STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345475	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tsali Care Center	267 Tsali Care Way Cherokee, NC 28719

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and review of facility documents, the facility failed to ensure one (1) of three (3) residents were provided their visitation rights. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Complete Traumatic Amputation to Left Lower Leg and Type 1 Diabetes Mellitus. He was cognitively intact. During and interview on 3/10/25 at 3:52 PM, Resident #1's wife stated she was not allowed to visit her husband at the facility inside or outside of the facility. She stated she had been visiting her husband several days prior to the interview and was stung or bitten by something in the resident's room. It must have come through the screen of the window we had open. She indicated she had been sitting in the window seat. She stated she began itching and having an allergic reaction to the bite so I told the staff. Resident #1's wife indicated that the facility Administrator, told her at the time of the incident, You must have some type of parasite and need to be checked at the hospital before you return to the facility. She stated on 3/8/25 she called and asked Resident #1 if he wanted something to eat from town and attempted to deliver him food. She stated she arrived at the facility at approximately 8:30 PM and was not allowed to enter the building because she was banned from the facility. She further stated the facility staff would not allow Resident #1 to come outside and pick up the food she had brought to him. During an interview on 4/8/25 at 9:00 AM, Resident #1 stated his wife had been banned from the facility after the administrator felt she had bugs of some kind and told her she needed clearance from the hospital before she could come back. The resident confirmed he had not been able to see his wife when she attended to delver food to him and that on 3/9/25, facility staff told her she would be arrested for trespassing if she did not leave the property.The resident confirmed he had not been able to see his wife when she attended to delver food to him and that on 3/9/25, facility staff told her she would be arrested for trespassing if she did not leave the property. During an interview on 4/8/25 at 10:18 AM, Certified Nurse Aide (CNA) #1 stated she was aware Resident #1's wife was not allowed to visit. She recalled the resident's room being deep cleaned after his wife claimed the facility had bugs. She stated no bugs were found. She confirmed she had never checked Resident #1 or his belongings after he had returned to the facility after visiting with his wife. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tsali Care Center	267 Tsali Care Way Cherokee, NC 28719

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During and interview on 4/9/25 at 10:18 AM, Licensed Practical Nurse (LPN) #2 stated her assignment included Resident #1. She stated it was her understanding the resident's wife was not allowed to visit the resident due to a bug infestation. She stated she had never seen any bugs on her, the resident, or in the room. She stated there was a time recently, but prior to visitation ban when the wife had been admitted to the hospital and was diagnosed with some kind of psychosis where she felt like her skin was crawling. She stated the resident now leaves frequently to be with his wife and has returned during her shift. She stated she has never checked the resident or the belonging he brings back into the facility. During a phone interview on 4/10/25 at 8:47 AM, the facility's pest control company receptionist stated the company had not been contacted to provide any extra services other than the regular monthly visits. During an interview on 4/10/25 at 9:04 AM, Social Service Director stated she was aware Resident #1's wife could not visit inside the facility. She was aware the resident's wife had been scratching herself and was to obtain medical clearance before she could return to the building. She stated the resident's wife had been diagnosed with delusional behavior and scratching and bugs is part of her delusion. She stated she had suggested the resident's wife obtain a physician note with the diagnosis of the delusional behavior. She confirmed Resident #1 should have been able to go outside to visit with his wife and not been stopped at the door. During an interview on 4/10/25 at 1:27 PM, Assistant Administrator (AA) and the Director of Nursing (DON), both agreed Resident #1's wife was asked not to come in the building to visit with the resident due to a possible infestation of some type of bug. The DON stated Resident #1's wife was asked to get medical clearance for the infestation by the administrator. Both the AA and DON stated there was no evidence of bugs found in the resident's room. Both were aware the nursing supervisor did not allow the resident's wife in the building or the property and that she prevented the resident from having any physical contact with his wife. Both stated the Administrator lifted the ban on the wife's visitation after two (2) weeks stating it had been long enough, and the bugs would be dead by now. The AA stated the wife was not banned from the property, only from the building. The DON stated, He should have been allowed to go out to see her and to get his food. The AA agreed. During an interview on 4/11/25 at 9:00 AM, the Housekeeping Supervisor and floor technician indicated Resident #1's room was deep cleaned on 3/7/25. His wife was complaining she was being bitten by something. He stated during the deep clean he saw no evidence of bed bugs. During a phone interview on 4/11/25 at 10:00 AM, the facility's pest control company supervisor stated that bed bugs will not die out after two (2) weeks unless treated. They will continue to get worse and worse. The resident handbook read, TCC [Tsali Care Center] will honor your right to receive visitors of your choosing providing visitation does not impose the rights of others .

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of facility documents, and review of the facility policy entitled Transfers and Discharges Policy, the facility failed to ensure one (1) of three (3) residents (Resident #1) was provided a discharge notice giving at least a 30-day notice of discharge and contained the necessary information required in the notice. Resident #1 was given a 48- hour discharge notice. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Complete Traumatic Amputation to Left Lower Leg and Type 1 Diabetes Mellitus. He was cognitively intact. During an interview on 4/8/25 at 9:00 AM, Resident #1 stated on 3/21/25, he was given a 48-hour discharge notice by the Assistant Administrator (AA) with no explanation. He stated later that afternoon, he was provided a 30-day discharge notice, with no explanation other than she had stated to him. He stated he was not provided information on an appeals process in either notices he received. He stated the notices informed him he was required to remove all personal items and himself from the room by the dates indicated on the notices, which were 3/24/25 for the 48-hour notice and 4/20/25 for the 30-day notice. He stated he was still receiving services at the facility that included physical therapy. During an interview on 4/9/25 at 1:47 PM, the AA stated was instructed by the Administrator to issue 48-hour discharge notice to Resident #1. She stated she drafted and delivered the notice to Resident #1 on 3/21/25. The notice indicated the discharge was effective 3/24/25. She stated Resident #1 was cognitively intact, and cognitively intact residents were permitted to leave the building without a physician's order. They should sign out and he was not always doing that. The AA received information regarding discharge notices and second 30-day notice was given to Resident #1 indicating he would be discharged on 4/20/25. The AA confirmed the resident was not provided a discharge notice that included all information required. Review of the facility policy entitled Transfers and Discharges Policy dated 12/24/24 read, TCC [Tsali Care Center] will provide residents with a thirty-day notice of an impending transfer or discharge except under emergency circumstances or under other circumstances as defined by regulation and as noted in the admission contract. Review of the facility document entitled Tsali Care Center Resident Contract Agreement dated 12/23/24 and signed by Resident #1 and the Admissions Director, page four (4) section III read,Termination, Transfer, or Discharge The facility reserves the right to discharge or transfer a resident with appropriate notice pursuant to applicable federal and state discharge regulations for any of the reasons set forth below, subject to any limitations on such discharge or transfer under the laws of the state in which the facility is located: 1. Transfer or discharge is necessary for the Resident's welfare and Resident's needs cannot be met in the Facility; (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident's health has improved sufficiently such that Resident no longer needs services provided by Facility; 3. The safety of individuals in the Facility is endangered by Resident; 4. The health of individuals in the Facility would otherwise be endangered unless Resident is discharged or transferred .Notice and Waiver of Notice: The facility will notify Resident and Personal Legal Representative or family member at least thirty (30) days in advance of transfer or discharge, except in situations when appropriate plans that are acceptable to Resident can be implemented earlier, and except cases of emergencies, including those situations described above in section 1-4 .

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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 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 interview, record review, review of facility documents, and review of the facility policy entitled TCC Nursing Services - Care Plans - Nursing Facility Policy, the facility failed to ensure one (1) of three (3) residents (Resident #1) or the resident's representative received notification of care plan meetings. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Complete Traumatic Amputation to Left Lower Leg and Type 1 Diabetes Mellitus. He was cognitively intact. During an interview on 3/10/25 at 3:52 PM, Resident #1's wife stated she had never received a notice of a care plan meeting. She stated she specifically asked to be invited to the care plan meeting on Resident #1's admission to the facility. She stated Resident #1 had not received a notice of a care plan meeting. During an interview on 4/8/25 at 9:00 AM, Resident #1 stated he and not received a notice of a care plan meeting. He stated I finally have a care plan now. They had a meeting recently. He was unaware of any care plan meeting that had occurred prior to March 2025, nor had he received a copy of any prior care plan. I know my wife wanted to attend a care plan meeting, but we weren't notified of any before March. During an interview on 4/10/25 at 9:04 AM, the Social Service Director (SSD) stated the facility was using a system through Point Click Care (electronic medical record) called ClinNEX that would send out an automated text and call as notification of care plan meetings. The SSD indicated that she had identified the system had not been working and Resident #1 nor his wife had received notification of the care plan meeting. During an interview on 4/10/25 at 1:27 PM, the Assistant Administrator (AA) and the Director of Nursing (DON) stated care plan meetings were set up by SSD. The AA stated it was her expectation the care plan meeting to be set up by personal phone call, mail, or hand delivered if the resident was their own representative. Review of the facility's policy entitled TCC Nursing Services - Care Plans - Nursing Facility Policy, dated 9/10/2024 read, Each resident and their family or responsible party are invited and encouraged to participate in the development of the resident's comprehensive assessment and plan of care .Baseline Care Plan .2. TCC will provide the resident and the responsible party, if applicable, with a written summary of the baseline care plan by the completion of the comprehensive care plan .Comprehensive Assessment .2. The resident and their family or responsible part are invited to attend and participate in the resident's assessment and care planning conference. Every effort will be made to schedule care plan meetings a the best time of day for the resident and family .The Social Services Director/worker or designee is responsible for contacting the resident's family or responsible party and for maintaining records of such notice. The notice should include date, time, and location of the care plan conference, name and date of family/responsible party notification, method of notification (mail, electronic, phone), input of resident if they are unable to attend , refusal of participation, if approachable, and signature of the individual making contact.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and review of the facility's policy titled Wound Care and Dressing Changes - Clinical Protocol Policy, the failed to ensure one (1) of three (3) sampled residents (Resident #6) received wound care daily as ordered by the physician. The findings include: Resident #6 was admitted to the facility 01/08/25 with diagnoses including heart failure, peripheral vascular disease, type 2 diabetes mellitus, and end stage renal disease. Review of the admission Minimum Data Set, dated [DATE] revealed Resident #6 had moderately impaired cognition and had one (1) stage 2 pressure ulcer and two (2) unstageable deep tissue injuries. Review of the Initial Evaluation Note from the facility physician revealed Resident #6 was transferred from a hospital and admitted to the facility for short-term rehab. The resident had a history of triple vessel coronary artery disease and was not a candidate for surgery. The resident was on dialysis for chronic kidney disease stage 5, chronic renal failure, peripheral vascular disease, open wound of the right ankle, diabetic foot, chronic arterial ulcer of the right ankle, and peripheral neuropathy due to diabetes mellitus type 2. His prognosis was .guarded given esrd [Ends Stage Renal Diease], triple vessel severe cad [coronary artery disease], copd [chronic obstructive pulmonary disease], pain issues - he is not ready to transition to comfort care . Review of the verbal physician orders dated 01/09/25 revealed Resident #6 had a stage 2 pressure injury to the right ankle and suspected deep tissue injuries to the right and left heels. Orders were to perform wound care and dressing changes every Monday, Wednesday, Friday and as needed. Review of a wound care Consultation (green sheet with orders) for Resident #6 dated 02/18/25 revealed, . Tsali Wound Care: change dressings to bilateral lower extremity ulcerations daily . The note was given to Registered Nurse (RN) #2 who signed that she received the note on 02/18/25 at 3:22 PM. Review of the February Treatment Administration Record (TAR) revealed Resident #6 had received wound care and dressing changes to the left heel and right ankle and heel every Monday, Wednesday, and Friday until 02/18/25, when he began receiving wound care and dressing changes every day. Review of a wound care Consultation for Resident #6 dated 02/27/25 revealed, Daily dressing changes to bilateral feet: - may be performed by nursing .change dressings sooner if soiled. The note was given to RN #2 who signed that she received the note on 02/27/25 at 2:08 PM. Review of a Nurses Note for Resident #6 dated 02/27/25 at 9:56 PM revealed, .LOA [leave of absence] for wound care appointment today at [podiatry], no new orders received. Continue with current treatment plan. Wound care nurse notified. Will make oncoming nurse aware. Review of an orthopedic Consultation for Resident #6 dated 03/06/25 revealed, .Follow up in 2 weeks - Podiatry. Change bilateral foot ulcer dressing Monday/Wednesday/Friday .Nursing may also perform dressing changes of the feet if soiled . The note was given to RN #2 who signed that she received the note on 03/06/25 at 3:21 PM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of verbal physician orders for Resident #6 dated 03/07/25 revealed wound care orders for the right heel, right ankle, and left heel were changed to dressing changes every Monday, Wednesday, and Friday and as needed. Review of the March TAR revealed Resident #6 had received wound care and dressing changes to the left heel and right ankle and heel every day from 03/01/25 until Friday 03/07/25. He received wound care and dressing changes every Monday, Wednesday, and Friday beginning on Monday 03/10/25. Review of a Skin/Wound Note dated 03/07/2025 at 4:15 PM revealed, .Spoke with resident's [#6] wife . regarding current wound care .Reviewed plan of care for wound treatment and vascular support. Next Vascular appt [appointment] for angioplasty on 3/30 per wife. Tx [treatment] orders changed to reflect new recommendations from podiatry. Wife reports that the resident tells her that he doesn't see wound care here at Tsali. Explained to [wife] that he is often seen early in the morning so that he can be taken to dialysis and not delay wound care. She reports she will speak with him regarding this. All questions answered. [Wife] verbalized understanding and satisfaction. Review of a Podiatry Clinic Progress Note dated 03/20/25 revealed Resident #6 was seen by Physician #8 for evaluation, management and treatment. Resident #6 had bilateral lower extremity pressure injury ulcerations, diabetes, and end stage renal disease with dialysis. The right ankle wound was assessed as a full thickness ulceration measuring 1.9 centimeters (cm) by (x) 1.4 cm x 0.5 cm (previous measurement 1.5 cm x 1.0 cm x 0.5 cm). The wound was able to be probed to the bone and did not have any mal odor, drainage, or purulence. The right heel was assessed as a partial thickness ulceration measuring 1.4 cm x 1.0 cm x 0.1 cm (previous measurement 1.0 cm x 0.7 cm x 0.1 cm). There was no access to the bone, no mal odor, minimal drainage, and it had necrotic wound borders and eschar. The left heel was assessed as a full thickness ulceration measuring 4.0 cm x 4.0 cm x 0.1 cm (previous measurement 3.5 cm x 3.0 cm x 0.1 cm). There was nonblanching erythema wound borders, and serous drainage, but no mal odor or access to the bone. The assessment indicated that Resident #6 was dependent on hemodialysis due to end stage renal disease and had peripheral neuropathy due to type 2 diabetes mellitus, peripheral vascular disease, pressure injury of left foot, pressure ulcer of right ankle stage 3, pressure injury of right lower limb, ulcer of left foot due to diabetes mellitus, and ulcer of right foot due to diabetes mellitus. Further review revealed, . Wrote orders/instructions for Tsali Care . Review of a wound care Consultation (green sheet with orders) for Resident #6 dated 03/20/25 revealed, . Ulcerations to bilateral posterior heels and right lateral ankle are pressure injuries, worsening, increased size and depth .Daily dressing changes to bilateral feet: - may be performed by nursing .Change dressings sooner if soiled . The note was given to RN #2 who signed that she received the note on 03/20/25 at 10:55 AM. Review of the March 2025 TAR revealed the TAR for Resident #6 was not updated to reflect the change to daily wound care and dressing changes as written by the podiatrist on 03/20/25, and Resident #6 continued to receive wound care and dressing changes on Monday, Wednesday, and Friday. Review of a verbal physician order for Resident #6 dated 03/26/25 revealed an order clarification. The left heel stage 2 pressure injury was an unstageable pressure injury as of 03/24/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Case Management note from the wound care outpatient clinic dated 03/28/25 at 3:05 PM revealed, Received telephone call from pt [patient] wife [Resident #6's wife] who is extremely upset that Tsali Care Center is not following the wound care order provided by [Physician #8], pt states that she brought him to a Podiatry appt last week and [Physician #8] wrote orders that he was to have his dressing changed daily but Tsali Care Center is refusing to change his dressing that many times saying they can only change it on Monday, Wednesday and Friday .I would provide the wound care orders from [Physician #8] to TCC [Tsali Care Center] for their records as they stated they did not have them despite the transportation being provided a copy at this last visit. I will send this to the administration at the patient's wife request. Review of a Social Service Note dated 03/28/25 at 3:33 PM revealed, .Social Worker spoke with resident's [#6] wife who was assured that resident's left heel bandage would be changed daily. Resident's wife also cancelled some of the [hospital outpatient] services related to resident's wound. Review of verbal physician orders for Resident #6 dated 03/28/25 revealed wound care orders for the left heel and right heel and ankle were all changed to daily wound care and dressing changes. Review of the March TAR revealed Resident #6 had received wound care and dressing changes to the left heel and right ankle and heel every Monday, Wednesday, and Friday beginning on Monday 03/10/25. The wound care and dressing changes were changed to daily on Monday 03/31/25. Review of a Case Management note from the wound care outpatient clinic dated 04/01/25 at 11:24 AM revealed, Nurse called spoke to [Licensed Practical Nurse (LPN) #1] who is caring for pt [Resident #6] today, nurse asking if pt is getting daily dressing changes as ordered by [Physician #8]. [LPN #1] states that she has not accessed pt's feet and legs today and is unaware if she can access notes from EHR [electronic health record] to view notes, but states she will find someone who can assist her with this and contact nurse back . Review of an Addendum to the wound care outpatient clinic notes dated 04/01/25 at 12:50 PM revealed, Spoke to [Director of Nursing (DON)] with Tsali Care who informs nurse they do not use EHR so the only way they get new orders is for the provider to complete the order sheet during the visit and them to be sent to Tsali Care with patient. Nurse informs [DON] that [Physician #8] wrote orders for dressing changes daily [for Resident #6] during last visit 03/20/25. Pt's wife contacted [Physician #8] upset that she was informed that Tsali Care would not change his dressing daily, so we are just reaching out to see if his dressings are being changed daily . Review of a Nurses Note dated 04/06/25 at 11:22 PM revealed, .Resident [#6] is currently hospitalized at [hospital] for treatment of bilateral wounds to lower extremities. During an interview with LPN #1 on 04/09/25, LPN #1 stated that she was caring for Resident #6 the morning he was sent to the podiatry/wound clinic and did not return. LPN #1 stated that he had not shown any changes or signs of distress and that she had felt around his feet, under the dressings, looking for a nitroglycerin patch placed after the revascularization procedure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Physician #8 on 04/09/25 at 12:07 PM, Physician #8 stated she had been providing podiatry/wound care for Resident #6. Resident #6 and his spouse had told Physician #8 daily dressing changes she had ordered were not being completed at the skilled nursing facility. She assessed the wounds as worsening and based on the worsening of the wounds, she thought dressing changes were not being completed daily as ordered. The physician confirmed Resident #6 had arterial disease and poor arterial blood flow which hindered healing. Resident #6 was feeling very sick and weak, she felt from the abscess, and she sent the resident to the ED for surgical intervention. During an interview with RN #2 on 04/10/25 at 8:46 AM, RN #2 stated when residents went to an outside facility for consults or appointments, they took a green consultation sheet with them that the provider would write any notes or orders on, and that sheet was returned with the resident and the transporter. The nurse receiving the copy had to sign the green sheet and date and time it. The transporter then kept a copy verifying it was given to nursing, and another copy was kept by nursing for upload to the electronic record. RN #2 stated RN #3, who was a wound care nurse, was responsible for transcribing all wound care orders. Interview with Social Worker (SW) #5 on 04/10/25 at 9:45 AM, revealed Resident #6's wife had called her 03/28/25 stating the resident's wound care and dressing changes were supposed to be done daily and asking if it was being done daily. SW #5 spoke with RN #3, who reviewed the last orders from the podiatry/wound clinic and confirmed that the orders were for daily dressing changes and the resident was not receiving daily dressing changes. The orders were corrected at that time. During an interview with RN #3, the wound care nurse, on 04/10/25 at 12:35 PM, RN #3 confirmed she was responsible for transcribing the orders to the resident's TAR and ensuring they were implemented. RN #3 stated Resident #6 had severe peripheral artery disease and was admitted with the wounds to both his feet. The resident was sent out for a vascular procedure to try to improve blood flow because wound healing was hindered by the poor blood flow. RN #3 stated the resident's wounds had been deteriorating and the poor blood flow contributed to the deterioration. The wife then contacted SW #5 prior to the vascular procedure (03/28/25) with concerns about the dressing changes not being done daily. RN #3 pulled the previous consult and discovered the facility orders had not been correctly changed to daily dressing changes, as ordered. The resident was instead received dressing changes on Monday, Wednesday, and Friday. The orders were incorrect for approximately one (1) week. During an interview with the DON on 04/10/25 at 2:30 PM, the DON confirmed the day the error in the dressing change orders was brought to the facility's attention, they reviewed the orders, called the podiatry clinic to review the orders, and the dressing changes were updated the same day to reflect the correct orders. During an interview with the resident's physician in the facility, Physician #7, who was also the Medical Director, on 04/10/25 at 3:25 PM, Physician #7 stated Resident #6 had some of the worse vascular disease she had seen. The hope was vascular physicians would be able to restore some blood flow to improve wound healing. Physician #7 was made aware Resident #6 received the incorrect dressing changes for approximately one week in March. Interview with the Facility Administrator for the dialysis center on 04/11/25 at 9:03 AM, revealed Resident #6 received dialysis on 03/31/25, the day before being sent out to the hospital. The resident had no changes from his baseline and received dialysis without incident or concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345475	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tsali Care Center	267 Tsali Care Way Cherokee, NC 28719

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Wound Care and Dressing Changes - Clinical Protocol Policy effective 11/25/24 revealed, .Provider's orders must be reviewed and followed prior to providing wound care .

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F 0689 Level of Harm - Actual harm 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 interviews, record review, and review of facility documents, the facility failed to ensure one (1) of three (3) residents (Resident #1) was safely transferred from the facility van. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Complete Traumatic Amputation to Left Lower Leg and Type 1 Diabetes Mellitus. He was cognitively intact. During an interview on 4/8/25 at 9:00 AM, Resident #1 stated on 12/27/24 he was returning to the facility from an appointment in Asheville for suture removal to his stump (amputated leg). He arrived back to the facility via Tsali's van with facility's staff driver #1. While she was getting him out of the van, and on the ramp down, I slid out of the chair and landed on my stump. This was the leg that just had sutures removed. He stated van driver #1 explained to him the reason he came out of the chair was due to the cushion not being properly secured to his wheelchair. He stated the accident caused him to have to be sent via ambulance to the hospital for staples to his stump. During an interview on 4/10/25 at 1:27 PM, the Assistant Administrator (AA) and the Director of Nursing (DON) stated they both responded to the scene when van driver #1 came into the building requesting help stating Resident #1 had slid from his wheelchair. The DON stated she arrived and observed the wheelchair's back wheels had crossed the threshold of the ramp and had begun the decent down the ramp. The front wheels had not yet crossed the threshold and remained in the van. The resident was sitting on the floor of the van in front of the wheelchair. She stated she performed an assessment and during this time the resident told her that as the chair began being brought down the ramp by van driver #1, he leaned forward with his arms at the front of wheelchair arms. When he did this, he slid from the chair and landed on the floor. The cushion in the chair had slid from the chair with the resident. Both the AA and the DON agreed the cushion was not properly secured to the wheelchair. She stated an ambulance was called and the resident was transported to the hospital and required staples to his stump. During an interview on 4/10/25 at 3:00 PM, Occupational Therapy Assistant (OTA) #1 stated Resident #1 was provided a cushion to his wheelchair by the facility's therapy department. She stated this was to help prevent skin breakdown and sores for people that sit up in the chair for long periods. The cushion covered the entire wheelchair seat and was secured with a buckle clip at the back of the wheelchair. She stated the cushion should always be clipped while in a chair. The cushion can be slick if not secured. If someone is trying to get up with their arms at the front of the chair and leaning forward, it could cause the cushion to slide out from under the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/10/25 at 5:06 PM, van driver #1 stated she had transported Resident #1 to a physician appointment for suture removal to his recently amputated leg. Upon return to the facility, she began removing the resident in his wheelchair from the facility's transport van down the ramp. As the back tires began coming down the ramp, the resident leaned forward grabbing onto the drink holders in the van. When he did this, he slid out of the chair. She stated the resident landed on his stump and ended up sitting in front of the chair. The cushion slid out from under him and ended up behind his back. She confirmed the cushion was not securely clipped to the chair. She stated she then went into the building and requested help. Review of a facility progress note dated 12/27/24 written by Licensed Practical Nurse (LPN) #2 read, Called to go downstairs at entrance to care center to assist with resident who slid out of wheelchair while being assisted out of transport van. Resident was sitting on the van floor with wheelchair behind him. Resident reports pain at a 10-12 for left lower leg, stump area, and lower back. EMS contacted to assist with transferring resident off of the floor of van onto the wheelchair or stretcher. Resident is requesting transport to the ER for evaluation. Review of a facility progress note dated 12/27/24 written by LPN #2 read, Resident returned to facility via [NAME] [Cherokee Indian Hospital Authority] EMS [Emergency Medical Services] .Resident has diagnosis of dehiscence of external surgical wound . Review of the emergency room Discharge Progress Notes dated 12/27/24 read, My Diagnosis today was: 1) Fall from wheelchair .2) Dehiscence of external surgical incision wound - Left BKA [Below Knee Amputation] stump with dehiscence of wound on ground impact . Review of the facility document entitled Tsali Care Center Plan of Correction Event: Fall from Wheelchair dated 12/27/24 read, 2 .b. Consideration of cause for event: The transportation specialist and Director of Nursing noted the wheelchair seat cushion strap was not completely 'buckled,' allowing the cushion to slid from secure position in wheelchair seat .c. The seat cushion was able to move from its position due to smooth surfaces of cushion and wheelchair seat. Review of instructions for Permobil Kwik Strap provided by OTA #1 dated 10/29/21 read, 3 Connect the buckle, and pull the strap tight. 4 Confirm the correct position of the cushion in the wheelchair, and adjust KWIK STRAP if needed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, interview, and review of the facility policy titled General Guidelines for Medication Administration Policy, the facility failed to ensure a resident received three (3) doses of an ordered medication that was required to prevent an allergic reaction during a procedure for one (1) resident of 10 residents reviewed (Resident #6). The finding included: Resident #6 was admitted to the facility 01/08/25 with diagnoses that included: heart failure, peripheral vascular disease, type 2 diabetes mellitus, and end stage renal disease. Review of the electronic health record revealed Resident #6 was allergic to iodine, iodine containing products, and Conray (radiopaque contrast dye used in radiographic procedures). The resident had moderate cognitive impairment. Review of a Nurses Note for Resident #6 dated 03/26/25 at 10:22 PM, written by Registered Nurse (RN) #2 revealed, .Received call from [Vascular physician office] regarding an appointment on 3/30/25. Pre op instructions faxed over to writer, emailed to ADON [Assistant Director of Nursing] and to transport. Instructions given to oncoming nurse to transcribe. MAR [Medication Administration Record] faxed over to vascular at .Patient will have angiogram on March 30th which is on a Sunday. Oncoming nurse made aware of appointment . Review of a pre-procedure checklist with a faxed stamp date of 03/27/25 at 11:10:55 revealed Resident #6 was scheduled for an angiogram to the left lower extremity on 03/30/25. The orders directed that if the resident was allergic to contrast dye, the facility was to pre-medicate the resident with three (3) doses of prednisone 50 milligrams (mg), at midnight before the procedure, at 6:00 AM the day of the procedure, and at 12:00 PM the day of the procedure. Review of verbal physician orders written by Licensed Practical Nurse (LPN) #4 on 03/26/25 and signed by Nurse Practitioner (NP) #9 on 03/28/25, revealed all the preprocedural orders for Resident #6 were transcribed from the pre-procedure checklist except the order for the three (3) doses of prednisone. Review of the March 2025 MAR for Resident #6 revealed the three (3) doses of prednisone had not been transcribed to the MAR and there was no documentation that Resident #6 received any doses of prednisone on 03/29 or 03/30/25. Review of a Nurses Note dated 03/30/25 at 3:22 PM revealed, .Resident [#6] wife called the facility asking if resident received his preprocedural dose of prednisone. I advised [Resident #6's wife] there was no order in the system for prednisone. [Resident's wife] was very upset. Resident unable to have procedure because allergy to iodine. Review of a Nurses Note dated 03/30/25 at 6:36 PM revealed, .Resident [#6] returned to facility via stretcher . Resident has [had] procedure completed today and the paperwork stated it was successful. Resident sitting in dining room in wheelchair eating dinner. Resident alert oriented denies pain at this time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN #2 on 04/10/25 at 8:46 AM, RN #2 stated the nurse who cared for the resident was responsible for making sure any preoperative orders were transcribed correctly and faxed to the pharmacy. RN #2 stated she received Resident #6's preoperative orders for the angiogram and LPN #4 had agreed to transcribe the orders to the MAR because LPN #4 stated she was a pro on transcribing orders. RN #2 was not aware the prednisone had not been placed on the MAR and Resident #6 did not receive the medication as ordered prior to his procedure. Interview with the Director of Nursing on 04/10/25 at 11:04 AM confirmed Resident #6 had not received the three (3) doses of prednisone as ordered. Review of the facility policy titled General Guidelines for Medication Administration Policy effective 03/04/25 revealed, .Medications are administered as prescribed in a safe and timely manner in accordance with good nursing principles and practices .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility policy entitled Cleaning and Disinfection Policies and Practices Policy, the facility failed to ensure a blood glucose monitor was properly cleaned and disinfected for one (1) of one (1) resident (Resident #2) observed after a blood glucose monitoring. The findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus. He was moderately cognitively impaired. During an observation and simultaneous interview on 4/8/25 at 8:54 AM, Registered Nurse (RN) #1 was observed exiting room [ROOM NUMBER] and returning to an insulin cart with a glucometer. She wiped the glucometer with an Oxivir TB wipe for five (5) seconds and then immediately placed the glucometer inside the cart into a plastic cup. She stated the proper amount of time to clean and disinfect the glucometer was one (1) minute. She confirmed she had not cleaned and disinfected the glucometer for the full one (1) minute wet/contact time. During an interview on 4/10/25 at 1:27 PM, the Director of Nursing (DON) stated her expectation was the glucometer should be cleaned and disinfected with a one-minute wet time, then air dry in a cup, and then after air drying placed in another cup and then placed in the drawer of the insulin cart. The Oxivir TB Wipes container read: Cleaner/Disinfectant .All surfaces must remain visibly wet for 1 minute . Allow to air dry . Review of the facility policy entitled Cleaning and Disinfection Policies and Practices Policy dated 12/3/24 read, Reusable items are cleaned and disinfected between residents (e.g., stethoscopes and durable medical equipment). Items that are used by a single resident are cleaned/disinfected between uses .