STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stokes County Nursing Home	1570 NC 8 and 89 Highway Danbury, NC 27016

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Physician and Consultant Pharmacist interviews, the facility failed to provide ongoing Abnormal Involuntary Movement Scale (AIMS) assessments for potential adverse reactions to antipsychotic medications for 3 of 5 residents reviewed for unnecessary medications (Residents #30, #2, and #3). The findings included: a. Resident #30 was readmitted on [DATE] with diagnoses including dementia with behaviors and generalized anxiety disorder. Physician order dated 6/13/24 included Olanzapine (antipsychotic) oral tablet 2.5 milligrams (MG). Give one (1) tablet by mouth at bedtime related to unspecified dementia, unspecified severity with other behavioral disturbances. Resident #30's active care plan dated 6/2/25 indicated a risk for complications related to the use of psychotropic and antipsychotic medications. Interventions included AIMS testing per protocol. Resident #30's medical record documented one AIMS assessment on file dated 3/10/25. There were no other AIMS found in the medical record. b. Resident #2 was admitted on [DATE] with diagnoses including unspecified dementia unspecified severity without behavior, psychotic disturbance, mood disturbance, and anxiety.Physician order dated 5/15/25 included Olanzapine (antipsychotic) oral tablet 5 milligrams (MG). Give one (1) tablet by mouth one time a day related to unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #2's active care plan dated 5/15/25 revealed goals and interventions for Resident #2's medication, Olanzapine. The interventions included monitoring/documenting for side effects and effectiveness. There were no interventions for an AIMS to be completed. The quarterly Minimum Data Assessment (MDS) dated [DATE] revealed Resident #2 was severely cognitively impaired. The MDS also revealed Resident #2 received antipsychotic medications. Review of Resident #2's medical record revealed there were no AIMS assessments completed. c. Resident #3 was readmitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance; anxiety disorder; anxiety with delusional thoughts and behaviors harmful to self and others with psychotic features and lying; major depressive disorder, recurrent, unspecified multiple episodes of paranoia and restlessness; cerebral infarction. Resident #3's active care plan after re-admission to the facility dated 6/10/25 did not have focus, goals and interventions for antipsychotic medication. Physician order dated 6/30/25 included Quetiapine Fumarate (antipsychotic) oral tablet 50 milligrams (MG). Give one (1) tablet by mouth in the morning related to anxiety disorder; major depressive disorder, recurrent; and give 2 tablets by mouth at bedtime related to anxiety disorder, unspecified; major depressive disorder, recurrent. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was cognitively intact and was coded for having verbal behaviors towards others 1-3 days during the look back period. The MDS also documented Resident #3 received antipsychotic and antidepressant medications routinely. The last Gradual Dose Reduction (GDR) documented was 5/19/25. Review of Resident #3's medical record revealed there were no AIMS assessments completed. An interview with the (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) on 11/19/25 at 2:30 PM revealed she was unaware the AIMS assessments were not being completed. She stated prior to her employment, the previous DON did not follow through with obtaining AIMS and she stated the unit went without a DON for a while and no one else followed up so the AIMS have not been completed as needed. The DON was unaware how often and when the AIMS assessments needed to be completed. She also stated in the past, the nurses were responsible for completing the AIMS assessments. The DON indicated there was not a process in place to alert staff when the AIMS assessments were due. She stated the AIMS assessments should have been completed as required. An interview was held with the Pharmacy Consultant on 11/19/25 at 3:45 PM. The Pharmacy Consultant stated she did not think the AIMS assessments still needed to be completed for residents prescribed antipsychotic medications. She indicated the AIMS was completed in one of the sections of the MDS. The Pharmacy Consultant stated she had not seen an AIMS assessment form in any of the residents' records. An interview with the Medical Director on 11/20/25 at 9:55 AM indicated he was unaware when and how often the AIMS assessment needed to be completed. He stated he would set up a meeting with the DON regarding completing the AIMS assessments. An interview conducted with the facility Physician on 11/20/25 at 10:22 AM revealed he did not complete the AIMS assessment for residents on antipsychotics. He discussed that since the facility had begun using the electronic medical record, he was unaware if staff were completing them. He stated since he assessed residents monthly, and if not monthly, then every other month, he could potentially add it to his list to do. The facility Physician stated he would meet with the DON to determine who would complete the AIMS going forward. An interview was held with the Administrator on 11/20/25 11:46 AM. The Administrator was made aware the AIMS assessments were missing or were past due. She stated the nursing staff historically were responsible for completing the AIMS assessments. Prior to transitioning to the electronic medical record, the AIMS assessment was included in a paper MDS packet. The AIMS assessment was supposed to be built into the electronic medical record software, but it was not. The Administrator stated other contributing factors to the missing and past due AIMS assessments were the MDS coordinator left in April 2025, the transition from paper chart to electronic medical record (EMR) at the end of May/beginning of June, and the previous DON left on 5/01/25.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to revise the comprehensive care plan to include antipsychotic medication use for 1 of 5 residents reviewed for care plans (Resident #3).The findings included:Resident #3 was readmitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, anxiety disorder, anxiety with psychotic features and, recurrent unspecified major depressive disorder.A review of Resident #3's active comprehensive care plan dated 6/10/25 did not reveal a care plan had been initiated for antipsychotic medication use.Resident #3's physician's orders revealed an order dated 6/29/25 to give one tablet of Quetiapine Fumarate (an antipsychotic medication) 50 milligrams (MG) by mouth in the morning and give two tablets by mouth at bedtime related to unspecified anxiety disorder and unspecified recurrent major depressive disorder.Review of Resident #3's Medication Administration Record (MAR) from June 2025 through November 2025 revealed Resident #3 received Quetiapine Fumarate as ordered. The MAR also indicated Resident #3 was observed three times per day for side effects and behaviors.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was cognitively intact and was coded for having verbal behaviors towards others 1-3 days during the look back period. The MDS also documented Resident #3 received antipsychotic medications routinely.The quarterly MDS dated [DATE] indicated Resident #3 was cognitively intact with no behaviors coded and received antipsychotic medication on a routine basis.An interview with the Director of Nursing (DON) on 11/20/2025 at 3:20 PM revealed she was not aware the care plan for Resident #3 did not include a plan for the antipsychotic medication, but there should be one. She stated the MDS coordinator or Administrator created and updated the care plans.Interview with the MDS Coordinator on 11/20/25 at 4:12 PM revealed that she was in training and was not responsible for creating care plans. She stated the Administrator was responsible for initiating and updating resident care plans.The Administrator was interviewed on 11/20/25 at 4:14 PM. The Administrator was made aware the care plans for Resident #3 did not include a care plan for antipsychotic medication. She stated the previous MDS Coordinator created resident care plans. The Administrator explained she had assisted with creating and updating care plans while the new MDS Coordinator was training. She stated the care plan was missing because Resident #3 was discharged to the hospital and later readmitted (6/2/25). Resident #3 was not prescribed an antipsychotic upon readmission. Resident #3 began to exhibit behaviors, and the antipsychotic medication was restarted on 6/29/25. The Administrator stated the care plan was not updated after the antipsychotic medication was resumed.

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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 staff interviews, the facility failed to post cautionary and safety signage that indicated the use of oxygen for 3 of 4 residents reviewed for respiratory care (Residents #2, #5, and #37).The findings included: a. Resident #2 was admitted to the facility on [DATE] with the diagnosis of Streptococcus pyogenes (Contagious bacterial infection that causes swelling and sudden painful sore throat). Resident #2's physician orders dated 6/19/25 revealed an order for oxygen to be administered continuously via nasal cannula at 2 liters per minute (lpm) to keep oxygen level above 90% (normal range for oxygen level is 95-100%) as needed. Resident #2's annual Minimum Data Set (MDS) dated [DATE] indicated Resident #2 was coded for receiving oxygen. Observations on 11/18/25 at 12:11 PM, 11/19/25 at 9:06 AM, 11/19/25 2:37 PM and 11/20/25 at 9:17 AM revealed Resident #2 was lying in bed in his room wearing a nasal cannula with oxygen administered at 2 lpm. There was no cautionary or safety signage posted at Resident #2's room to indicate oxygen was in use during the observations. b. Resident #5 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). On 11/17/25, the physician ordered oxygen to be administered to Resident #5 at 2 liters per minute via nasal cannula.Observations conducted on 11/18/25 at 12:12 PM, 11/19/25 at 2:52 PM, and 11/20/25 at 9:17 AM revealed there was no cautionary signage at Resident #5's room indicating oxygen was in use. Resident #5 was in her room using oxygen delivered via nasal cannula during the observation times. c. Resident #37 was admitted to the facility on [DATE] with the diagnosis of COPD. Resident #37's physician orders dated 6/19/25 revealed an order for oxygen to be administered continuously via nasal cannula at 2 lpm to keep oxygen level above 90% as needed. A review of the annual MDS dated [DATE] indicated Resident #2 was coded for receiving oxygen. Observations on 11/18/25 at 12:11 PM, 11/19/25 at 9:06 AM, 11/19/25 2:37 PM and 11/20/25 at 9:17 AM revealed Resident #37 was lying in bed in her room wearing a nasal cannula with oxygen administered at 2 lpm. There was no cautionary or safety signage posted at Resident #37's room to indicate oxygen was in use during the observations. An interview with Nurse Aide (NA) #5 was conducted on 11/19/25 at 2:34 PM. She stated she does not recall ever seeing cautionary signs at the residents' doors for oxygen in use. The NA stated she was made aware of which residents were on oxygen during her shift report. She was unaware of why there were no signs. An interview was conducted with Nurse #6 on 11/19/25 at 2:52 PM. The Nurse stated she had not seen any oxygen in use signs posted in the facility. On 11/20/25 at 9:21 AM an interview was conducted with the Director of Nursing (DON). The DON stated the facility did not need precaution signs for oxygen in use since they were a smoke free facility. An interview with the Administrator was conducted on 11/20/25 at 3:26 PM. The Administrator stated no smoking signs were posted throughout the campus. She stated with being a smoke free facility, there was no need for cautionary oxygen in use signs on the residents' doors.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review, and staff interviews, the facility failed to post accurate daily nurse staffing information for 30 of 30 days reviewed (10/20/25, 10/21/25, 10/22/25, 10/23/25, 10/24/25, 10/25/25, 10/26/25, 10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25, 11/1/25, 11/2/25, 11/3/25, 11/4/25, 11/5/25, 11/6/25, 11/7/25, 11/8/25, 11/9/25, 11/10/25, 11/11/25, 11/12/25, 11/13/25, 11/14/25, 11/15/25, 11/16/25, 11/17/25, and 11/18/25). The findings included: A review of the daily nurse staffing sheets dated 10/20/25 to 11/18/25 revealed:- The Registered Nurse (RN)/Licensed Practical Nurse (LPN) designation was not indicated for the assigned nurses. -The census was not listed and left blank for the morning (7:00 AM- 3:00 PM) and evening shifts (3:00 PM- 11:00 PM) for 10/21/25, 10/26/25, 10/27/25, 10/30/25, 11/5/25, 11/13/25, 11/16/25, and 11/18/25. -The census was also not listed and left blank for the evening shifts (3:00 PM-11:00 PM) for 10/20/25, 10/23/25, 10/24/25, 10/25/25, 10/28/25, 10/29/25, 11/3/25, 11/4/25, 11/6/25, 11/10/25, 11/11/25, 11/12/25, 11/14/25, 11/15/25, and 11/17/25. An interview conducted with Nurse #1 on 11/21/25 at 9:11 AM revealed she was trained on how to complete the daily staffing report during her orientation with an LPN preceptor. Her employment started in April 2025. She was aware that all areas on the form needed to be completed. However, she only documented the census for the 11:00 PM to 7:00 AM shift because the number could change with the other shifts. Nurse #1 stated she was not aware the designation of RN and LPN needed to be listed beside each nurse's name. An Interview held with the Director of Nursing (DON) on 11/21/25 at 11:41 AM revealed she was unsure how training was completed for the nurses completing the daily staffing report. She stated it was always completed before she arrived at work in the mornings. The DON also stated she was not aware that the census needed to be fully completed. She thought it was per day, not per shift. However, this facility's report was always completed by the night shift nurse. She was not sure if the designation between RN/LPN was a state thing or a facility process. An interview with the Administrator on 11/21/25 at 11:04 AM indicated the nurses received training on completing the daily staffing report during orientation with their preceptor. The Administrator stated all areas of the report should be completed including the census. She also stated each nurse should have their designation listed next to their name determining whether they were an RN or LPN. The Administrator stated education would be provided to staff on how to correctly complete the daily staffing report and was not sure why the daily staffing report was being completed incorrectly.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Pharmacy Consultant, Facility Physician, and the Medical Director, the Pharmacy Consultant failed to identify and report irregularities when conducting monthly drug regimen reviews for 2 of 5 residents reviewed for unnecessary medications (Resident #3, and Resident #30).The findings included:a. Resident #3 was readmitted to the facility on [DATE] with diagnoses including unspecified dementia with unspecified severity and other behavioral disturbance, anxiety disorder, anxiety with delusional thoughts and behaviors harmful to self and others with psychotic features and lying, recurrent unspecified major depressive disorder, multiple episodes of paranoia and restlessness, and cerebral infarction.Review of Resident #3's medical record revealed Resident #3 did not have an Abnormal Involuntary Movement Scale (AIMS) assessment on file. The AIMS is an assessment that determines the severity of uncontrollable and involuntary movements in people prescribed antipsychotic medications.Resident #3's physician's orders revealed an order dated 6/29/25 to give one tablet of Quetiapine Fumarate (an antipsychotic medication) 50 milligrams (MG) by mouth in the morning related to unspecified anxiety disorder and unspecified recurrent major depressive disorder; and give two tablets by mouth at bedtime related to unspecified anxiety disorder and unspecified recurrent major depressive disorder.Review of the facility Pharmacy Consultant monthly drug regimen reviews for Resident #3 dated 7/20/25, 8/15/25, 8/18/25, 9/21/25, and 10/21/25, revealed no documentation of the need for the facility to complete AIMS assessments.b. Resident #30 was readmitted on [DATE] with diagnoses including dementia with behaviors and generalized anxiety disorder.Review of the physician order initiated on 6/13/24 documented an order to give one Olanzapine (antipsychotic) 2.5 milligrams (MG) tablet by mouth at bedtime related to unspecified dementia, unspecified severity with other behavioral disturbances.Resident #30's medical record documented one AIMS assessment on file dated 3/10/25 since the last recertification survey completed on 9/19/24.Review of the facility Pharmacy Consultant monthly drug regimen reviews for Resident #5 dated 8/19/25, 9/23/25, and 10/29/25 revealed no documentation of the need for the facility to complete AIMS assessments.During an interview on 11/19/25 at 3:45 PM, the Pharmacy Consultant stated she did not think the AIMS assessments still needed to be completed for residents prescribed antipsychotic medications. The Pharmacy Consultant communicated she rarely looked at the AIMS assessment unless one of the staff members informed her that a resident could be having side effects. The Pharmacy Consultant expressed she had not seen an AIMS assessment form in any of the residents' records.An interview with the Director of Nursing (DON) on 11/19/25 at 2:30 PM revealed she was unaware if the Pharmacy Consultant reviewed the residents' medical records for AIMS assessments during her monthly medication review. The DON indicated the Administrator reviewed the Pharmacy Consultant's report every month.On 11/20/25 at 9:55 AM an interview occurred with the Medical Director. He stated he was not aware if the Pharmacy Consultant performed complete medical record reviews that would include reviewing for the completion of AIMS assessments.An interview occurred with the Facility Physician on 11/20/25 at 10:22 AM. The Facility Physician was made aware that the Consultant Pharmacist was not reviewing resident medical records for AIMS assessments. He stated he was unaware the Pharmacy Consultant was not performing complete medical record reviews. The Facility Physician stated he would expect the Pharmacy Consultant to review the entire medical record during each monthly medical record review.An interview was held with the Administrator on 11/20/25 at 11:46 AM. The Administrator discussed being unaware that the Pharmacy Consultant was not reviewing the residents' medical records for an AIMS assessment. She stated she expected the Pharmacy Consultant would (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identify and report irregularities including the need for AIMS assessments during the monthly drug regimen reviews. The Administrator stated she did review the monthly Pharmacy Consultant reports but did not realize the Pharmacy Consultant was not reviewing for the AIMS assessments.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and staff interview, the facility failed to ensure the facility assessment included a contingency plan that was informed by the facility assessment to address the availability of staff and other resources for events that did not require activation of the facility's emergency plan but had the potential to affect resident care. This had the potential to affect 38 of 38 facility residents. The findings included:The review of the facility assessment dated 2025 did not identify a written contingency plan that was informed by the facility assessment to address the availability of nursing staff and other resources for events that did not require activation of the facility's emergency plan but had the potential to affect resident care. An interview occurred with the Assistant Administrator on 11/20/2025 at 2:30 pm. She stated she was unaware that a contingency plan for staffing/resources for events that did not require activation of the facility's emergency plan needed to be addressed in the facility assessment. She was uncertain why this was not completed.An interview with the Director of Nursing (DON) on 11/20/2025 at 9:15 am, revealed there was no plan in writing that specified what to do when the facility had an event that had the potential to affect resident care. The DON did not know why there was not a written plan in place for staffing/resources during an event that could interrupt resident care needs. An interview with the Administrator on 11/20/2025 at 3:40 pm revealed the Facility Assessment was reviewed and revised annually, however the written contingency plan informed by the facility assessment was not included in the facility assessment. She stated that turnover had been complex related to increased management changes that started in 2025, but the facility still had a responsibility to complete the requirements of the facility assessment.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to ensure a resident call light system was accessible for 1 of 3 residents (Resident # 28) observed for call light system.The findings included: Resident # 28 was admitted to the facility on [DATE] with multiple diagnoses that included absence of left leg above the knee. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 28 was assessed as cognitively intact. Resident #28 was independent for transfers, bed mobility, and toileting.An observation of Resident # 28's bathroom was conducted on 11/18/2025 at 12:05 pm. The call light in the bathroom did not have an attached pull cord.Resident # 28 was interviewed on 11/18/2025 at 12:42 pm. The resident stated he was independent with Activities of Daily Living (ADL) which included getting out of bed, transferring, and using the toilet. Resident # 28 confirmed there was no pull cord for the call light in the bathroom and stated he could not remember the last time the call light had a pull cord. He also stated if he was lying on the floor, he would be unable to use the call light for assistance. Another observation of Resident #28's bathroom occurred on 11/19/2025 at 1:35 pm. The call light in the bathroom did not have an attached pull cord.An observation of Resident # 28's bathroom was conducted on 11/20/2025 at 8:45 am. The call light in the bathroom did not have an attached pull cord.During an interview on 11/19/2025 at 2:30 PM with Nursing Assistant (NA) #6, the NA stated Resident # 28 was able to complete all ADL independently but needed assistance with showers. An interview occurred on 11/19/2025 at 4:15pm with NA #1. She stated Resident # 28 did not ask for assistance with grooming, toileting and transferring because he was able to complete the tasks on his own. An interview occurred on 11/20/2025 8:45AM with Occupational Therapist (OT) #1. She stated Resident # 28 was independent in daily care items such as, transferring from wheelchair to bed / toilet. An interview with the Facility Maintenance Director on 11/20/2025 at 8:50 am revealed the facility had a preventative maintenance program but they had been unable to complete the preventative maintenance. He stated he was unaware of the lack of the call light pull cord in Resident # 28's bathroom. The Facility Maintenance Director stated if staff did not call him or placed the repair needed in the engineering book at the nurse's station he would not know of the concern. Observation of the engineering book on 11/20/2025 at 9:10 am revealed that from 10/1/2025 through 11/20/2025 no service request was placed in the book for a replacement of the pull cord on the call light in Resident # 28's bathroom.An interview with the facility Environmental Service Manager on 11/20/2025 at 10:10 am revealed she utilized weekly checklist to review all rooms. She stated the checklist did not address the call lights and pull cords. She observed Resident # 28's bathroom on her weekly rounds on 11/19/2025 but did not notice the pull cord was missing from the call light. The Environmental Service Manager stated if she had noticed the pull cord was missing, she would have called maintenance to fix it.An interview with the Director of Nursing (DON) on 11/20/2025 at 9:15 am revealed that she was unaware the call light did not have a pull cord and that if a resident was on the floor they would have to yell out as the call light would be unavailable. The DON stated if she was aware of the missing pull cord she would have contacted maintenance to have it replaced. During an interview with the Administrator on 11/20/2025 at 9:40 am, the Administrator stated staff communicated with the maintenance department by writing in the engineering book at the nurse's station or if the area needed an immediate response staff would call maintenance directly. She stated staff would have been expected to call maintenance with a missing pull cord for the call light system.