hospital on [DATE] when he attempted to climb on the roof the second time.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Preadmission Screening and Resident Review (PASRR) status for 1 of 5 residents (Resident #15) reviewed for PASRR.The findings included: Resident #15 was admitted to the facility on [DATE] with cumulative diagnoses which included non-Alzheimer's dementia; anxiety disorder; bipolar disorder; and psychotic disorder. A PASRR Level II Determination Notification letter for Resident #15 (dated 11/14/23) was reviewed. This letter noted Resident #15 had a PASRR number ending with the letter H, which indicated a halted PASRR Level II determination was made due to the resident having a primary diagnosis of dementia. The results of the evaluation, including the determination of a PASRR Level II status, are used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. Resident #15's most recent comprehensive MDS was a significant change assessment dated [DATE]. The Identification Information section of this MDS reported Resident #15 was not determined to have a PASRR Level II status. An interview was conducted on 12/18/25 at 8:56 AM with MDS Nurse #1 related to the PASRR determination reported on Resident #15's significant change MDS assessment dated [DATE]. Upon review of this MDS assessment, MDS Nurse #1 confirmed the assessment was incorrect and that it should have indicated Resident #15 was a PASRR Level II resident. On 12/18/25 at 11:15 AM, an interview was conducted with the facility's Director of Nursing (DON) #1. At that time, the DON reported she would expect the residents' MDS assessments to be accurate.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) for residents previously determined to have a Level I status for a PASRR after a new serious mental disorder was identified for 4 of 5 residents reviewed for PASRR (Resident #14, Resident #83, Resident #107 and Resident #9). The findings included: 1. Review of Resident #14's medical record revealed a PASSR Level I was completed on 1/18/13 prior to admission with a recommendation to resubmit paperwork for PASSR Level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident # 14 was admitted to the facility on [DATE]. The electronic medical record revealed Resident #14 was diagnosed with dementia with behavioral disturbance on 02/23/24, schizophrenia on 8/21/24, and anxiety on 10/09/24. Review of the medical record revealed there was no documented evidence a request for an evaluation for a Level II PASRR was made. Review of the Nurse Practitioner's 8/1/25 progress note revealed schizophrenia was a diagnosis listed in the assessment and plan with olanzapine prescribed twice daily. Review of the psychiatric nurse practitioner's 10/14/25 progress note for consideration of a gradual dose reduction of olanzapine for schizophrenia revealed that it was contraindicated because the resident was stable and would continue to see and reassess the resident every 4 weeks for a gradual dose reduction of psychiatric medications for his schizophrenia and anxiety. During an interview on 12/17/25 at 3:45 PM with the Minimum Data Set (MDS) Nurse, she communicated it was her understanding that if a resident had a change in condition along with a new mental health diagnosis, then she was required to notify the Social Work Director the resident should be referred for evaluation for a Level II PASSR. The MDS Nurse stated she provided a copy of her handwritten list of 25 residents who had new mental health diagnoses that required a referral for a PASSR Level II evaluation to the Directors of Social Work and Nursing. Resident #14's name was on the handwritten list she shared. During an interview on 12/17/25 at 3:30 PM with the Social Work Director, she stated she initiated a PASSR Level I or Level II request for an evaluation if the Minimum Dat Set Nurse notified her that a resident had a significant change or a new mental health diagnosis. The Social Work Director stated Resident #14 was on an August 2025 list of names from an audit the MDS Nurse provided to the Social Work Director that still needed to be submitted for a PASSR Level II evaluation. The Social Work Director shared the list of 25 residents that needed to be submitted for PASSR Level I or II evaluation due to a mental health diagnosis and stated she crossed off resident names when she submitted them for a PASSR Level II evaluation. Resident #14's name did not have a line through it. The Social Work Director was unable to provide a date when the submission would be completed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/25 at 3:00 PM with the Director of Nursing, she communicated her understanding that a request for an evaluation for a Level II PASRR should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. The Director of Nursing stated she has been in the position less than one month and was aware the MDS nurse and Social Work Director were updating their list of residents who still needed to be referred. The Director of Nursing stated she needed to review the performance improvement plan developed by the MDS Nurse and Social Work Director to address the staff's knowledge gap and lack of a process to identify residents who needed a referral for a PASSR Level I or II evaluation. The Director of Nursing stated she was not aware of any details or the residents' names on the list of 25. 2. Review of Resident #83's medical record revealed a PASRR Level I was completed on 3/8/17 prior to admission to the facility with a recommendation to resubmit paperwork for PASSR Level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. The resident was admitted to the facility on [DATE] with diagnoses including schizophrenia. The electronic medical record revealed Resident #83 was diagnosed with severe depression on 3/8/23, dementia on 9/3/24, and bipolar disorder on 9/3/24. Review of the Psychiatric Nurse Practitioner's 9/11/25 progress note revealed that the resident was stable on current regiment and would be seen routinely for her schizophrenia, depression, and bipolar disorder. Review of the medical record revealed there was no documented evidence a request for an evaluation for a Level II PASRR was made. During an interview on 12/17/25 at 3:45 PM with the Minimum Data Set (MDS) Nurse, she communicated it was her understanding that if a resident had a change in condition along with a new mental health diagnosis, then she was required to notify the Social Work Director the resident should be referred for evaluation for a Level II PASSR. The MDS Nurse stated she provided a copy of her handwritten list of 25 residents who had new mental health diagnoses that required a referral for a PASSR Level II evaluation to the Directors of Social Work and Nursing. Resident #14's name was on the handwritten list she shared. During an interview on 12/17/25 at 3:30 PM with the Social Work Director, she stated she initiated a PASSR Level I or Level II request for an evaluation if the Minimum Dat Set Nurse notified her that a resident had a significant change or a new mental health diagnosis. The Social Work Director stated Resident #14 was on an August 2025 list of names from an audit the MDS Nurse provided to the Social Work Director that still needed to be submitted for a PASSR Level II evaluation. The Social Work Director shared the list of 25 residents that needed to be submitted for PASSR Level I or II evaluation due to a mental health diagnosis and stated she crossed off resident names when she submitted them for a PASSR Level II evaluation. Resident #83's name did not have a line through it. The Social Work Director was unable to provide a date when the submission would be completed. During an interview on 12/18/25 at 3:00 PM with the Director of Nursing, she communicated her understanding that a request for an evaluation for a Level II PASRR should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident has had a change of condition or received a new mental health diagnosis. The Director of Nursing stated she has been in the position less than one month and was aware the MDS nurse and Social Work Director were updating their list of residents who still needed to be referred. The Director of Nursing stated she needed to review the performance improvement plan developed by the MDS Nurse and Social Work Director to address the staff's knowledge gap and lack of a process to identify residents who needed a referral for a PASSR Level I or II evaluation. The Director of Nursing stated she was not aware of any details or the residents' names on the list of 25. 3. Review of Resident #107's medical record revealed a PASSR Level I was completed 3/22/18 prior to admission to the facility with a recommendation to resubmit paperwork for a PASSR Level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. The resident was admitted to the facility on [DATE] with readmission on [DATE]. The electronic medical record revealed Resident #107 was diagnosed with psychosis on 9/11/24, dementia on 9/11/24, bipolar disorder on 9/11/24, anxiety on 9/11/24, and schizophrenia on 6/10/25. Review of the Psychiatric Nurse Practitioner's 6/10/25 progress note revealed the resident had a diagnosis of schizophrenia listed in their assessment and plan for Resident #103. Resident #107 would be seen every 4 weeks for psychiatric follow-up and assessment for a gradual dose reduction of psychiatric medications prescribed for her bipolar disorder, schizophrenia, and anxiety. Review of the medical record revealed there was no documented evidence a request for an evaluation for a Level II PASRR determination was made. During an interview on 12/17/25 at 3:45 PM with the Minimum Data Set (MDS) Nurse, she communicated it was her understanding that if a resident had a change in condition along with a new mental health diagnosis, then she was required to notify the Social Work Director the resident should be referred for evaluation for a Level II PASSR. The MDS Nurse stated she provided a copy of her handwritten list of 25 residents who had new mental health diagnoses that required a referral for a PASSR Level II evaluation to the Directors of Social Work and Nursing. Resident #14's name was on the handwritten list she shared. During an interview on 12/17/25 at 3:30 PM with the Social Work Director, she stated she initiated a PASSR Level I or Level II request for an evaluation if the Minimum Dat Set Nurse notified her that a resident had a significant change or a new mental health diagnosis. The Social Work Director stated Resident #14 was on an August 2025 list of names from an audit the MDS Nurse provided to the Social Work Director that still needed to be submitted for a PASSR Level II evaluation. The Social Work Director shared the list of 25 residents that needed to be submitted for PASSR Level I or II evaluation due to a mental health diagnosis and stated she crossed off resident names when she submitted them for a PASSR Level II evaluation. Resident #107's name did not have a line through it. The Social Work Director was unable to provide a date when the submission would be completed. During an interview on 12/18/25 at 3:00 PM with the Director of Nursing, she communicated her understanding that a request for an evaluation for a Level II PASRR should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. The Director of Nursing stated she has been in the position less than one month and was aware the MDS nurse and Social Work (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director were updating their list of residents who still needed to be referred. The Director of Nursing stated she needed to review the performance improvement plan developed by the MDS Nurse and Social Work Director to address the staff's knowledge gap and lack of a process to identify residents who needed a referral for a PASSR Level I or II evaluation. The Director of Nursing stated she was not aware of any details or the residents' names on the list of 25. 4. Resident #9 electronic medical record included a pre-admission document dated 8/21/23 entitled FL-2. An FL-2 form is a medical assessment form which details a resident's diagnoses, medications, and care needed for admission to a long-term care facility. The FL-2 form reported Resident #9 was determined to have a PASRR Level I status. A PASRR Level I status indicated the resident was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or related condition. The resident was admitted to the facility on [DATE]. His diagnoses included a history of a stroke. Resident #9's electronic medical record (EMR) reported under the Diagnosis tab that additional diagnoses were added for this resident on 8/7/24. These included dementia with psychotic disorder, bipolar disorder, and unspecified psychosis not due to a substance or known physiological condition. Resident #9's most recent comprehensive Minimum Data Set (MDS) assessment was a significant change in condition MDS dated [DATE]. The Identification Information section of this MDS reported Resident #9 was not determined to have a PASRR Level II status. A PASRR Level II status would be indicative of serious mental illness and/or intellectual disability or related condition. The resident's EMR included a Care Area Assessment (CAA) worksheet for Functional Abilities dated 6/18/25. The Nature of the problem/condition read, in part, The resident's medical history includes.a diagnosis of bipolar disorder, which was made after admission to the facility. As a result of this new diagnosis, a significant change in status assessment has been completed. An interview was conducted on 12/18/25 at 8:32 AM with the facility's Director of Social Services. During the interview, the Director was asked if Resident #9 was referred to the state authority for a PASRR evaluation and determination at any point in time due to the identification of a possible mental illness after his admission to the facility. The Director reported Resident #9 was one of the residents she had on a list (provided by the facility's MDS nurse) as needing to be referred for a PASRR evaluation. She stated, I'm still working on it. When asked if the referral had been initiated, she clarified that it had not. An interview was conducted on 12/18/25 at 8:56 AM with MDS Nurse #1. During the interview, the MDS Nurse reported that the facility's prior administration did an audit. The results of the audit indicated that all current residents needed to be reviewed for changes in his/her diagnoses in order to identify those who had a significant change and whose PASRR status should be re-evaluated. The nurse reported that once she completed a resident's significant change MDS, she would refer that resident to Social Services so they could request a PASRR referral, as needed. The facility provided a Performance Improvement Plan (PIP) entitled, Missed PASRR Level Screening After Psychiatric Diagnosis Change. The initial plan provided for review indicated the facility's date of compliance was 8/25/25 with a goal compliance of greater than or equal to 95% by 3/31/26. The initial date of compliance was not met. Also, the date of the facility's compliance goal (3/31/26) was not acceptable due to the extended time frame. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 12/18/25 at 11:15 AM with the facility's Director of Nursing (DON) #1. The DON indicated she has only worked at the facility for a few weeks but understood a PIP had been previously started related to PASRR screenings. During the interview, the DON was informed that the facility's plan could not be accepted for past non-compliance. The DON stated that she understood this issue continued to be a concern.

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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 staff interviews and record review, the facility failed to submit a request for an evaluation for a level II Preadmission Screening and Resident Review (PASRR) for a resident previously determined to have a Level II PASRR status after a significant change in physical and/or mental status was identified. This occurred for 1 of 5 residents (Resident #15) reviewed for PASRR.The findings included:Resident #15 was admitted to the facility on [DATE] with cumulative diagnoses which included non-Alzheimer's dementia; anxiety disorder; bipolar disorder; and psychotic disorder. A PASRR Level II Determination Notification letter dated 11/14/23 for Resident #15 was reviewed. This letter noted Resident #15 had a PASRR number ending with the letter H, which indicated a halted PASRR Level II determination was made due to the resident having a primary diagnosis of dementia. The results of the evaluation, including the determination of a PASRR Level II status, are used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care.The resident's electronic medical record (EMR) census reported Resident #15 was hospitalized from [DATE] to 7/23/25.Resident #15's most recent comprehensive MDS was a significant change assessment dated [DATE]. The MDS section on Special Treatments, Procedures, and Programs indicated the resident received Hospice Care. The resident's EMR included her Care Area Assessment (CAA) worksheet for Cognitive Loss/Dementia dated 7/29/25. The nature of the problem/condition reported that Resident #15 was now under the care of Hospice.Upon request, the facility provided a current list of PASRR Level II residents on 12/16/25. This list reported Resident #15 was determined to have a PASRR Level II status. An interview was conducted with MDS Nurse #1 on 12/18/25 at 8:56 AM. During the interview, the MDS nurse reported she was aware that Resident #15 was a PASRR Level II resident and should have been referred for a PASRR re-evaluation when the significant change MDS was completed. The nurse stated this resident was on the original list for needing a PASRR referral. However, she did not know whether Social Services had made the referral.An interview was conducted on 12/18/25 at 9:28 AM with the facility's Director of Social Services. Upon inquiry, the Director reported she did not make a referral for Resident #15 to have a PASRR re-evaluation based on the resident having a significant change MDS dated [DATE]. She stated that because the resident already had a PASRR Level II status, she did not think a referral was necessary.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to develop a baseline care plan within 48 hours of the resident's admission for 1 of 11 newly admitted residents reviewed (Resident #119).The findings included: Resident #119 was initially admitted to the facility on [DATE]. She was discharged home with a family member on 11/12/25. The resident had a second admission to the facility on [DATE]. Her cumulative diagnoses included emphysema, a history of a cerebral infarction (a type of stroke) and repeated falls. Resident #119's electronic medical record (EMR) included a Nursing re-admission Assessment Tool completed by Nurse #3 and dated 12/13/25. This document included information on the resident's mental and physical health, a pain tool, Braden Scale, Patient Record of Tuberculosis Screening, Fall Risk/Medication, Smoking Safety Screen, Device / Air Mattress Safety Observation, and an Elopement Evaluation. Further review of Resident #119's EMR revealed there was no baseline care plan completed for this resident. A comprehensive care plan was initiated on 12/16/25 for Resident #119. As of the date of the review on 12/18/25, this care plan included only one area of focus (related to her nutritional status). An interview was conducted on 12/18/25 at 11:15 AM with the facility's Director of Nursing (DON) #1. During the interview, the DON was asked if a baseline care plan was completed for Resident #119 after her 12/12/25 admission. Upon review of the resident EMR, the DON reported she did not see where a baseline care plan was completed. She reported that normally a baseline care plan would be done by the resident's admitting nurse within 24 hours of admission. An interview was conducted on 12/18/25 at 2:31 AM with Unit Manager #1. Upon inquiry, Unit Manager #1 reported the admitting nurse was responsible to complete a baseline care plan for a newly admitted resident using the admission Nursing Collection Tool form. Upon review of Resident #119's EMR, the Unit Manager reported that Nurse #3 had admitted the resident to the facility on [DATE]. She stated the nurse completed a re-admission assessment form instead of the required admission assessment when the resident was admitted to the facility. However, she reported the re-assessment form was missing the baseline care plan component (which included focus areas, goals, and interventions). Completing the wrong form resulted in a failure to complete a baseline care plan for Resident #119. A telephone interview was conducted on 12/18/25 at 3:58 PM with Nurse #3. Nurse #3 was identified as the nurse who admitted Resident #119 to the facility on [DATE]. When asked, the nurse reported that as the admission nurse, she was responsible to complete the admission packet forms for a newly admitted resident. She reported the admission packet consistent of several required forms that were auto populated by the facility's electronic software as needing to be completed. Nurse #3 stated, I did what was there for me to do. The nurse stated that these forms included the re-admission assessment form, so she filled it out. Nurse #3 reported she did not know the admission Nursing Collection Tool form needed to be completed in order for the resident to have a baseline care plan.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and record review, the facility failed to obtain a provider's diet order for a resident after her admission to the facility. This occurred for 1 of 11 newly admitted residents reviewed (Resident #119).The findings included: Resident #119 was initially admitted to the facility on [DATE]. The resident's diet order (dated 10/15/25) was a Regular diet with mechanical soft textures and regular, thin liquids. On 10/22/25, Med Pass 2.0 (a high calorie, high protein nutritional supplement) was added to her diet order as 120 milliliters (ml) to be given at bedtime daily. Resident #119 was discharged to her home with a family member on 11/12/25. Resident #119 was hospitalized from [DATE] to 12/12/25. Her hospital Inpatient Discharge summary dated [DATE] included Diet and Nourishment Orders for a pureed diet with thin liquids. The resident was admitted a second time to the facility on [DATE]. Her cumulative diagnoses included emphysema, a history of cerebral infarction (a type of stroke) and repeated falls. Resident #119's electronic medical record (EMR) included a Nursing re-admission Assessment Tool completed by Nurse #3 and dated 12/13/25. This document included information on the resident's mental and physical health. Resident #119 was described as cognitively impaired, oriented to person only, and confused. A short section on nutrition noted her usual food intake pattern was Probably Inadequate. It also reported that the resident had some or all natural teeth and required partial to moderate assistance for eating. An observation was conducted on 12/16/25 at 8:42 AM as a nurse aide removed Resident #119's breakfast meal tray from her room. The meal ticket and observation of the food remaining on Resident #119's tray indicated she was served a regular, pureed diet. The resident consumed approximately 25% of the meal. A review of the resident's electronic medical record (EMR) conducted on 12/16/25 at 10:23 AM revealed Resident #119 did not have a provider's diet order. On 12/16/25 at 12:07 PM, Resident #119 was observed sitting in a reclining wheelchair (reclined at approximately 110 degrees) in her room as she was served a lunch meal tray by the nurse aide. The meal ticket and observation of the resident's meal tray indicated the resident received a regular diet with pureed foods. Resident #119 was observed as she picked up her silverware and began to feed herself. An interview was conducted on 12/16/25 at 2:14 PM with the facility's Dietary Manager in the presence of the Regional Dietary Manager. Upon review of Resident #119's EMR, the Dietary Manager confirmed the resident did not have a provider's diet order. The Dietary Manager located a Communication Form regarding Resident #119 (from Nursing to Dietary) that he had found on his desk. This Communication Form indicated the resident was to receive a regular diet with pureed textures and thin liquids. Unit Manager #1 was identified by her signature as having completed the Communication Form (not dated). When asked about a provider's diet order for the resident, both the Dietary Manager and Regional Dietary Manager confirmed that a diet order was still needed. An interview was conducted with Unit Manager #1 on 12/16/25 at 3:09 PM. During the interview, the Unit Manager confirmed she put Resident #119's diet order into her EMR this afternoon after she was alerted that the order was missing. Upon inquiry, Unit Manager #1 reported an order for a newly admitted resident would typically be put into his/her EMR upon admission to the facility. She recalled filling out a Communication Form for this resident after she was admitted on [DATE] and bringing it to the Dietary Department so she wouldn't miss any meals. The Unit Manager reported the diet written on this Communication Form was based on Resident #1's hospital discharge information from 12/12/25, which recommended a regular pureed diet with thin liquids. However, when asked, Unit Manager #1 confirmed there should have been a diet order put into Resident #119's EMR upon admission to the facility. An interview was conducted with the facility's Director of Nursing (DON) #1 on 12/18/25 at 11:15 AM. During the interview, the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON was asked what her thoughts were regarding the failure to have a provider's order for Resident #119's diet in her EMR after admission to the facility. The DON stated, That's a huge problem. She reported the diet order should have been put into the EMR and then the Communication Form sent from Nursing to the Dietary Department upon the resident's admission.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to maintain a urinary catheter drainage bag off the floor to prevent the risk of infection for 1 of 1 resident reviewed for indwelling urinary catheter (Resident #8). The findings included:Resident #8 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder. Review of Resident #8's significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #8's cognition was severely impaired and was totally dependent for most activities of daily living (ADL). The MDS further revealed Resident #8 was coded for having an indwelling urinary catheter.Review of Resident #8's physician orders revealed an order dated 12/09/25 for an indwelling urinary catheter for neurogenic bladder with urinary retention.Review of Resident #8's care plan revised on 12/16/25 revealed the resident was readmitted to the facility from the hospital with a catheter for neurogenic bladder with urinary retention. The goal was Resident #8 would not have any complications. Interventions included the catheter tubing are to be free of any kinks or obstruction and drainage bag in proper location.An observation conducted on 12/17/25 at 9:55 AM revealed Resident #8 was in bed with the bed in a low position and urinary catheter drainage bag was lying flat on the floor.An observation and interview with Nurse Aide (NA) #8 on 12/17/25 at 11:50 AM revealed Resident #8's urinary catheter drainage bag was on the floor. NA #8 stated she was in the resident's room about an hour ago and did not recall seeing Resident #8's catheter bag lying flat on the floor. NA #8 stated she had been educated to hang the bag at the side of the bed on the metal bed frame, but it often fell off due to the resident's bed being in low position and slipping off the bed frame.An observation and interview with Unit Manager (UM) #1 on 12/17/25 at 12:00 PM revealed the urinary catheter drainage bag was on the floor beside Resident #8's bed. UM #1 hung the urinary catheter drainage bag on the side of the resident's bed frame, and the urinary catheter drainage bag still touched the floor. UM #1 indicated the resident's bed needed to be raised some to ensure the bag did not touch the ground. UM #1 revealed Resident #8's catheter bag should never touch the ground due to possible contamination and germs.An interview with the Assistant Director of Nursing (ADON) on 12/18/25 at 4:30 PM revealed she had completed training with nursing staff a month ago about catheter care. It was further revealed it was never acceptable for a urinary catheter drainage bag to touch the ground due to contamination.An interview conducted with the Director of Nursing on 12/18/25 at 6:00 PM revealed Resident #8's urinary catheter drainage bag was expected to be off the floor. The DON further revealed nursing staff had been educated on the importance of catheter care and urinary catheter drainage bags touching the ground was not acceptable.

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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 observations, record review, and interviews with staff, the facility failed to enter a physician's order for oxygen delivery for 1 of 1 resident reviewed for respiratory care (Resident #101).The findings included: Resident #101 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, tobacco use, and anemia. On 12/15/25 at 3:55 PM Resident #101 was observed asleep in bed and wearing oxygen via nasal cannula at 3 Liters/minute (L/min) connected to portable oxygen next to her bed. The resident did not show any signs of discomfort or difficulty breathing. Review of the nurse progress note date 12/15/25 2:52 PM progress note revealed Nurse #8 notified the provider that Resident #101 had abnormal vital signs: blood pressure 159/101, pulse 104, and oxygen saturation level of 64% on room air. A normal oxygen saturation level is at, or above, 90%. Nurse #8 documented she was ordered to start Resident #101 on 2L/min of oxygen. Nurse #8 wrote that she communicated with provider Resident #101's oxygen saturation level increased to 89% on the 2L/min and the oxygen was increased to 3L/min and Resident #101's oxygen saturation level went up to 91%. On 12/15/25 at 3:55 PM Resident #101 was observed asleep in bed and wearing oxygen via nasal cannula at 3 L/min connected to portable oxygen next to her bed. The resident did not show any signs of discomfort or difficulty breathing. On 12/15/2025 at 4:00 PM an attempt was made to interview Nurse #8 about the oxygen order, but Nurse #8's was not present at the facility and the attempt was unsuccessful. Review of orders in the electronic medical record on 12/15/25 at 3:00 PM revealed there was no order for oxygen use. On 12/16/25 at 9:18 AM Resident #101 was observed resting in bed and wearing oxygen via nasal cannula at 3 L/min connected to a portable oxygen next to her bed. Resident #101 was alert and oriented to self and did not show any signs of discomfort or difficulty breathing. Review of the provider progress note dated 12/16/25 12:00 PM revealed Resident #101 had upper respiratory infection symptoms with difficulty breathing and oxygen saturation level was 90% while on oxygen via nasal cannula at 3L/minute. Review of orders in the electronic medical record on 12/16/25 3:00 PM revealed there was no order for oxygen use. Review of the provider progress note dated 12/17/25 8:45 AM revealed Resident #101 had mild upper respiratory infection symptoms during the week of 12/15/25 through 12/17/25 and the oxygen saturation levels dipped below 90% so they started oxygen, antibiotics, and nebulizers; Resident #101 responded quickly and oxygen saturation levels returned to the low 90%'s on room air. Review of orders in the electronic medical record on 12/17/25 12:00 PM revealed there was no order for oxygen in the chart. An interview was conducted on 12/17/25 at 3:25 PM with Unit Manager #1. Unit Manager #1 reviewed Resident #101's medical record with the surveyor present and stated she found a note entered on 12/15/25 by Nurse #8 that stated Nurse #8 contacted the provider about Resident 101's low oxygen saturation levels and the provider gave an order for oxygen to be applied. Unit Manager #1 further revealed Nurse #8 failed to create an order in the electronic medical record which was required to be done at the time the order was received on 12/15/25 but still had not done so on 12/17/25. Unit Manager #1 indicated she was updating the orders at the end of the interview.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, record review and staff interviews, the facility failed to ensure daily nurse staffing sheets accurately reflected the nursing staff who worked for 6 of 7 days reviewed (12/11/25, 12/12/15, 12/13/25, 12/14/25, 12/15/25, and 12/17/25).The findings included:Review of the facility's daily nurse staffing sheet revealed underneath the facility's name was a space to specify the date and resident census along with columns to specify the number of staff and hours worked for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Medicine Aides (CMAs), and Certified Nursing Assistants (CNAs) for each 8-hour shift, 7:00 AM to 3:00 PM (first shift), 3:00 PM to 11:00 PM (second shift) and 11:00 PM to 7:00 AM (third shift).a. The nursing staff schedule dated 12/11/25 revealed on the1st shift (6:00 AM to 2:00 PM) there were 5 LPN's and 11 CNAs. On the 2nd shift there was one (1) LPN, 8 CNAs, and 3 CMAs. Review of the daily nurse staffing sheet dated 12/11/25 revealed that for the 1st shift, the facility had 4 LPNs and 9 CNAs. On the 2nd shift (2:00 PM to 10:00 PM) the daily nurse staffing sheet indicated the facility had 2 LPNs, 9 CNAs, and One (1) CMA.b. The nursing staff schedule dated 12/12/25 revealed on 1st shift there were 4 LPNs. Review of the daily nurse staffing sheet for 12/12/25 revealed the1st shift had 3 LPNs.c. The nursing staff schedule dated 12/13/25 revealed on the 1st shift there were 4 LPNs and one (1) CMA. Review of the 12/13/25 daily nurse staffing sheet revealed the 1st shift had 3 LPN's and 2 CMAs.d. The nursing staff schedule dated 12/14/25 revealed on 3rd shift (10:00 PM to 6:00 AM) there were 7 CNAs. Review of the daily nurse staffing sheet dated 12/14/25 indicated there were 6 CNAs on the 3rd shift. e. Review of the nursing staff schedule dated 12/15/25 revealed on the 1st shift there were 5 LPNs. Review of the daily nurse staffing sheet for 12/14/25, revealed the 1st shift had 4 LPNs.f. Review of the nursing staff schedule dated 12/17/25 revealed on the 3rd shift there was one (1) RN. Review of the daily nurse staffing sheet dated 12/17/25 revealed there were 3 RNs on the 3rd shift. An interview with the Staff Coordinator on 12/18/25 at 1:10 PM revealed she and Receptionist #1 and Receptionist #2 were responsible for posting the daily staffing sheets and usually posted them first thing in the morning for all three shifts. The Staff Coordinator stated she and Receptionist #1 and Receptionist #2 were responsible for updating the daily staffing sheets to reflect callouts and/or staff schedule changes. The Staff Coordinator was not aware the daily staffing sheets had not been updated on 12/11/25, 12/12/15, 12/13/25, 12/14/25, 12/15/25, and 12/17/25. The Staff Coordinator indicated she worked Monday through Friday and on the weekends and after 5:00 PM assigned nurses were responsible for making revisions.An interview with the Receptionist #1 on 12/18/25 at 1:35 PM revealed she assisted the Staff Coordinator with posting the staffing sheet. Receptionist #1 indicated that she, the Staffing Coordinator, and nursing staff were responsible for revising the staff posting if needed. Receptionist #1 stated nursing staff had sometimes failed to communicate changes if staff called out of work. An interview with Receptionist #2 on 12/18/25 at 2:20 PM revealed she never made revisions and had not been educated to revise daily posted staffing sheets. Receptionist #2 indicated she had never been told it was her responsibility to revise the daily posted staffing sheets.An interview with the Administrator on 12/18/25 at 6:00 PM revealed the Staffing Coordinate was responsible for posting and updating the daily nurse staffing sheets. The Administrator stated he would expect for daily nursing staffing sheets to be updated as needed to reflect the correct number and hours of nursing staff that worked each shift. The Administrator indicated he assumed nursing staff had made revisions if the Staffing Coordinator was unable to.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6% for 2 of 6 residents (Resident #35 and Resident #105) observed during the medication administration. The findings included: 1. On [DATE] at 8:16 AM, Medication Aide (Med Aide) #1 was observed as she prepared and administered fifteen (15) medications to Resident #35. A review of Resident #35's current orders revealed a medication order was initiated on [DATE] for 200 - 25 micrograms (mcg) per actuation of Breo Ellipta aerosol powder to be given as one puff by mouth one time a day for shortness of breath / wheezing. Breo Ellipta is an inhaled medication used for the management of chronic obstructive pulmonary disease (COPD) and/or asthma. Resident #35's Breo Ellipta was scheduled for administration at 8:00 AM once daily in accordance with the physician's orders. This medication was not given to Resident #35 during the morning medication administration observation conducted on [DATE]. An interview was conducted on [DATE] at 9:12 AM with Med Aide #1, who was joined by Unit Manager #1. When asked about the omission of Resident #35's Breo Ellipta inhaler during the morning medication pass, Med Aide #1 reported this inhaler was not available on the medication cart. Unit Manager #1 added that the Breo Ellipta inhaler was identified as expired and removed from the medication cart on [DATE]. The Unit Manager reported another inhaler was ordered from the pharmacy, but that it had not yet been delivered. An interview was conducted on [DATE] at 11:15 AM with the facility's Director of Nursing (DON) to discuss the results of the medication administration observation. At that time, the DON reported she would have expected Resident #35's Breo Ellipta inhaler to have been ordered before it was out or expired so it would have been available for administration as scheduled. 2. The manufacturer's Full Prescribing Information for the Insulin Lispro prefilled insulin pen included Instructions for Use. These instructions indicated the insulin pen needed to be primed with 2 units of insulin prior to each injection. Priming ensures the insulin pen is ready to dose and removes air that may collect in the cartridge during normal use. If the pen is not primed before each injection, too much or too little insulin may be delivered. On [DATE] at 11:05 AM, Nurse #1 was observed as she prepared to administer insulin to Resident #105. The nurse withdrew an Insulin Lispro prefilled insulin pen from the medication cart, placed a needle on the pen, and turned the dose selector to select 15 units of insulin in preparation for the injection. The nurse did not prime the insulin pen. Nurse #1 was accompanied as she brought the insulin pen down the hallway to the resident's room. Upon reaching Resident #105's door (before entering the room), the nurse was asked to stop. At that time, Nurse #1 was asked if she had primed the insulin pen. She stated No. Upon further inquiry, the nurse was asked if she was supposed to prime the insulin pen before each injection. She responded, Yes and was then observed as she primed the insulin pen. After priming the insulin pen and re-setting the dose selector to select 15 units of insulin, Nurse #1 was observed as she administered the insulin to Resident #105 in accordance with the physician's orders. An interview was conducted on [DATE] at 11:15 AM with the facility's Director of Nursing (DON). During the interview, the DON confirmed that the Insulin Lispro pen needed to be primed with 2 units of insulin prior to each use. The DON further stated that she would expect nursing staff to follow the clinical guidelines for each medication they are administering.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to remove expired leftover and unopened food items stored for use in 1 of 1 walk-in cooler, 1 of 1 dry goods storage room, and 2 of 2 nourishment rooms (100 and 200 Hall nourishment rooms), and failed to remove dented cans stored for use in the dry goods storage room. These practices had the potential to affect food served to residents.Findings included: 1a. An observation and interview with the Dietary Manager of the dry goods storage room was conducted on 12/15/25 at 10:20 AM. There were products that were expired and unlabeled. The expired products included:- thirteen thickened orange juice cups with a manufacturer's expiration date of 11/21/25.- one case of one hundred-fifty packages of animal crackers with a manufacturer's expiration date of 9/21/25.- one and a half cases of twelve-cup ground coffee packets with a manufacturer's expiration date of 11/20/24.- three containers of vegetable soup base with a manufacturer's expiration date of 11/8/25.- dozens of single use creamy French dressing packets in a storage bin that was labeled with a sticker for Italian dressing with 11/24/25 as the date the Italian dressing package was opened, hundreds of 1000 island single use dressing packets in an unlabeled storage bin without any date for when it was opened. The Dietary Manager stated the individual dressing packets had no expiration date printed on them and the expiration dates would have been on the original box, which was previously discarded, so the Dietary Manager was unsure of their expiration date.There was one case of dented cans of vegetables that were stored for use on the shelf with other canned goods and were not stored in the designated space for dented items. The signage on the designated space directed staff not to use dented items and to store them there for return and/or credit from their supplier. The Dietary Manager indicated the case needed to be removed and then placed it on the shelf next to the door which was designated for dented cans. The Dietary Manager revealed he was responsible for inspecting the storage areas and for checking for expired items and had no designated schedule for the checks.b. An observation and interview with the Dietary Manager of the walk-in cooler was conducted on 12/15/25 at 10:40 AM and revealed expired items which included two full 5-pound containers of chicken salad with a manufacturer's expiration date of 12/12/25 and one half full 5-pound container of chicken salad with a manufacturer's expiration date of 11/26/25. The three containers of chicken salad were removed by the Dietary Manager and placed on a shelf in the walk-in cooler that was designated for returns and credit from their supplier. The Dietary Manager stated his standard practice was to put any expired cold foods in the garbage.2a. An observation with the Dietary Manager and Regional Dietary Manager of the 200-hall nourishment room was conducted on 12/15/25 at 11:00 AM. In the 200-hall nourishment room there were two opened and partially used 32-ounce containers of nutritional supplement, one opened and partially used gallon of sweet tea, and three opened and partially used 32-ounce containers of thickened orange juice that were not labeled with a date the package was opened for use because manufacturer's directions stated the product was shelf stable for a predetermined number of days once opened. Manufacturer guidelines stated the sweet tea must be consumed within 5 to 7 days after opening, if stored refrigerated and the thickened drink products and nutritional supplement must be used within 4 days of opening, when refrigerated after opening. There were three personal individual food packages not labeled: one medium to-go paper container of partially eaten food, one partially eaten baked good wrapped in plastic packaging, and one fast food bag with items in it with the top folded down.b. An observation with the Dietary Manager of the 100-hall nourishment room was conducted on 12/15/25 at 11:08 AM and revealed there was one opened and partially used 32-ounce container of thickened lemonade and one opened and partially used 32-ounce container of nutritional supplement that was not (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

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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	labeled with the date the packages were opened. Manufacturer guidelines stated the thickened drink products must be used within 4 days of opening, when refrigerated after opening. There were two personal individual food packages which were not labeled: one partially eaten cake in a disposable plastic container and one medium size bag from a fast-food restaurant. An interview conducted with Dietary Manager on 12/15/25 at 11:10 AM. The Dietary Manager reported he was responsible for checking the nourishment refrigerators for expired items and had no designated schedule for the checks. The Dietary Manager stated that nursing staff were responsible for checking the nourishment rooms for any expired items. The Dietary Manager stated it was the responsibility of any staff that placed residents' personal food in the refrigerator to label it with the residents' name and date they place it in the fridge or freezer.An interview conducted with the Regional Dietary Manager on 12/15/25 at 11:20 AM revealed his company's food service contract began 6 weeks ago. The Regional Dietary Manager stated he expected food items to be stored and labeled with resident's name and date of when the item was received for storage, and for expired items to be removed from circulation. An interview was conducted on 12/18/25 at 9:45 AM with Unit Manager #2 on the 200 Hall. The Unit Manager #2 stated two staff who were assigned to the nourishment room task were responsible for removing outdated, mislabeled, or unlabeled items at the end of the shift. The Unit Manager was aware there were items not labeled and stored in the refrigerator which were removed by the Dietary Manager on 12/15/25 and stated the policy for food storage and labeling was posted in the nourishment rooms, but she also gave verbal reminders in her daily huddle.