STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	115 N Country Club Road Brevard, NC 28712

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review and staff interviews, the facility failed to provide a dignified dining experience for a dependent resident seated at a table in the main dining room waiting to be served and assisted with his lunch while watching other residents in the main dining room receive and eat their lunch for 1 of 2 residents reviewed for dignity (Resident #49). The reasonable person concept was applied to this deficiency as an individual might feel forgotten or experience frustration at not being able to eat while watching others receive and eat their meals. Findings included: Resident #49 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the left non-dominant side and vascular dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had severe cognitive impairment. He had impairment on one side of both the upper and lower extremities and required substantial/maximal staff assistance with eating. Review of the scheduled meal time posted at the facility revealed lunch was to be served in the main dining room at 12:30 PM. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation of the lunch meal was conducted on 03/06/25 from 12:00 PM to 1:30 PM. At 12:00 PM, Resident #49 was observed sitting in his wheelchair at a table in the back of the main dining room. Resident #49 was alert and looking around, watching the activity in the dining room. When asked if he was hungry, Resident #49 replied, yeah lawd (term often used as an expression to heighten an emotion). At 12:30 PM, meal carts had not arrived to the main dining room. At 12:40 PM, the meal cart arrived in the main dining room and there were five staff present who immediately started passing out meal trays to residents seated at the tables in the front of the main dining room. At 12:55 PM, the residents who were able to eat independently had all received their meal tray and were eating their lunch while the residents in the back of the main dining room, who needed staff assistance including Resident #49, had not been served their meal. At 1:00 PM, another meal cart arrived in the main dining room and staff started sitting down at other tables assisting dependent residents with their meal. Resident #49 looked over at the staff assisting residents with their meals with a look of confusion on his face and made a groaning sound. When asked if he was ok, Resident #49 stated no and when asked if he was hungry, he replied yeah lawd. At 1:25 PM, staff brought Resident #49's meal tray to the table and began assisting Resident #49 with his meal. Resident #49 eagerly accepted sips of fluid and bites of food when offered by staff. Resident #49 waited approximately one hour from the scheduled mealtime to be served and assisted with his lunch. During an interview on 03/07/25 at 4:34 PM, the Administrator expressed it was a dignity issue when residents sat in the main dining room an hour or longer waiting to be served their meal or receive assistance with a meal. She explained staff assisted residents to the dining room a little earlier than the scheduled meal time because once the meal trays arrived on the hall, staff couldn't stop passing meal trays out to the residents eating in their rooms in order to bring other residents to the main dining room. The Administrator revealed she was aware of the issue with meals being served late and stated while she was not sure where or how the breakdown occurred she felt it could be more of a process issue rather than a staffing issue.

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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 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** 37538 Based on observations, record review, resident and staff interviews the facility failed to honor a resident's preference for twice weekly showers for 1 of 3 residents reviewed for choices (Resident #104). Findings included: Resident #104 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy and heart failure. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #104's cognition was moderately impaired, she had limited range of motion affecting one side of the upper extremity, and bathe/shower was not applicable and not attempted. A review of the shower assignment revealed Resident #104's showers were scheduled on Tuesday and Friday. There was no documented shower sheets to indicate a bed bath or shower was provided on 02/25/25 (Tuesday) or 02/28/25 (Friday). A shower sheet dated 03/04/25 revealed Resident #104 had received one shower since admission on 02/24/25. During an interview and observation on 03/03/25 at 2:36 PM Resident #104 revealed she had not received a shower since being admitted to the facility. Resident #104's hair and face appeared clean, and she had no body odors. The care plan initiated on 03/04/25 revealed Resident #104 required assistance from staff for activities of daily living related to weakness with the goal to be clean and well-groomed daily through the next review. Interventions included provide assistance with activities of daily living. During an interview on 03/07/25 at 8:37 AM the Unit Manager (UM) revealed bathing was documented by Nurse Aide (NA) staff included using a paper shower sheet that was kept in a binder at the nurse station. The UM revealed the shower sheets were kept in the binder for one month then placed in medical record storage. The UM confirmed Resident #104 showers were scheduled on Tuesday and Friday and the first one should have been given on 02/25/25. The UM was unable to provide a shower sheet for 02/25/25 and 02/28/25. The UM revealed she filled out the shower assignment using room numbers to identify which residents NA staff were to provide a shower/bathe. After reviewing the assignment, the UM revealed Resident #104's room number was not added, and the assigned NA would not have known to provide the shower and was an oversight on her part. During an interview on 03/07/25 at 9:24 AM in presence of the UM, Resident #104 stated she had received only one shower (3/4/25) since her admission and wanted two showers a week and it was her preference not to receive a bed bath in place of a shower. The UM reassured Resident #104 her bathing preference for a shower twice a week would be honored. An interview was conducted with the Administrator on 03/07/25 at 6:10 PM. The Administrator revealed she expected resident bathing preferences for two showers a week were honored.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 37014 Based on record review, resident and staff interviews, the facility failed to communicate resolution to concerns voiced for 1 of 2 Resident Council meetings reviewed (January 2025). Findings included: A review of the Resident Council Meeting policy revised 01/01/25 stated the facility would act upon concerns and recommendations of the Resident Council, make attempts to accommodate recommendations to the extent practicable and communicate its decisions to the Resident Council. The Resident Council meeting minutes dated 01/31/25 noted under new business that residents communicated to the Dietary Manager, who was in attendance at the meeting, their preferences for specific beverages with an outcome noted as resolved-still monitoring. It was also noted under new business that residents voiced laundry concerns regarding clothing being placed in the wrong closets. The action to the concern indicated a grievance form regarding missing items would be completed and the outcome was noted as resolved-still monitoring. A grievance form dated 01/31/25 noted attendees of the Resident Council meeting voiced concerns about laundry staff putting clothing in the wrong resident closets. There was no staff member assigned to investigate the concern and no summary of the investigation. The plan to resolve the grievance indicated the concern would be reviewed with the Environmental Services Director and noted the concerns was ongoing. It was further noted the investigation results and resolution was provided to the Resident Council. There were no other details listed on the grievance form. The Resident Council meeting minutes dated 02/26/25 revealed the last meeting's minutes was read and approved. There was no notation under old or new business that the facility's efforts (response, action and/or rationale) to address the concerns voiced during the 01/31/25 meeting was communicated to the Resident Council. A Resident Council group interview was conducted on 03/05/25 at 3:32 PM with Resident #4, Resident #11, Resident #35, Resident #42, Resident #51, Resident #62, and Resident #74 in attendance. The residents stated when they voiced concerns during meetings, they rarely received communication from facility staff regarding what was done to address the concerns. The residents stated they did not feel the ongoing concerns they voiced related to clothing not being returned from laundry and dietary, specifically meals being served late, had been resolved. They stated if facility administration did attempt to address their concerns, it took a long time and the situation might get better for a little while but improvement didn't last long. The residents all stated they felt when they voiced concerns either in the Resident Council meetings or directly to the Administrator, Director of Nursing or Social Worker (SW), it didn't do any good. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/07/25 at 12:15 PM, the Activities Director (AD) revealed she just started conducting Resident Council meetings in January 2025 and most of the groups concerns revolved around dietary or laundry. She verified that residents had voiced concerns with late meals. She explained she followed up with residents regarding resolution to individual concerns but did not follow-up with the Resident Council regarding resolution to group concerns. She stated she was still learning the process and would do much better about that in the future. During an interview on 03/07/25 at 3:44 PM, the SW revealed the staff member who facilitated the Resident Council meeting was the one responsible for communicating the resolution of group concern(s) to the members of the Resident Council. During an interview on 03/07/25 at 4:34 PM, the Administrator revealed she was aware of the issue with meals being served late and confirmed residents had brought their concerns regarding late meals to her attention. She stated she was not sure what the root cause was regarding late meals but felt it could be more of a process issue rather than a staffing issue. The Administrator expressed she was not aware that residents felt they did not receive communication regarding resolution to their concerns or that they felt voicing their concerns would not do any good. The Administrator stated resolution to concerns voiced during the Resident Council meetings should be discussed with and communicated to the Resident Council attendees at the next meeting.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on record review and staff and resident interviews the facility failed to implement their grievance policy for 1 of 1 resident (Resident #8) reviewed for grievances. Findings included: Review of the facility's grievance policy revised 01/01/25 read in part as follows: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. [Prompt Efforts to Resolve] include facility acknowledgement of a complaint grievance and actively working toward resolution of that complaint/grievance. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; and issuing written grievance decisions to the resident. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. The Grievance Official will take steps to resolve the grievance and record information about the grievance and those actions on the grievance form. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. If the resident or complainant do not wish to have a written copy of the decision, verbal discussion is acceptable. The written decision will include at a minimum: (a). The date the grievance was received (b). The steps taken to investigate the grievance (c). A summary of the pertinent findings or conclusions regarding the resident's concern (f). A statement as to whether the grievance was confirmed or not confirmed (g). Any corrective action taken or to be taken by the facility as a result of the grievance (h). The date the written decision was issued. Resident #8 was admitted to the facility 11/24/23 with diagnoses including non-Alzheimer's dementia. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #8 was cognitively intact and was always incontinent of bowel and bladder. Review of the facility's grievance logs from December 2023 through March 2025 revealed Resident #8 had filed 2 grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A grievance filed by Resident #8 on 01/08/24 regarding various care concerns. The nursing department investigated the grievance and findings of the investigation were blank. The form indicated the plan to resolve the grievance included staff counseling and medication review. An in-service dated 01/08/24 revealed nursing staff were educated on Respectful Talk to Residents and the grievance was considered resolved. The results of the investigation were verbally communicated to Resident #8 on 01/09/24. The grievance form did not contain any additional information regarding the care concerns and was not signed by Resident #8. A grievance was filed by Resident #8 on 02/10/25 regarding timely response to incontinence care. The Director of Nursing (DON) investigated and determined Resident #8 received incontinence care, but had to wait until care staff were done with another resident. The plan to resolve the grievance was to encourage staff to notify Resident #8 they will be right there or as soon as possible when she is waiting. Resident #8 verbalized understanding that staff were to notify and respond to call lights in timely manner. The result of the investigation was verbally communicated to Resident #8 and the grievance was considered resolved 02/10/25. The grievance did not contain any additional information regarding Resident #8's concern and was not signed by Resident #8. In an interview with the Social Worker (SW) on 03/05/25 at 9:31 AM he confirmed he was the Grievance Officer. When he was asked what various care concerns meant on the grievance filed by Resident #8 on 01/08/24 he stated her concerns were usually the same and were concerns regarding not receiving water, call light response time, or the length of time it took to receive incontinence care. The SW stated when Resident #8 filed a grievance he verbally discussed the resolution with her, and she seemed to be satisfied. He confirmed he did not provide written resolutions to grievances. An interview with Resident #8 on 03/05/25 at 4:22 PM revealed she had never been provided with a resolution to any grievance she filed. She stated she would like to receive a resolution to her grievances in writing so she would know what had been done to address the grievances, but she didn't know that was an option. An interview with the Administrator on 03/07/25 at 5:16 PM revealed grievance forms could probably contain a little more information about what the grievance was regarding and what had been done to resolve the grievance.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on record review and staff interviews the facility failed to complete a thorough investigation of an allegation of staff-to-resident abuse for 1 of 9 residents reviewed for abuse (Resident #8). Findings included: The facility's Abuse, Neglect, and Exploitation policy revised 03/02/23 read in part as follows: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: 1. Identifying staff responsible for the investigation 2. Investigating different types of alleged violations 3. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations 4. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause 5. Providing complete and thorough documentation of the investigation. Review of the medical record revealed Resident #8 was admitted to the facility 11/24/23. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact and had a diagnosis of non-Alzheimer's dementia. A summary of the initial investigation report completed by the Director of Nursing (DON) indicated the incident date was 05/14/24 and the facility became aware of the incident on 05/15/24 10:15 AM. The fax date and time revealed the report was submitted at 12:18 PM on 05/15/24. A summary of the investigation was as follows: Resident #8 reported on the night of 05/14/24 as she was being put to bed, Nurse Aide (NA) #1 pushed her head onto the bed. A facility investigation was initiated, NA #1 was suspended pending the investigation, and the Physician, Responsible Party (RP), Adult Protective Services (APS), and Transylvania Police were notified of the incident. Resident abuse questionnaires were initiated with alert and oriented residents and body audits for residents with impaired cognition were initiated. Staff abuse education was being completed. The investigation was ongoing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A summary of NA #1's written statement dated 05/15/24 is as follows: First shift reported they assisted Resident #8 to bed the evening of 05/14/24 but she had since gotten up in her wheelchair. The statement indicated Medication Aide (MA) #1 informed her Resident #8 was asking about her mother, so NA #1 went to the resident's room to check on her. The statement further stated as NA #1 walked into Resident #8's room she was trying to get in bed, but she was going down to the floor, so she grabbed the back of Resident #8's pants and pulled her up and onto the bed. An undated document titled Root Cause is as follows: The Interdisciplinary Team (IDT) determined the incident occurred because the resident did not wait for assistance to transfer. The resident did get moved quickly onto the bed, but her face was not pushed into/onto the bed. The resident was re-assured and reminded to use her call bell for assistance. An unnamed typed document dated 05/20/25 revealed the Director of Nursing (DON) had NA #1 do a re-enactment of how she transferred Resident #8 to bed the night of 05/14/25 and determined NA #1 prevented Resident #8 from falling. A summary of the facility 5-day report completed by the Administrator and faxed on 05/20/24 at 5:01 PM is as follows: Resident #8 reported as she was being assisted to bed on the night of 05/14/24, NA#1 pushed her head down onto the bed. Resident abuse questionnaires and body audits revealed no concerns of abuse. A written statement was obtained from NA #1 on 05/15/24 and did not address whether Resident #8's head was pushed into the bed or not. The facility determined Resident #8 was trying to self-transfer from the wheelchair to the bed and was falling. The investigation further determined NA #1 grabbed Resident #8 and pulled her up and onto the bed. The allegation of abuse was not substantiated. The investigation did not include a statement from Resident #8. An interview with the Director of Nursing (DON) on 03/06/25 at 2:52 PM revealed he could not recall how he became aware of the allegation of abuse from Resident #8 and was unable to provide an answer for why the investigation did not contain a statement from Resident #8. He confirmed there were no other interviews included in the investigation. An interview with the Administrator on 03/07/25 at 5:15 PM revealed she could not recall how she became aware of the allegation of abuse from Resident #8 and was unable to provide an answer for why the investigation did not contain a statement from Resident #8. She stated she did not have concerns with the way the abuse investigation was conducted. The Administrator confirmed she was not aware of any other interviews obtained during the course of the investigation.

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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** 39037 Based on record review, observations and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of restraints (Resident #71), dental (Resident #20), and falls (Resident #4) for 3 of 26 resident assessments reviewed for accuracy. Findings included: 1. Resident #71 was admitted to the facility 06/12/24. Review of Resident #71's quarterly Minimum Data Assessment (MDS) dated [DATE] indicated Resident #71 had bed rails that were used daily as a restraint. Observations of Resident #71's bed on 03/05/25 at 8:49 AM and 03/07/25 at 9:17 AM revealed no bed rails were observed on his bed. An interview with the MDS Coordinator on 03/07/25 at 3:52 PM revealed Resident #71's quarterly MDS assessment was coded by an employee that did not work in the building. He stated it was difficult to accurately code MDS assessments if you were not present in the building. The MDS Coordinator stated that the MDS should not have reflected that bed rails were used as a restraint, and it was a coding error. An interview with the Director of Nursing (DON) on 03/07/25 at 4:11 PM revealed he expected MDS assessments to be coded correctly and no residents in the facility used a restraint. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected MDS assessments to be coded correctly and be an accurate reflection of the resident. 2. Resident #20 was admitted to the facility 04/06/23. Review of a dentist's note dated 01/08/25 revealed Resident #20 had multiple teeth that were broken to the gum line and had hopeless dentition (teeth that are severely compromised due to gum disease or other problems). Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] indicated she did not have any dental problems. Review of Resident #20's dental care plan last updated 03/05/25 revealed she had poor dentition/broken and carious teeth (teeth with cavities). Interventions included providing her diet as ordered and monitoring and reporting any signs or symptoms of oral problems. An observation of Resident #20's teeth on 03/05/25 at 8:29 AM revealed multiple broken teeth. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MDS Coordinator on 03/07/25 at 3:47 PM revealed Resident #20's teeth were not in good shape, and they had been that way for a while. He stated the significant change MDS assessment should have reflected Resident #20 had obvious or likely cavities. The MDS Coordinator stated another staff member coded the section for Oral/Dental Status, but he was responsible for ensuring it was correct, and it was an oversight. An interview with the Director of Nursing (DON) on 03/07/25 at 4:11 PM revealed he expected MDS assessments to be coded correctly. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected MDS assessments to be coded correctly and be an accurate reflection of the resident. 37538 3. Resident #4 was admitted to the facility on [DATE] with diagnoses including poly-osteoarthritis (arthritis that involves at least five joints). A review of the nurse's progress note dated 1/17/25 at 3:54 PM revealed when assisted to the bathroom Resident #4 was unable to complete the transfer and was lowered to the floor using a gait belt and two person assistance. A review of the discharge MDS assessment dated [DATE] indicated Resident #4 had not had any falls since the prior assessment. During an interview on 3/6/25 at 2:16 PM the MDS Coordinator confirmed he completed the discharge MDS assessment on 1/17/25 for Resident #4 and did not code the fall. He revealed the discharge MDS assessment dated [DATE] should reflect Resident #4 had a fall with no injury. During an interview on 03/07/25 at 4:12 PM the Director of Nursing (DON) revealed the discharge MDS assessment dated [DATE] should reflect Resident #4 had fall. An interview was conducted on 03/07/25 at 5:17 PM with the Administrator. The Administrator revealed she expected MDS coding to be accurate and reflect Resident #4 had a fall.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on observations, record review, resident, and staff interviews the facility failed to provide assistance with nail care and shaving for 1 of 5 dependent residents reviewed for activities of daily living (Resident #99). Findings included: 1. Resident #99 was admitted to the facility on [DATE] with diagnoses including a right femur (upper leg bone) fracture, presence of artificial hip joint, and epilepsy (a brain condition causing recurring seizures with varying symptoms). The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #99's cognition was moderately impaired with no rejection of care behaviors during the lookback period. Resident #99 had impaired range of motion affecting one side of the lower extremity and required setup/clean up assistance for personal hygiene and substantial to maximal assistance for shower/bathing. The care plan revised on 2/12/25 revealed Resident #99 had a deficit in the ability to perform activities of daily living related to a fracture of the right femur, epilepsy, and pain. Interventions included provide extensive assistance using one person assist for shower/bathing and personal hygiene. A review of the shower assignment revealed Resident #99 was scheduled to receive a shower every Tuesday and Friday. The Shower sheets documented Resident #99 had received two showers since admission on 2/17, and 2/24 and a bed bath on 2/7, 2/11, 2/20, and 3/4. There was no shower sheet completed for 2/14 and 2/28 to indicate bathing was provided. During an observation and interview on 03/03/25 at 2:32 PM Resident #99 fingernails were approximately one-half inch past the tip of the finger, and she had multiple patchy areas of overgrown gray chin hairs. When asked Resident #99 revealed her fingernails were long and she wanted them cut and she was not aware of the chin hair but if she had a pair of tweezers would pull them out. Resident #99 revealed she had not requested her fingernails be trimmed or to shave her chin hair and was not offered assistance by staff. During an interview on 03/07/25 at 8:58 AM Nurse Aide (NA) #2 revealed fingernails were trimmed and chin hairs shaved during bath days. An interview and observation was conducted on 03/07/25 at 9:21 AM with Resident #99 in the presence of the Unit Manager (UM). The UM observed Resident #99's long fingernails and multiple patchy areas of overgrown gray chin hairs and revealed if chin hairs needed to be shaved, and fingernails trimmed it was done during a bed bath or shower and as needed. Resident #99 shared with the UM a staff member recently gave her a pair of nail clippers, but she was unable to cut her own fingernails because they were too hard. Resident #99 shared she did not like long chin hairs and normally plucked them. The UM reassured Resident #99 her fingernails would be trimmed and chin hair shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 03/07/25 at 6:10 PM. The Administrator stated she would expect Resident #99 to be offered assistance to shave long chin hairs and clip long fingernails and was typically done by the NA during a bed bath or shower.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37538 Based on an observation of the lunch meal tray preparation, record review, and interviews with the Dietary Manager and staff, the facility failed to provide the correct portion size of beef hamburger steak for residents receiving a mechanically altered diet. This failure had the potential to affect 18 of 97 residents who received a lunch meal tray with a mechanically altered diet. Findings included: The facility's diet consistency census report dated 03/03/25 revealed 18 of 97 residents received a mechanically altered diet. The facility's planned menu for Wednesday (03/05/25) listed beef hamburger steak as the protein being served for lunch. The portion size listed on the menu indicated each plate received one beef hamburger steak. The beef hamburger steak packaging revealed each steak was a 4-ounce portion. A continuous observation of lunch trays being prepared for residents was conducted on 03/05/25 at 11:54 AM through 1:38 PM. The Dietary Manager served one (4 ounce) beef hamburger steak for residents that received a regular diet. The Dietary Manager and [NAME] used a ladle with a red colored handle (2 ounce) to portion each plate of beef hamburger steak for residents that received a mechanically altered diet. During an interview on 03/05/25 at 12:50 PM the [NAME] confirmed the red handle ladle was used to portion the beef hamburger steak for residents receiving a mechanically altered diet and confirmed the ladle was for plating a 2-ounce portion. The [NAME] revealed for portion sizes he used a guide to select the correct one based on the color of the handle and pointed to a guide posted on wall behind the steam table. The guide was a picture of kitchen scoop sizes in ounces and milliliters but did not include ladles or other utensils. During an interview on 03/05/25 at 1:30 PM the Dietary Manager confirmed the correct portion size for the beef hamburger steak being served to residents was 4 ounces. The Dietary Manager stated residents receiving a mechanically altered diet received half a portion because the incorrect ladle was used to portion the beef hamburger steak onto the plate. The Dietary Manager confirmed the incorrect ladle had a red handle and was a 2-ounce portion used by him and the [NAME] by mistake and was an oversight. During an interview on 03/07/25 at 6:14 PM the Administrator revealed she expected the residents who received a mechanically altered diet to be served the correct portion size. The Administrator revealed she expected the correct utensil to be used by dietary staff when plating food to ensure portion sizes were accurate.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review and resident, family and staff interviews, the facility failed to serve the lunch meal at the posted times on 03/05/25 and 03/06/25 in the main dining room during 2 of 3 meal observations. The findings included: Review of the facility's meal times schedule revealed lunch was to be served in the main dining room at 12:30 PM. a. Resident #54 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #54 had severe cognitive impairment, required partial/moderate assistance with eating and received a mechanically altered diet. Resident #101 was admitted to the facility on [DATE]. The admission MDS assessment dated [DATE] indicated Resident #101 had severe cognitive impairment, required setup or cleanup assistance with eating and received a mechanically altered diet. An observation of the lunch meal service in the main dining room on 03/05/25 at 1:10 PM revealed residents were seated at various tables eating their lunch. Resident #54 was seated at a table in the back of the dining room by herself and had not received her meal tray. Resident #101 was seated at a table in the middle of the dining room and had not received her meal tray. There were three other residents sitting at the table with Resident #101 who all had received their meal tray and were eating their lunch. At 1:20 PM, both Resident #54 and Resident #101 received their lunch meal tray. During the lunch meal observation, an interview was conducted with the Responsible Party (RP) for another resident on 03/05/25 at 1:11 PM. The RP stated they came to the facility every day to sit with their family member during lunch. The RP expressed it was a regular occurrence that meals were often served late, which was why they made sure they were at the facility daily for at least one meal. During the lunch meal observation, an interview was conducted with the Speech Therapist on 03/05/25 at 1:13 PM. The Speech Therapist stated she was working with Resident #101 for therapy and was not sure why Resident #101 had not received her lunch meal tray. The Speech Therapist stated the Administrator was aware that both Resident #54 and Resident #101 had not received their meal trays. During an interview on 03/05/25 at 1:20 PM, the Administrator confirmed that meal trays were delivered late to the main dining but could not provide an explanation for the delay. The Administrator stated both Resident #54 and Resident #101 did not normally eat in the main dining room and their meal trays were delivered to the hall. She acknowledged that it was too late for both residents to just now receive their meals. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Resident Council group interview was conducted on 03/05/25 at 3:32 PM with Resident #4, Resident #11, Resident #35, Resident #42, Resident #51, Resident #62, and Resident #74 in attendance. The residents all voiced meals were served late on a daily basis regardless if they ate in their rooms or the main dining room. b. A continuous observation of the lunch meal service in the main dining room was conducted on 03/06/25 from 12:00 PM to 1:30 PM. At 12:00 PM, there were several residents already seated at various tables while staff continued to bring other residents into the dining room for lunch. Staff were observed assisting residents with donning clothing protectors and providing drinks to residents at the tables while they waited on lunch to be served. At 12:30 PM, meal carts had not arrived to the main dining room. At 12:40 PM, the meal cart arrived in the main dining room and there were five staff present who immediately started passing out meal trays to residents seated at the tables in the front of the main dining room. At 12:55 PM, the residents who were able to eat independently had all received their meal tray and were eating their lunch while the residents in the back of the main dining room, who needed staff assistance, had not been served their meal. At 1:00 PM, another meal cart arrived in the main dining room and staff started sitting down at the tables assisting dependent residents with their meal. At 1:25 PM the last two residents were provided their meal tray and staff proceeded to assist the residents with eating lunch. During the lunch meal observation on 03/06/25 at 1:21 PM, the Responsible Party (RP) for another resident, who was seated at the table with her family member, expressed now you understand why I make sure I am present for at least one meal. During an interview on 03/07/25 at 2:50 PM, the Dietary Manager (DM) revealed he was aware of the issue with meals being served late and there were several contributing factors. He explained one contributing factor was dietary had a limited amount of dinnerware to serve resident meals such as plates, plate covers and base, and silverware. He had ordered more dinnerware but the vendor had trouble getting certain items. The DM stated he requested facility staff collect and return meal trays by a certain time after each meal so that dietary staff could get the dinnerware clean and ready for the next meal service but that did not always happen. As a result, he stated there had been times they had to stop meal service just to wash dishes in order to finish serving meals. The DM stated he was provided a list of residents who ate in the main dining room and if a resident was not on that list, their meal tray was sent in the meal cart to the hall. He stated when a resident's meal tray was not delivered on the meal cart for the main dining room staff called the kitchen requesting they bring a meal tray to the dining room which took one of the three dietary staff off the meal line slowing production. He explained if a resident who normally ate in their room decided they wanted to eat in the main dining room, he relied on staff to let him know prior to the start of meal service so the resident's meal tray would be delivered to the correct location. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/07/25 at 4:34 PM, the Administrator revealed she was aware of the issue with meals being served late and confirmed residents had also brought their concerns regarding late meals to her attention. The Administrator stated when meal trays were not on the meal cart, facility staff would go down to the kitchen to get a resident's meal tray to help out but dietary staff were usually in the middle of tray line production and if they stopped to look for a certain meal ticket it would disrupt the process causing further delay. The Administrator acknowledged she knew there was a shortage of dinnerware for residents' meals and explained when meals were served late, she was not going to have staff rush residents to finish the meal so that dietary staff could get the dinnerware washed at a certain time. She stated when the lunch meal was served late, she expected dietary staff to push back the time dinner was served so that residents were not going throughout the night hungry. The Administrator stated she was not sure what the root cause was regarding late meals but felt it could be more of a process issue rather than a staffing issue.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on record review, observations, and staff interviews the facility failed to remove food items stored and available for use that had signs of spoilage or were past the expiration date from the walk-in refrigerator and dry goods storage area located in the kitchen. The facility also failed to date an opened container of nectar thick milk stored in the nutrition refrigerator used for residents on the memory care unit for 1 of 2 nutrition refrigerators. This deficient practice had the potential to affect food and beverages served to residents. Findings included: The initial tour of the kitchen with the Dietary Manager on [DATE] at 7:55 AM revealed the following: 1a. A container of enchilada sauce with an expiration date ,d+[DATE] stored in the walk-in refrigerator and available for use. b. A container of sliced lemons with a white, slimy discoloration with a use by date [DATE] stored in the walk-in refrigerator and available for use. c. A container of sliced bananas mixed with pineapple tidbits with the slices of banana that had turned brown to black in color. The use by date written on the container was [DATE] and stored in the walk-in refrigerator available for use. d. A 32-ounce container of vanilla flavored nutritional drink supplement with a use by date [DATE] stored in the dry goods storage area of the kitchen and available for use. e. Forty-eight 4 ounce containers of thickened lemon flavor water of honey thick consistency with a use by date [DATE] stored in the dry goods storage area of the kitchen and available for use. f. Nine 32 fluid ounce containers of vanilla protein drink supplement with an expiration date [DATE] stored in the dry goods storage area of the kitchen and available for use. During an interview on [DATE] at the Dietary Manager revealed for open food containers dietary staff were expected to the label with an open and use by date and the item was kept available for use in the walk-in refrigerator for seven days then discarded. The Dietary Manager stated he checked food items stored in the walk-in refrigerator daily to ensure foods were labeled and discarded if there were signs of spoilage or it was out of date. He revealed today ([DATE]) he was busy and had not had time to check the walk-in refrigerator for out of date or spoiled food. The Dietary Manager revealed he checked the dates on food items in dry goods storage area when putting away newly delivered items. He revealed the expired items in the dry goods storage area were stored on the shelf designated for emergency food and he had not checked the expiration dates on those. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator on [DATE] at 6:14 PM. The Administrator revealed she expected food items were appropriately discarded. The Administrator revealed she expected food items were discarded based on expiration or use by dates and not left available for use. 2. An observation of the nutrition refrigerator designated for residents located on the memory care unit was conducted on [DATE] at 12:41 PM in the presence of Nurse #1. Stored and available for use was an open 32-ounce container of nectar-thick milk with an expiration date of [DATE]. The label on the container read discard 4 days after opening. There was no date on the container to identify when it was opened. During an interview on [DATE] at 12:41 PM Nurse #1 revealed nutritional supplements were provided to residents by the nursing staff and she did not know when the container of nectar-thick milk was first opened or how long it was in use. Nurse #1 revealed she was unsure how long a container of nectar-thick milk could be kept in use after opened but thought it was good for seven days. Nurse #1 revealed it was the responsibility of the person who opened the container to write the date it was opened and confirmed the label read to discard 4 days after opened. Nurse #1 discarded the container of milk. An interview was conducted with the Administrator on [DATE] at 6:14 PM. The Administrator revealed she expected food items were appropriately discarded. The Administrator revealed she expected food items served to residents were discarded based on expiration or use by dates and not left available for use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on record review and staff interviews the facility failed to include documentation in the medical record of refusal or acceptance of influenza and pneumonia vaccinations for 5 of 5 residents (Resident #20, Resident #44, Resident #37, Resident #80, and Resident #62) reviewed for immunizations and failed to assess the eligibility to receive the influenza and pneumonia vaccines for 2 of 5 (Resident #44 and Resident #37). Findings included: 1. (a). Resident #20 was admitted to the facility 04/06/23. Review of an unsigned Vaccine Declination Form dated 08/01/24 for influenza and pneumonia vaccines revealed multiple attempts to contact Resident #20's Power of Attorney (POA) were unsuccessful. The significant change Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #20 was severely cognitively impaired. The MDS reflected Resident #20 had not received the influenza or pneumonia vaccine. Review of Resident #20's electronic medical record revealed the Vaccine Declination Form dated 08/01/24 was not included in her medical record. (b). Resident #44 was admitted to the facility 05/05/23. Review of a Vaccine Consent Form dated 07/18/24 revealed Resident #44's Guardian had provided a verbal consent for Resident #44 to receive the pneumonia vaccine, and he received the pneumonia vaccine on 07/18/24. Review of a Vaccine Consent Form dated 10/04/24 revealed Resident #44's [NAME] had provided email consent dated 07/09/24 to receive the influenza vaccine, and he received the influenza vaccine on 10/04/24. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was severely cognitively impaired. The MDS reflected Resident #44 received the influenza vaccine 10/04/24 and was up to date with the pneumonia vaccine. Review of Resident #44's electronic medical record revealed the Vaccine Consent Form dated 07/18/24 and 10/04/24 were not included in his medical record. (c). Resident #37 was admitted to the facility 10/11/23. Review of the Vaccine Declination Form dated 07/09/24 revealed Resident #37 declined the influenza and pneumonia vaccines. Review of a Vaccine Consent Form dated 10/04/24 revealed Resident #37 consented to receive the influenza vaccine, and the vaccine was administered 10/04/24. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact. The MDS reflected he received the influenza vaccine 10/04/24, was not up to date on the pneumonia vaccine, and had been offered and declined the pneumonia vaccine. Review of Resident #37's electronic medical record revealed the Vaccine Declination Form dated 07/09/24 and Vaccine Consent Form dated 10/04/24 were not included in his medical record. (d). Resident #80 was admitted to the facility 05/12/24. Review of a Vaccine Declination Form dated 07/10/24 revealed Resident #80's family member verbally declined the influenza vaccine. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was severely cognitively impaired. The MDS reflected resident #80 received the influenza vaccine on 09/08/24 and was not up to date on the pneumonia vaccine. Review of Resident #80's electronic medical record revealed the Vaccine Declination Form dated 07/10/24 was not included in her medical record. No consent or declination form for the pneumonia vaccine was present in Resident #80's medical record. (e). Resident #62 was admitted to the facility 04/05/23. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact. The MDS reflected Resident #62 was offered and declined the influenza and pneumonia vaccines. Review of Resident #62's electronic medical record revealed no documentation of acceptance or declination of the influenza and pneumonia vaccines. An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed he tried to keep all resident consents or declinations for vaccines in a binder in his office and he was not aware that they needed to be included in the resident's medical record. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccination consents or declinations to be a part of the medical record. 2. (a). Resident #44 was admitted to the facility 05/05/23. Review of a document titled Vaccine Consent Form dated 07/18/24 for Resident #44 read in part as follows: Please answer the following questions so we can assess the safety and the appropriateness of vaccination. Each of the fourteen questions had a box for yes or no and all of the questions were blank. The Vaccine Consent Form dated 07/18/24 revealed Resident #44 received the pneumonia vaccine on 07/18/24. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a document titled Vaccine Consent Form dated 10/08/24 for Resident #44 read in part as follows: Please answer the following questions so we can assess the safety and the appropriateness of vaccination. Each of the fourteen questions had a box for yes or no and all of the questions were blank. The Vaccine Consent Form dated 10/04/24 revealed Resident #44 received the influenza vaccine on 10/04/24. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was severely cognitively impaired. The MDS reflected Resident #44 received the influenza vaccine 10/04/24 and was up to date with the pneumonia vaccine. (b). Resident #37 was admitted to the facility 10/11/23. Review of a document titled Vaccine Consent Form dated 10/08/24 for Resident #37 read in part as follows: Please answer the following questions so we can assess the safety and the appropriateness of vaccination. Each of the fourteen questions had a box for yes or no and all of the questions were blank. The Vaccine Consent Form dated 10/04/24 revealed Resident #37 received the influenza vaccine on 10/04/24. The quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact. The MDS reflected he received the influenza vaccine 10/04/24, was not up to date on the pneumonia vaccine, and had been offered and declined the pneumonia vaccine. An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed influenza and pneumonia vaccines were administered through an outside vaccination company that came to the facility at least every six months but his staff were responsible for obtaining consent. He stated the staff member obtaining consent for the influenza or pneumonia vaccine was responsible for determining if it was appropriate to offer the resident the vaccine or not and the questions for vaccine appropriateness should have been answered. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccine consents to contain all the required information and questions should not be left blank.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on record review and staff interviews the facility failed to include documentation in the medical record of refusal or acceptance of the COVID-19 vaccination for 5 of 5 residents (Resident #20, Resident #44, Resident #37, Resident #80, and Resident #62) reviewed for immunizations and failed to assess the eligibility to receive the COVID-19 vaccine for 1 of 5 (Resident #44) residents reviewed for immunizations. Findings included: 1. (a). Resident #20 was admitted to the facility on [DATE]. Review of an unsigned Vaccine Declination Form dated 08/01/24 for COVID-19 revealed multiple attempts to contact Resident #20's Power of Attorney (POA) were unsuccessful. The significant change Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #20 was severely cognitively impaired. Review of Resident #20's electronic medical record revealed the Vaccine Declination Form dated 08/01/24 was not included in her medical record. (b). Resident #44 was admitted to the facility on [DATE]. Review of a Vaccine Consent Form dated 07/18/24 revealed Resident #44's Guardian had provided a verbal consent for Resident #44 to receive the COVID-19 vaccine, and he received the COVID-19 vaccine on 07/18/24. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was severely cognitively impaired. Review of Resident #44's electronic medical record revealed the Vaccine Consent Form dated 07/18/24 was not included in his medical record. (c). Resident #37 was admitted to the facility on [DATE]. Review of the Vaccine Declination Form dated 07/09/24 revealed Resident #37 declined the COVID-19 vaccine. The quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact. Review of Resident #37's electronic medical record revealed the Vaccine Declination Form dated 07/09/24 was not included in his medical record. (d). Resident #80 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	115 N Country Club Road Brevard, NC 28712

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Vaccine Declination Form dated 07/10/24 revealed Resident #80's family member verbally declined the COVID-19 vaccine. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was severely cognitively impaired. Review of Resident #80's electronic medical record revealed the Vaccine Declination Form dated 07/10/24 was not included in her medical record. (e). Resident #62 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact. Review of Resident #62's electronic medical record revealed no documentation of acceptance or declination of the COVID-19 vaccine. An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed he tried to keep all resident consents or declination forms for vaccines in a binder in his office and he was not aware that they needed to be included in the resident's medical record. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccination consents or declination forms to be a part of the medical record. 2. Resident #44 was admitted to the facility on [DATE]. Review of a document titled Vaccine Consent Form dated 07/18/24 for Resident #44 read in part as follows: Please answer the following questions so we can assess the safety and the appropriateness of vaccination. Each of the fourteen questions had a box for yes or no and all of the questions were blank. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was severely cognitively impaired. The Vaccine Consent Form dated 07/18/24 revealed Resident #44 received a COVID-19 vaccine on 07/18/24. An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed the COVID-19 vaccine was administered through an outside vaccination company that came to the facility at least every six months but his staff were responsible for obtaining consent. He stated the staff member obtaining consent for the COVID-19 vaccine was responsible for determining if it was appropriate to offer the resident the vaccine or not and the questions for vaccine appropriateness should have been answered. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccine consents to contain all the required information and questions should not be left blank.