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	08/01/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on document review, interview, record review, and policy review, the facility's Administrator and Director of Nursing (DON) failed to identify there was no physician order in the electronic medical record (EMR) orders to correctly identify all residents' code status, and failed to provide oversight of staff's audits of residents' EMR Code Status to ensure the audits were accurate and to make corrections to ensure sustained compliance with the citation which had the potential to affect 72 of 72 residents who resided in the facility. The findings include: During an interview on 11/14/25 at 5:28 PM, the Administrator could not provide audit tools related to the monitoring of code status in resident records. The Administrator stated, The Director of Admissions and Marketing is not in the facility and has the audit tools on her computer. She would need to come into the facility to forward the audit tools electronically. On 11/14/25 at 7:30 PM, the Administrator provided a copy of the audit tool for monitoring code status. The Administrator stated the audit tool was completed by Medical Records staff and Admissions staff. Review of the audit tool revealed the new admissions were reviewed for Advance Directives and requested code status on the clinical consent form. The audit tool did not include that orders were received for Do Not Resuscitate (DNR) wishes for Resident #110 or that code status was updated and correct in the EMR for both Resident #109 and Resident #110. During a follow up interview on 11/14/25 at 8:00 PM, the audit tool was reviewed with Administrator again. The Administrator stated she did not think the audit tool used had included the necessary information to ensure compliance. The Administrator indicated she had not previously reviewed the audit tool and had just received a copy of it. The Administrator, who should have reviewed the audit tool as part of the facility's Quality Assurance Process, had not even reviewed the tool for accuracy prior to beginning the improvement plan. During an interview on 11/15/25 at 2:58 PM, the Administrator stated that she reviewed all of the audits in the plan of correction (POC) that were conducted after the recertification survey dated 08/01/25. The Administrator confirmed she had not conducted any oversight of the audit to determine whether the audits were accurate or if the audits captured what was necessary to ensure compliance. The Administrator further stated, I reviewed all of the audits. I did not see anything that stood out as deficient. I did not audit the audits. That was a missed opportunity. I agree that audit tool did not include information regarding code status entered into the electronic medical record. The Director of Admissions was responsible for new admissions, and the Social Workers were responsible for [code status] changes when residents are admitted . Ultimately, I am responsible for oversight for each audit after the department director. The DON is more responsible for oversight involving clinical care. During an interview on 11/16/25 at 11:10 AM, Medical Records (MR) stated, I completed the audit for Advance Directives/Code status. Once a month I look at everyone's admission clinical consent form for Advance Directives and requested code status and MOST [Medical Orders for Scope of Treatment] form. I look in the EMR for clinical agreement and that documents have been uploaded. I did not verify that code status was ordered or included on the profile screen. My understanding of my audit responsibilities were to check for advance directive to be uploaded, code status requested on clinical consent, and if they have a MOST form. Review of the Administrator's job description dated 10/21 indicated, .the primary function of this position is responsible for the daily operation.maintaining the highest standard of quality services (continued on next page)

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in compliance with federal.regulations that govern nursing facilities.As Administrator.will delegate as necessary to the administrative authority, responsibility, and accountability for carrying out assigned duties. Job Description Coordinate the provision of services to residents to assure that provisions of care are appropriate to resident's needs. Plan, develop, organizes, implements, evaluates and direct the facility's programs and activities in accordance with guidelines issued by the governing board.Keeps up to date on CMS [Centers for Medicare & Medicaid Services] regulations.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, interviews, record review, and review of the facility's policy titled Quality Assessment and Assurance Committee, the facility Quality Assurance and Performance Improvement (QAPI) committee failed to 1. ensure the QAPI committee policy addressed data collection and analysis, data and adverse event monitoring, and feedback; 2. track and analyze data and conduct at least one process improvement plan (PIP) this year; and 3. maintain implemented procedures and monitor interventions that the committee put into place following the recertification survey of 08/22/24 and the complaint surveys on 10/18/24 and 04/10/25. This was for deficiencies re-cited during the recertification and complaint survey conducted 07/28/25-08/01/25. The recited deficiencies included F 550, F 578, F645, F689, F698, and F761. The continued failure of the facility during three (3) Federal Jurisdictional surveys indicates a pattern of the facility to sustain an effective QAPI program. This was for six (6) of 25 deficient practice citations.The findings include:1.Review of the facility's policy titled Quality Assessment and Assurance Committee, revised 07/23/25, did not address data collection and analysis, data and adverse event monitoring, and feedback.During an interview with the Administrator on 08/01/25 at 11:58 AM, she confirmed that data collection and analysis, data and adverse event monitoring, and feedback information was not in the policy. She stated that the QAPI policy was recently revised and that information was left out.2. During an interview with the Administrator, Director of Nursing (DON), Infection Preventionist (IP), and Medical Records Director on 08/01/25 at 12:05 PM, she stated that the facility did not do any PIPs this year. The facility's management team discussed concerns during the QAPI meetings and the cross-functional Monday meetings, but no formal PIP was started. She stated that she had no documentation supporting the tracking and analyzing of data for a PIP. The Administrator further stated that the facility had identified that this was an opportunity to improve the QAPI process. 3. During the complaint survey on 10/18/24 the facility was cited F 698. During the complaint survey on 04/10/25 the facility was cited harm at F 689. During the recertification and complaint survey on 07/28/25-08/01/25 the facility was cited F 550, F 578, F 645, and F761.During an interview with the Administrator on 08/01/25 at 12:05 PM, she stated that for the repeated deficient citations, the staff was provided with education. She confirmed that for F 578, there was a change in the Advance Directive form, but currently there was no monitoring or auditing on the repeat deficiencies nor policy changes.Review of the facility policy titled Quality Assessment and Assurance Committee, revised 07/23/25, read .Committee Audit Process.3. The Quality Assessment and Assurance Committee shall help various departments/ committees/disciplines/individuals develop and implement plans of correction and monitoring approaches. 4. The committee shall track the progress of any active plans of correction. 5. The committee shall advise the administration of the need for policy or procedural changes and, as appropriate, monitor to ensure that such changes are implemented.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility policy titled Administrative-Residents Rights for Senior Service, the facility failed to ensure residents were informed of the risks of treatment of prescribed medications for four (4) of five (5) residents sampled for unnecessary medications (Resident #'s 1,4, 7 and 8). The findings include: 1.Resident #7 was admitted to the facility 06/26/25 with diagnoses that included Parkinsonism, type 2 diabetes, insomnia, benign prostatic hyperplasia, and heart failure. The resident had moderate cognitive impairment. Review of physicians orders revealed Resident #7 was receiving quetiapine (an antipsychotic) 25 milligrams (mg) as needed for agitation every afternoon/evening; empagliflozin (for diabetes) 10 mg once a day; paroxetine (antidepressant) 10 mg once a day; insulin in the morning and at bedtime; sitagliptin (for diabetes) 100 mg every morning; acetaminophen (pain reliever) 500 mg twice a day; carbidopa-levodopa (for Parkinson's disease) 25-100 mg three times a day; MiraLAX (laxative) 17 grams every morning; tamsulosin (for benign prostatic hyperplasia) 0.4 mg every night; metoprolol (for blood pressure) 25 mg half a tablet twice a day; losartan potassium (for blood pressure) 50 mg once a day; isosorbide mononitrate (for coronary artery disease) 30 mg every morning; furosemide (diuretic) 40 mg every day; and atorvastatin calcium (for cholesterol) 80 mg every day. Review of the medical record revealed no documentation Resident #7 or the resident's representative had been provided information in advance of the risks and benefits of the prescribed medications, the treatment alternatives or other options, and consented to the medications. During an interview with the Director of Nursing (DON) on 08/01/25 at 11:04 AM, she confirmed that the facility did not have documentation Resident #7 or the resident's representative had consented to the prescribed medications. 2. Resident#1 was admitted to the facility on [DATE] with diagnoses that included heart failure, depression, type 2 diabetes, anxiety, and unspecified psychosis. The resident had mild cognitive impairment. Review of the physicians orders revealed Resident #1 received Fluoxetine HCL 40 mg capsule once a day(for major depressive disorder) , hydroxyzine HCL 25 mg tablet once a day(for anxiety); Olanzapine 5 mg tablet at bedtime (for psychosis),trazodone HCL 25 mg at bedtime (for insomnia), Propranolol HCL 20 mg as needed for (for panic); Lantus Solostar 16 units at bedtime (for Diabetes). Review of the medical record revealed no documentation that Resident # 1or the resident's representative had been provided information in advance of the risks and benefits of the prescribed medications, the treatment alternatives, or other options, and consented to the medications. 3.Resident #4 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure, unspecified psychosis, manic episode, and type 2 diabetes. The resident was cognitively intact. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physicians' orders revealed Resident #4 received quetiapine now discontinued (an antipsychotic); Ozempic 1 mg Subcutaneous twice a day (for diabetes); Lantus Solostar 72 units Subcutaneous Solution Pen -injector twice a day (for diabetes); Eliquis Oral Tablet 5 mg twice a day (anticoagulant), Hydrocodone-Acetaminophen 1 tablet as needed (pain); NovoLog Flex Pen 29 units subcutaneous with meals (for diabetes), Gabapentin 1tablet twice a day (for neuropathy), Jardiance 25 mg tablet once a day (for diabetes). Review of the medical record revealed no documentation that Resident # #4 or the resident's representative had been provided information in advance of the risks and benefits of the prescribed medications, the treatment alternatives, or other options, and consented to the medications. 4.Resident #8 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type; post-traumatic stress disorder; depression; bipolar disorder and type 2 diabetes. The resident was cognitively intact. Review of the physicians' orders revealed Resident #8 received Gabapentin 300 mg three times a day; Ozempic Subcutaneous Solution Pen -injector 0.5 mg once a day every Wednesday (for diabetes), Risperidone 3 mg tablet at bedtime (for mood) ; Duloxetine HCL Capsule Delayed release Sprinkle 60 mg once a day (for pain). Review of the medical record revealed no documentation that Resident #8 or the resident's representative had been provided information in advance of the risks and benefits of the prescribed medications, the treatment alternatives, or other options, and consented to the medications. During an interview with the DON on 08/01/25 at 11:04 AM, she confirmed the facility did not have documentation for Residents' # 1,4, and 8 or that the resident's representative had consented to the prescribed medications. Review of the facility policy titled (Facility Name) Administrative-Residents Rights for Senior Service dated 10/30/24 read . Policy .Implementation.F552 (5.) The resident has the right to be informed of and participate in their treatment, including: (c) The right to be informed in advance of risks and benefits of proposed care, of treatment alternatives, and the right to choose the option they prefer.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and the facility's Medication Self-Administration and Storage policy, the facility staff failed to assess residents for safe self-administration and storage of medications/biologicals, i.e., medicated cough drops, Zinc Oxide topical ointment, Anesep antimicrobial skin wound cleanser, and Betadine Gluconate 4% Solution Antiseptic Surgical Scrub, left unsecured at the bedside for four (4) of 23 sampled residents (Resident #s 17, 18, 21, and 45). The findings include: 1. Resident #17 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, unspecified sequelae of cerebral infarction, and potential/impaired skin integrity. On 07/29/25 at 4:30 PM and 07/30/25 at 11:00 AM, and 07/31/25 at 11:30 AM, an open four-ounce tube of Zinc Oxide topical ointment was observed on top of the resident's bedside table. Review of medical records revealed no evidence of an interdisciplinary team (IDT) assessment of the resident's ability to safely self-administer or store medications/biologicals at the bedside. Further reviews of medical records revealed no physician's order for residents to self-administer or store medications/biological at the bedside. On 07/31/25 at 10:05 AM, the Registered/Wound Care Nurse (RN) #1 confirmed the Zinc Oxide topical ointment was left at the bedside for the Certified Nurse Aides (CNA) to apply during personal care. RN #2 further verified Resident #17 have not been assessed for safe self-administration and/or storage of medication/biologicals at the bedside. She stated, It should not have been left in the room or should have been placed inside a drawer. 2. Resident #18 was admitted to the facility on [DATE] with diagnoses that included encephalopathy, type 2 diabetes mellitus, vascular dementia without behavioral, peripheral vascular disease and glaucoma. During observations on 07/29/25 at 4:30 PM and 07/30/25 at 11:00 AM, and 07/31/25 at 11:30 AM, an open eight-ounce spray bottle of Anesep Antimicrobial Skin and Wound Cleanser—Hospital & Professional Use—was observed on the resident's bedside table. On 07/31/25 at 10:05 AM, RN #1 confirmed the Anesep spray bottle should not have been left in the resident's room. RN #2 stated, Resident #18 had not been assessed for self-administration or safe storage of medications/biologicals at the bedside. It should not have been left there. 3. Resident #45 was admitted to the facility on [DATE] with diagnoses that included non-pressure chronic ulcer of left foot, viral intestinal infection and end stage renal disease with hemodialysis. During an observation on 07/29/25 at 11:17 AM, an open and partially used four-ounce bottle of Betadine Gluconate 4% Solution Antiseptic Surgical Scrub, with a partially intact prescription label, was on Resident #45 over bed table. Review of the medical records revealed no physician's order for the betadine solution to be self-applied or stored at the bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/31/25 at 9:36 AM, Licensed Practical Nurse (LPN) #2 verified Resident #45 was transported to the hospital earlier for a scheduled procedure, where the betadine solution was used as a pre-surgical skin prep. On 07/31/25 at 10:05 AM, RN #1 confirmed the prescription betadine scrub solution may have been used to prep the resident before her procedure. She stated that the resident would not have been assessed for self-administration or safe storage at the bedside for the betadine solution because it was a one-time only treatment prior to the procedure. RN #1 stated, The betadine solution should not have been left in the resident's room; it should have been immediately disposed of. Review of the facility's Self-Administration of Medication policy, revised 09/21/19 revealed, .Bedside medication storage is permitted only when it does not present a risk to other residents. the facility will obtain an order to effect may keep at bedside . Medications stored at bedside shall be secure from other residents. are kept in the containers dispensed by the provider pharmacy. 4. Resident #21 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF) and dysphagia. Review of Resident #21's Minimum Data Set (MDS) dated [DATE] revealed the resident was moderately cognitively impaired. On 07/29/25 at 11:22 AM, an observation and interview were conducted with Resident #21. During the observation, three (3) bags of cough drops were on the bedside dresser. Resident #21 stated the cough drops had been there for a few weeks and that she self-administered the cough drops several times throughout the day. Resident #21 stated that she had not been assessed to take medication, she had not informed the nursing staff, and that she would like to keep the cough drops at the bedside. Photographic evidence obtained. On 07/30/25 at 1:41 PM, an observation and interview was conducted with RN#2. Three (3) bags of cough drops were on the bedside dresser. RN #2 stated that she did not notice the cough drops at the resident's bedside previously. RN #2 stated that residents were required to have a self-administration medication assessment to ensure the residents can safely self-administer medications and a doctor's order to self-administer medications. RN #2 confirmed that neither of those requirements for self-administration of medication were done for Resident #21. During an interview on 07/31/25 at 8:45 AM with the Director of Nursing (DON), she confirmed that the resident was not assessed to self-administer medications. The expectation was that the resident had an assessment to determine if she was appropriate to self-administer medications and had a physician's order. Review of the facility's Self Administration of Medication policy, revised 09/21/19 read, . A. Residents who request approval to self-administer shall be assessed by the interdisciplinary team to determine if the resident is competent. B. The interdisciplinary team will assess the resident's cognitive physical and visual ability to carry out this responsibility by reviewing the six areas on the Assessment for Self Administration of Medication . If the team determines that the resident is competent, the attending physician shall be contacted to request a specific order for self administration of the medication. C. If the resident demonstrates the ability to self administer medications, a further assessment of the safety of the bedside medication storage shall be done .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy titled Advance Directives Policy, the facility failed to ensure appropriate Advance Directives were readily available in resident records or appropriate Advance Directives were in place for six (6) of 23 residents (Resident #'s 16, 17, 27, 34, 51, and 66) reviewed for Advance Directives. The findings include: 1.Resident #16 was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus and encephalopathy She was moderately cognitively impaired. Review of Resident #16's medical record revealed an Advance Directive and Code Status Acknowledgment of Receipt form with the box checked I have chosen to formulate and issue Advance Directives. The form also indicated a Guardianship Letter. There were no Advance Directives or Guardianship Letter readily available in her medical record. 2. Resident #17 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, and heart failure She was cognitively intact. Review of Resident #17's medical record revealed an Advance Directive and Code Status Acknowledgment of Receipt form with the box checked I have chosen to formulate and issue Advance Directives. I will provide (Facility Name) with a copy of my Advance Directives There was no copy of her Advance Directives readily available in her medical record. 3. Resident #34 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, and degenerative disease of nervous system. She was cognitively impaired. Review of Resident #34's medical record revealed an Advance Directive and Code Status Acknowledgment of Receipt form with the box checked I have chosen to formulate and issue Advance Directives. There was no copy of her Advance Directives readily available in her medical record. 4. Resident #51 was admitted to the facility on [DATE] with diagnoses that included dementia and hallucinations. She was cognitively impaired. Review of Resident #51's medical record revealed an Advance Directive and Code Status Acknowledgment of Receipt form with the box checked I have chosen to formulate and issue Advance Directives. There was no copy of her Advance Directives readily available in her medical record. 5. Resident #66 was admitted to the facility on [DATE] with diagnoses that included: major depressive disorder and type 2 diabetes mellitus. She was cognitively intact. Review of Resident #66's medical record revealed an Advance Directive and Code Status Acknowledgment of Receipt form with the box checked I have chosen to formulate and issue Advance Directives. I will provide (Facility Name) with a copy of my Advance Directives There was no copy of her Advance Directives readily available in her medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:14 AM, the Director of Social Services (DSS) stated admissions took care of advance directives. Social Services was responsible for the follow up for any changes. During an interview on [DATE] at 11:03 AM, the Director of admission and Marketing confirmed the appropriate advance directives were not included in resident records for Resident #'s 16, 17, 27, 34, 51 and 66. She stated she had been in touch with Resident #66's daughter and after an investigation, discovered the resident did not, in fact, have an Advance Directive in place. Review of the facility's policy titled Advance Directives Policy, undated read, .Procedure .5. Documentation will be made in the medial record whether or not the resident has executed advance directives. If a resident or resident's responsible party indicated that the resident has executed an advance directive, facility staff will request that a copy of the advance directives be provided to the facility for inclusion in the resident's medical record as soon as possible. (Facility Name) will not honor a written advance directive unless and until a copy thereof is provided to the facility . 6. Resident #27 was admitted to the facility [DATE] with diagnoses including type 2 diabetes, major depressive disorder, anxiety disorder, and adjustment disorder with depressed mood. The resident was cognitively intact. Record review of a Medical Orders for Scope of Treatment (MOST) form dated [DATE] and signed by Resident #27 revealed Resident #27 chose Do Not Attempt Resuscitation (DNR) if the resident was found with no pulse and was not breathing. Record review of the Clinical Care Agreement signed by Resident #27 [DATE] revealed I hereby direct that in the event of my.cardiac and/or respiratory arrest, efforts at CPR (cardiopulmonary resuscitation) SHOULD NOT be initiated. Record review of a physician's order dated [DATE] revealed a DNR order for Resident #27. Record review of the monthly physician order sheet signed by the Nurse Practitioner [DATE] revealed the order sheet documented Full Code with a start date of [DATE]. Review of the record revealed no documentation supporting the resident had chosen Full Code status and no verbal or written order for Full Code. Review of the banner in the electronic medical record that indicated a resident's code status revealed Resident #27 was a full code. During an interview on [DATE] at 4:01 PM, Resident #27 stated, If it's my time to go, I want them to just let me go. The resident did not want CPR. During an interview on [DATE] at 4:18 PM, Licensed Practical Nurse (LPN) #5 reviewed Resident #27's medical record and said the nursing staff identified the code status of a resident by looking at the banner in the electronic medical record. LPN #5 stated Resident #27 was a Full Code. During an interview on [DATE] at 12:29 PM, Social Worker (SW) #1 stated she was not aware Resident #27 needed a DNR form prepared and placed in the medical record. SW #1 reviewed the medical record and confirmed that the medical record documentation of Full Code did not match Resident #27's wishes to be a DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Advance Directives Policy, undated read, 12. The IDT, Charge Nurse, or designee will notify the Provider of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. Neither the facility nor its staff will make any decision, even if requested by the resident or the resident's legal responsible party that a particular treatment or procedure be provided, withheld, or withdrawn without an order from the resident's provider.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policy titled Resident Rights for Senior Services Policy, the facility failed to provide privacy for one (1) of 25 resident residents (Resident #51) during a temperature monitoring. The facility also failed to ensure staff did not leave resident protected health information (PHI) unattended, uncovered and visible on top of the [NAME] neighborhood's diabetic treatment cart for 13 of 23 sampled residents (Residents #s 1, 8, 10, 15, 18, 23, 24, 32, 44, 45, 58, 61, and 71). The findings include: 1.During an observation on 07/28/25 at 4:36 PM, a clip board with a Vital Signs Chart attached, dated July 28, 2025, was observed atop of the diabetic treatment cart, which sat on the north wall inside the [NAME] neighborhood's resident day room. The vital signs sheet contained the blood pressure, temperature, pulse, respiration, and/or pulse oximetry results for Resident #s 15, 44, 58 and 71. Additionally, an 8 x 11-inch sheet of blue/white paper with the heading . HAVE THEM READY BY THIS TIME!! WEEK OF 07/28/25-08/01/25 was also observed atop of the diabetic treatment cart and revealed the full name and clinical appointment details for Resident #s 1, 8, 10, 18, 23, 24, 32, 45, and 61. The documents were uncovered and highly visible to passersby and the public. On 07/28/25 at 4:50 PM, Licensed Practice Nurse (LPN) #1 returned to the day room and performed various tasks on top of and the uncovered clip board and clinical appointment sheet for 3-5 minutes but did not attempt to cover or hide the visible PHI. During an interview on 07/30/25 at 1:30 PM, LPN #1 confirmed that the vital sign sheet and resident appointment schedule were visible on top of the cart and should have been turned over or covered. During an interview on 07/31/25 at 10:03 AM, the Director of Nursing (DON) and the Registered Nurse Manager (RNM) #3 stated that staff were expected to protect the resident's health and personal identifying information. The DON stated, The vital sign sheets should have been covered and not left out on the cart. Review of the facility's Resident Rights for Seniors policy, revised 10/30/24 read, The resident has the right to personal privacy and confidentiality of their personal and medical records . The facility must keep confidential all information contained in the resident's records. 2. Resident #51 was admitted to the facility on [DATE] with diagnoses that included dementia and abnormalities of gait and mobility. During an observation on 07/29/25 at 3:58 PM, Certified Nurse Aide (CNA) #7 was observed taking an oral temperature for Resident #51 in the common area. There were nine (9) other residents present at the time. During an interview on 07/29/25 at 4:15 PM, CNA #7 confirmed she performed an oral temperature check for Resident #51 in the common area. During an interview on 07/30/25 at 3:46 PM , RN #4 stated I've never know vital signs couldn't be done in the common areas. During an interview on 07/31/25 at 3:43 PM, CNA #11 stated Over the years, times have changed and (continued on next page)

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	345475	A. Building B. Wing	08/01/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vital signs can be taken in front of other residents as long as the screen isn't visible to others. During an interview on 07/31/25 at 4:33 PM, the DON confirmed it was her expectation that privacy be provided when care was provided. She further confirmed this included vital sign monitoring. Review of the facility's policy titled Resident Rights for Senior Services Policy, revised 10/30/24 read, 34 .Personal privacy includes accommodations, medical treatment .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on record review, interview, and review of the facility's policy titled Complaints and Grievances Policy, the facility failed to resolve a grievance timely for one (1) resident of 23 sampled residents (Resident #66). The findings include:Resident #66 was admitted to the facility 11/14/24 with diagnoses that included unspecified atrial fibrillation, cerebrovascular disease, and moderate persistent asthma. The resident was cognitively intact.During an interview on 07/29/25 at 11:42 AM, Resident #66 stated approximately two and a half (2 1/2) weeks ago she woke up and there were ants all over her bed. The Certified Nurse Aide (CNA) and the housekeeper tried to get all the ants up, but they were in the mattress. Resident #66 stated she continued to see ants for seven (7) days. Resident #66 stated she slept on that same mattress with the ants during that week. The facility would not change the mattress.During an interview on 07/31/25 at 9:56 AM, Housekeeper #1 stated about a week or two ago, the housekeeper saw ants in the room of Resident #66. Housekeeper #1 saw a trail of ants by the bathroom door area going across the room. They were the little black ants. The room was cleaned, the linens were changed, and later the mattress was changed out. The housekeeper stated there were ants on the resident's mattress.During an interview on 07/31/25 at 10:14 AM, Licensed Practical Nurse (LPN) #2 confirmed staff were aware that ants had been found in Resident #66's room. LPN #2 stated it occurred about a week ago and the room was deep cleaned. During an interview on 07/31/25 at 10:23 AM, CNA #12 stated there were ants in Resident #66's room. The ants were getting on the resident's mattress and staff wiped off the mattress and cleaned it, but the ants came back. CNA #12 stated the facility took the mattress out and wiped it down and brought it back.During a telephone interview with Resident #66's daughter on 07/31/25 at 11:36 AM, the daughter stated Resident #66 called the daughter on 07/17/25 and reported there were ants in the resident's room. The daughter talked to Resident #66 again on 07/24/25 and Resident #66 stated the ants were still in her room, in her bed, and they were biting her. The daughter called the hospital associated with the nursing facility and talked with two (2) administrative personnel who told her to file a complaint, and they would give it to the nursing home Administrator. The nursing home Administrator called the daughter on 07/24/25 at 8:30 PM. The daughter told the Administrator that the situation with the ants had gone on too long and something needed to be done immediately; it had been going on for seven (7) days. Resident #66 just wanted the bed to be changed out and maintenance had stated they could not change the bed because they left at 4:30 PM. The daughter stated within two (2) hours of her telephone conversation with the Administrator, the bed was replaced.During an interview on 07/31/25 at 3:00 PM, Registered Nurse (RN) #1 stated that Resident #66 reported that there were ants in the room. RN #1 did not see the ants but confirmed that it was discussed in a morning Interdisciplinary Team Meeting (IDT) and the plan was to bring in pest control, clean the room, and the resident was offered another room, which the resident refused. The ants were reported on 07/17/25. RN #1 stated that a CNA had seen ants in Resident #66's room.During a follow-up interview on 07/31/25 at 4:07 PM, Resident #66 stated that all she had wanted was to resolve her concerns and get the ants out of her room. Resident #66 stated the facility washed her sheets and blankets and cleaned her room, but they did not replace the mattress until 07/24/25. She was initially told the mattress could not be replaced because she had a specialty mattress and they did not have another one. During an interview on 08/01/25 at 10:26 AM, the Administrator stated the first time she was made aware of any issues with ants in Resident #66's room was when the resident's daughter called her. She stated there was no problem with changing the mattress out and she had a new bed and mattress moved in right after she got off the phone with the daughter. The Administrator did not know who Resident #66 initially talked to and requested the mattress be changed, but the mattress could have been changed immediately.Review of the facility's policy titled Complaints and Grievances Policy, effective 11/12/24 read (Facility Name) will make every effort to (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resolve grievances the resident may have in a timely manner. Complaints or grievances may be filed orally (spoken word) or in writing to any (Facility Name) team member. Complaints will be addressed immediately by (Facility Name) team members. If unable to resolve immediately, a grievance will be formulated, reviewed, and addressed within seven (7) business days from the receipt of the grievance .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of the facility's Medication Storage policy, the failed to ensure staff secured medication inside a locked medication cart and did not repeatedly leave one (1) of three (3) medication carts unlocked, unattended, and accessible to residents, staff, and the general public. The facility also failed to ensure staff did not leave one (1) of two (2) diabetic treatment carts unlocked and unattended. The findings include: 1. During multiple observations on 07/28/25 at 4:37 PM and on 07/30/25 at 10:00 AM and at 1:23 PM, the diabetic treatment cart was left unlocked and unattended. The top drawer of the cart was full of lancets (sharp device used to prick the finger for blood glucose test), chemical cleansing wipes, and a pressurized can of Febreze deodorizing spray. On 07/29/25 at 4:50 PM, Licensed Practical Nurse (LPN) #1 returned to the medication cart, parked next to the treatment cart, completed a task, and left the treatment cart unlocked. On 07/30/25 at 1:33 PM, LPN #2 was made aware of the unlocked treatment cart. She stated, The treatment cart should be kept locked. 2. On 07/30/25 at 1:28 PM, the medication cart, located in the [NAME] neighborhood's day room, was observed unlocked, unattended, and accessible to residents and staff. The cart was behind a partial wall and not within the line of sight of any licensed clinical staff. On 07/30/25 at 1:33 PM, LPN #2 returned to the unlocked cart and acknowledged she had not locked the cart, and the cart was not within her line of sight. LPN #2 stated, I knew better not to step away from the cart without locking it. Certified Nurse Aide (CNA) #s 4 and 5 were seen in the day room with the unlocked cart. 3. During a medication pass observation on the [NAME] Unit hallway on 07/31/25 at 8:47 AM, LPN #2 did not lock the medication cart while it was unattended. During an interview with LPN #2 on 07/31/25, at the time of the observation, when she noticed the medication cart was unlocked and unattended, she stated, Oh no, and then locked the medication cart. She confirmed that the medication cart should always be locked when unattended for the safety of the residents. During an interview on 07/31/25 at 10:15 AM, the Director of Nursing (DON) and the Registered Nurse Manager (RNM) #3 stated that their expectation was for staff to secure/lock the medication and treatment carts when not in use or unattended. Review of the facility's policy titled Medication Storage Policy dated 07/16/24 read, 2. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications, such as medication aides, are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 07/29/25 at 9:38 AM, a Lidocaine 5% patch (topical pain reliever) was observed on top of the medication cart in the nurse station on the Laurel Unit. LPN #3 was in and out of the nurse station. At 9:49 AM, the restorative aide entered the nurse station. The nurse was not present at this time. During an interview on 07/29/25 at 10:03 AM, LPN #3 confirmed the Lidocaine 5% patch was on top of the medication cart unsecured and unattended. She stated That's my fault. She stated the patch should have been secured inside the medication cart. During an interview on 07/31/25 at 4:50 PM, the DON confirmed the medication should have been locked inside the cart. Review of the facility's policy titled Medication Storage Policy dated 07/16/24 read, 3. Medications shall be stored in a orderly manner in the medication cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of the facility's policies titled Personal Protective Equipment Policy, Catheter Drainage Bags and Tubing-Clinical Protocol, and Infection Control- Hand Hygiene, the facility failed to ensure 1. staff appropriately donned and doffed personal protective equipment (PPE) when providing laundry services; 2. staff kept indwelling catheter bags and/or tubing off the floor for one (1) of three (3) residents sampled for indwelling catheters (Resident #21); and 3. that during dining ,the staff performed hand hygiene before and after resident contact and after touching soiled surfaces (i.e. garbage can lid), and avoided touching inside of the residents' plates with while serving food.The findings include: 1. During an observation and simultaneous interview on 07/29/25 at 9:55 AM, Laundry Aide #2 was observed wearing an N95 face mask, a face shield, gown, and gloves while walking around on the Laurel Unit. He touched the nurse station door attempting to locate staff. During the interview, he stated he had donned the personal protective equipment (PPE) prior to sorting dirty laundry that morning. He confirmed he was wearing the same PPE at the time. He stated he was attempting to locate staff to see if any laundry needed to be washed. After the interview, he continued to the porch door and opened it with his gloved hand to talk to staff. During an interview on 07/31/25 at 4:51 PM, the Director of Nursing (DON) confirmed PPE should be doffed in an appropriate container inside a room prior to exiting. She further confirmed PPE should not be worn in the hallways and common areas. She stated He should have removed the PPE before he left the laundry room. Review of the facility policy titled Personal Protective Equipment Policy dated 1/28/25 read, Gowns .6. To remove the gown: .Remove the gloves [sic] and discard them into a waste receptacle in the room .Gloves .2. Glove should be worn only once and discarded into the appropriate receptacle located in the room where the procedure or task was performed . Face Masks .3. A face mask should only be used once and then discarded into the appropriate receptacle located in the room where the procedure or task is being performed . 2. Resident #21 was admitted to the facility on [DATE] with diagnoses that included flaccid neuropathic bladder and a history urinary tract infection (UTI). During an observation on 07/29/25 at 11:04 AM, Resident #21's catheter was in a privacy bag on the floor and the catheter tubing was on the floor with clear yellow urine visible. During an observation and interview on 07/30/25 at 1:41 PM with Registered Nurse (RN) #2, Resident #21 was observed sitting up in the bedside chair with the catheter bag partially in the privacy bag on the floor and the other half of the catheter bag on the floor. The catheter tubing was on the floor with clear yellow urine visible. RN #2 stated that the catheter bag and tubing should be off the floor to prevent an infection. During an interview on 07/30/25 at 11:55 AM with the DON, she stated that the expectation was that urinary catheter tubing and bags should not be on the floor. Review of the facility's policy titled Catheter Drainage Bags and Tubing-Clinical Protocol, revised 9/10/24, read .9. Keep the drainage bag and tubing off the floor at all times to prevent contamination (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and damage . 3. During a dining observation on 07/28/25 at 5:45 PM, Certified Nurse Aide (CNA) #s 2 and 3 did not consistently perform hand hygiene while serving and assisting Resident #s 15, 22, 35, 43, 44, 48, 71, 33, and 50, who ate in the [NAME] neighborhood's dining room. During the same time window, CNA #s 2 and 3 handled the resident's meal plates with their thumb on the inner edge of plate's rim. CNA #1 did not conduct hand hygiene between direct contact between multiple residents, including Resident #s 22, 43, 71, 44, and 33; or after she lifted the garbage lid with her ungloved hand to discard refuse. During an interview on 07/31/25 at 10:15 AM, the DON stated that it was her expectation that staff follow the policy and wash or sanitize their hands frequently, but especially before, after, and between contact with each resident, when passing trays, and after touching multiple surfaces. Review of the facility's policy titled Infection Control- Hand Hygiene dated 12/03/24, read .Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: .Before and after direct contact with residents.After handling soiled or used linens, dressings, bedpans, catheters, and urinals, equipment, or utensils.Before and after assisting resident with meals.

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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** Based on interviews, record review, facility policy review, and the online resource from the Centers for Disease Control and Prevention (CDC), the facility failed to ensure residents received education and were given the opportunity to accept or decline immunizations according to the CDC Adult Immunization schedule for four (4) residents (Resident #'s 21, 23, 45, and 71) of the five (5) residents reviewed for Immunizations.The findings include:1. Resident #21 was admitted on [DATE] with diagnoses that included methicillin-resistant Staphylococcus aureus (MRSA), urinary tract infection (UTI), heart failure, and diabetes mellitus type two (2).Review of Resident #21's immunization record revealed the followingInfluenza administered - 10/11/23Pneumonia vaccination - no documentation 2. Resident #23 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM) type two (2), and end-stage renal disease (ESRD).Review of Resident #23's immunization record revealed the following:Influenza administered - 10/11/04Pneumonia vaccination - 11/02/18 3. Resident #45 was admitted on [DATE] with diagnoses that included cardiovascular disease, infection, methicillin-resistant Staphylococcus aureus (MRSA), and hypertension.Review of Resident #45's immunization record revealed the following:Pneumonia vaccination - no documentationReview of Resident #45's consent form titled, (Facility Name) Vaccine Consent Form dated 1/9/25 revealed the following information: .Vaccine Consent Form: 2024-2025 COVID, RSV, and Influenza. Please provide the Vaccine Information Sheet(s) (VIS) that have been provided. This form serves as a record of your consent to receive vaccinations during your stay, based on the last national guidelines and your eligibility. The form indicated a Yes consent to COVID-19 and Influenza vaccines. 4. Resident #71 was admitted on [DATE] with diagnoses that included coronary artery disease (CAD) and retention of urine.Review of Resident #71's immunization record revealed the following:Pneumonia vaccination - 12/13/19Further review of the medical record for Residents #21, #23, and #71 revealed there was no Vaccine Consent Form to indicate the residents were provided education, offered, and/or administered the appropriate vaccinations.During an interview with the Infection Control Preventionist (ICP) on 07/31/25 at 3:47 PM, she stated that while she was on leave, the staff member responsible for the residents' immunizations had not been consistent with the facility's immunization program. She stated that she was only able to locate two (2) of the five (5) residents' information, and it was not complete. She confirmed that the facility should annually offer the influenza vaccine during flu season and assess, review, and offer pneumonia vaccinations according to the CDC Adult Immunization Schedule. During an interview with the ICP on 08/01/25 at 10:12 AM, she stated the facility did not have vaccination declination documentation for Residents #21, #23, #45, and #71. A review of the facility's policy titled (Facility Name) Infection Control - Immunization of Residents Policy dated 12/12/24 read. Purpose: The purpose of this policy is to provide (Facility Name) teammates with guidelines for immunization of residents to aid in preventing infectious diseases. Policy: All residents will be offered the influenza, pneumonia, and COVID-19 vaccinations to aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been immunized. Herpes Zoster and respiratory syncytial virus (RSV) vaccinations may also be offered, as noted at the end of this policy. Administration of all vaccinations is made in accordance with the current CDC recommendations at the time of the vaccination. Refer to the CDC for vaccine information statements.Procedure: General Guidelines. 2. Prior to the immunization, the resident or the resident's responsible party will be provided information and education regarding the benefits and potential side effects of the vaccination being offered. Vaccine information statements and educational materials are updated yearly by the CDC and can be obtained on the CDC website. Written consent should be obtained from the resident or the personal legal representative prior to administering any vaccination. If it is not possible to obtain written consent, verbal consent may be given if witnessed by a teammate and documented in the electronic (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record (EMR). 3. Prior to admission, residents will be assessed for eligibility to receive. vaccines, and when indicated, will be offered the vaccinations within 30 days of admission to the facility. 4. The resident or the resident's responsible party may refuse immunization for any reason. If immunizations are refused, the refusal should be documented in the resident's medical record or on the appropriate form, which is scanned into the medical record. 5. If the resident receives an immunization, at least the following information should be documented in the resident's medical record: Site of administration; Date of administration; Lot number of the vaccine and manufacturer (located on the vial); Expiration date (located on the vial); Name of person administering the vaccine.Influenza Vaccination: The influenza vaccine will be available to all residents between October and March of each year. Pneumococcal Vaccination: Refer to the Pneumococcal Vaccine Timing for Adults document on the CDC Website. 11. (Facility Name) will maintain a record of the vaccination status of residents in the EMR.

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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** Based on observations, interviews, and record reviews, the facility failed to treat two (2) residents (Resident #6 and #23) in a dignified manner to promote the residents' quality of care and quality of life in a sample size of 23 residents who were reviewed for resident rights. The findings include: 1.Resident #6 was admitted on [DATE] with diagnoses that included vascular dementia, type 2 diabetes, and major depressive disorder. Resident #6’s quarterly Minimum Data Set (MDS) dated [DATE] revealed that he was cognitively impaired, dependent on activities for daily living (ADLs) and required a two person assist Hoyer lift transfer. In a telephone interview with the resident representative for Resident #6 on 07/29/25 at 11:12 AM, she stated she filed a complaint/grievance with Social Worker (SW) #3 regarding an incident that occurred with her uncle while she visited the facility sometime in June. She recounted that, on this day, she requested that the Certified Nurse Aide (CNA) staff put her uncle in his chair so that he could visit with them out on the covered porch. She stated, “When my uncle appeared from his room sitting in the chair, his hair was uncombed, his clothes were twisted, and his socks were on wrong.” She stated, “no one should be treated that way.” During an interview with SW #3 on 07/30/25 at 2:34 PM, she verified that resident representative for Resident #6 did file a complaint/grievance on 06/16/25 regarding an incident in which Resident #6 when put in his chair and not properly groomed. She stated the Director of Nursing (DON) was made aware and provided a resolution. Review of the facility Concern, Complaint or Grievance form on 07/30/25 revealed, the incident was reported by the resident representative for Resident #6 on 06/16/25 but occurred on 06/8/25 around 3:00 PM. She reported that the resident wanted to get up. She asked both CNAs to get Resident #6 up. They both rolled their eyes. CNA #10 glared and ran the Hoyer lift into the wall. When asked, CNA #10 stated, I’m not mad, I’m just a bad driver.” After 8-9 minutes, the resident representative for Resident #6 reported, Resident #6 was brought out of his room with his shirt all twisted up, his socks halfway up and uncombed hair.” During an interview with the DON on 07/31/25 at 11:00 AM, she verified that she received a complaint/grievance reported by the resident representative for Resident #6 and interviewed both CNAs. She stated she discussed providing resident care with dignity with both CNAs. She stated her expectation was that when a resident is gotten out of bed, all of the ADLS are provided. She stated she completed verbal coaching/coaching for success with both CNAs and removed CNA #10 from Resident #6’s staffing assignment on the 7 AM to 7 PM shift to prevent any future interactions with Resident #6 or his representative as requested. Review of the facility's policy titled “(Facility Name) Administrative-Residents Rights for Senior Service, dated 10/30/24 read “…. Policy …(Facility Name) will treat each resident with respect and dignity and will care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life…. F550 1. The resident has the right to a dignified existence, …. with persons and services inside and outside of the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility.” 2. Resident #23 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and anxiety disorder. Review of Resident #23's quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #23 was cognitively intact and required staff assistance with activities of daily living (ADL), including bathing and grooming. Review of the medical record for ADL bathing documentation dated 07/29/25 revealed that Resident #23 had received a shower. During an observation and interview on 07/30/25 at 4:00 PM, Resident #23 was lying in bed watching television. She appeared groomed except for the visible scattered chin hairs of different lengths. She stated she was supposed to have her chin hairs shaved on shower days. She stated she had a shower yesterday, but the staff had not shaved her or asked her if she wanted to be shaved. During an interview with Certified Medication Aide (CMA) #10 on 07/30/25 at 4:00 PM while she was standing outside of Resident #23's room, she stated that as a female resident, she would not want her chin hairs to look like how Resident #23's chin hairs looked. She stated that with each shower, the residents should be shaved or offered to be shaved. Review of the facility's policy titled Resident Rights for Senior Service, dated 10/30/24 read .to provide (Facility Name) teammates with guidelines for resident rights for senior services . Policy: It is the policy of (Facility Name) to recognize that all residents have the right to a dignified existence, self-determination, and access to persons and services inside and outside the facility. (Facility Name) will treat each resident with respect and dignity and will care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. (Facility Name) will protect and promote the rights of all residents .I. The resident has the right to a dignified existence, self-determination, and communication with persons and services inside and outside of the facility. 2. The resident has the right to exercise their rights as a resident of (Facility Name) and as a citizen or resident of the United States without interference, coercion, discrimination, or reprisal from the facility, and to be supported by (Facility Name) in the exercising of these rights. 3. (Facility Name) provides equal access to quality care regardless of diagnosis, severity of condition, or payment source. (Facility Name) has established and maintained identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all residents regardless of payment source .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy titled (Facility Name) Administrative-Residents Rights for Senior Service, the facility failed to ensure Resident #4 was provided appropriate durable medical equipment (DME) that allowed the use of the bathroom for one (1) of twenty-three (23) sampled residents.The findings include:Resident #4 was admitted to the facility on [DATE] with diagnoses that included obesity, acute respiratory failure, unspecified psychosis, manic episode, and type 2 diabetes.Resident #4's quarterly Minimum Data Set (MDS) dated [DATE] revealed that he was cognitively intact, dependent for activities for daily living (ADLs) and required a one person assist for transfers.During an observation and interview on 07/30/25 at 4:32 PM Resident #4 reported he smashed the pointer finger on his left-hand a couple of months ago while attempting to self-propel his wheelchair (WC) through the threshold of the bathroom to access the sink. He stated, look at the dark marks on the wall, those marks are from my WC wheels. My WC can barely fit. It is a very tight fit. The resident stated once he was up in the WC, he would access the sink to perform activities of daily living (ADLs). The resident did not notify the facility staff how he injured his finger. He stated, I did ask for a band-aid. It was noted that Resident #4 had an extra wide WC at the bedside. The resident stated, Physical Therapy (PT) ordered me a smaller WC about three weeks ago, but I haven't heard anything about it since. He stated, Me and another resident told the Physical Therapy Assistant (PTA) in the hall that we had problems getting in the bathroom and we wanted smaller chairs.During an interview on 07/31/25 at 9:05 AM, the Certified Occupational Therapy Assistant (COTA) verified that a WC had not been ordered for Resident #4, that Resident #4 started physical therapy/occupational therapy (OT) service on 03/07/25 and ended service on 07/16/25, and the resident was non-ambulatory due to hip pain. She stated she was unaware the resident had injured his finger and that if the WC did not fit through the door, a bedside commode should be provided to accommodate the resident's needs.During an interview on 07/31/25 at 10:15 AM with the PTA , she stated she was unaware that the resident injured his finger due to the tight fit of his WC through the threshold of the bathroom door. During an interview on 07/31/25 at 4:05 PM , the Administrator, Director of Nursing (DON) and Administration staff #6 were notified that Resident #4 injured his finger when entering the bathroom with his WC. The Administrator was aware the resident was unable to enter and exit the bathroom, but no additional accommodations had been offered.Review of the facility policy titled (Facility Name) Administrative-Residents Rights for Senior Service dated 10/30/24 read . Policy .Implementation.F558 (10.) The resident has the right to reside and received services in the (Facility Name) facility with reasonable accommodation of the resident needs and preferences except when to do so would endanger the health or safety of other residents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of the facility's policy titled Medication Regimen Review, the facility failed to ensure an order for an as needed (PRN) antipsychotic had a stop date and a supporting diagnosis for use for one (1) resident of five (5) sampled for unnecessary medications (Resident #7). The findings include:Resident #7 was admitted to the facility 06/26/25 with diagnoses that included Parkinsonism, type 2 diabetes, insomnia, benign prostatic hyperplasia, and heart failure.Review of the admission Minimum Data Set, dated [DATE] revealed Resident #7 was moderately cognitively impaired; had verbal behavioral symptoms directed towards others, other behavioral symptoms not directed towards others, and rejected care one (1) to three (3) days during the seven (7) day look back period; did not have any psychiatric or mood disorder diagnoses; and in the past seven (7) days had received antianxiety, antidepressant, and hypnotic medications.Review of the physician's orders revealed an order dated 07/29/25 at 2:15 PM for quetiapine fumarate (antipsychotic) 25 milligrams (mg) give 0.5 tablet by mouth as needed for agitation PM PRN; may give in the afternoon/evening once daily. The start date was 07/29/25 at 2:15 PM and there was no end date written for the PRN antipsychotic order.Review of the nurse's notes revealed the following:1. 7/25/2025 19:27 [7:27 PM].Resident had multiple new orders today from physician. Trazadone [antidepressant] was discontinued for reports of history of causing hallucinations.2. 7/29/2025 16:40 [4:40 PM] Orders - Administration Note.Quetiapine Fumarate Oral Tablet 25 MG Give 0.5 tablet by mouth as needed for agitation PM PRN; may give in the afternoon/evening once daily PRN Administration was: Ineffective.3. 7/30/2025 20:31[8:31 PM] Orders - Administration Note.Quetiapine Fumarate Oral Tablet 25 MG Give 0.5 tablet by mouth as needed for agitation PM PRN; may give in the afternoon/evening once daily. There was no documentation whether it was effective.4. 07/31/2025 00:58 [12:58 AM].Resident has not been comfortable this evening. PRN melatonin [herbal sleep aid] and PRN ibuprofen [anti-inflammatory] administered d/t [due to] insomnia and leg pain. Vital signs have been consistent throughout this evening. Resident has been restless and is consistently being transferred from the recliner to the bed per resident request. Resident has been receptive to care and the call light has remained in reach. When resident is in bed fall mats X 2 [fall mats on each side of the bed] are in place to help prevent fall or injury. Currently there is a CNA [Certified Nurse Aide] providing one on one care and supervision.5. 07/31/2025 04:16 [4:16 AM] Orders - Administration Note.Quetiapine Fumarate Oral Tablet 25 MG Give 0.5 tablet by mouth as needed for agitation PM PRN; may give in the afternoon/evening once daily PRN Administration was: Ineffective.During an observation and interview on 07/29/25 at 3:12 PM, attempts were made to interview Resident #7 for approximately 20 minutes, but the resident would only be able to answer one (1) or two (2) questions before falling asleep while sitting in a recliner. Resident #7 appeared very tired and had difficulty staying awake.Observation on 07/30/25 at 1:11 PM, revealed Resident #7 in his room with CNA #14. Resident #7 was in his recliner, trying to stand up, and CNA #14 was standing with a wheelchair between her and the resident. CNA #14 was talking to the resident in an argumentative tone and the resident was agitated.During an observation on 07/30/25 at 1:31 PM, Resident #7 was yelling out help me while attempting to get up out of a chair. A staff member entered the resident's room and asked Resident #7 what he was doing and if he wanted to get in his wheelchair. The resident was placed in his wheelchair and the resident was calm and cooperative.During an observation and interview on 07/31/25 from 3:30 PM to 3:39 PM, Resident #7 was in the unit dayroom sitting in his wheelchair with two (2) staff members. The resident was falling asleep in his wheelchair. CNA #15 took Resident #7 back to his room and put him to bed. Resident #7 was cooperative and went to bed without any problems. During an interview, CNA #15 stated she had never had any problems caring for Resident #7 and he had never had any behaviors with her.During an interview on 07/31/25 at 10:50 AM, Licensed (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse (LPN) #5 stated Resident #7 had Parkinson's with behaviors and the providers were adjusting his medications to achieve a balance between managing his anxiety and behaviors, and not over sedating him. The Nurse Practitioner had just ordered a prn medication he started the night before. LPN #5 stated Resident #5 had worked lot of night hours previously now seemed to have a problem with being awake all night and not being able to sleep. During an interview on 08/01/25 at 9:52 AM, Registered Nurse (RN) #5 stated she was the one who took the order for the PRN antipsychotic. She stated the medication was ordered because Resident #7 showed behaviors recently when he put his hands around a CNA's neck. RN #5 called the Nurse Practitioner (NP) who gave RN #5 the order. RN #5 stated she was aware there had to be a 14 day stop date for all PRN antipsychotics and a diagnosis for using antipsychotics. She stated the facility was thinking Resident #7 would only be on the medication for a few days then they would prescribe something else.Review of the facility's policy titled Medication Regimen Review effective June 2025 read, .'Irregularity' refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy.Evaluating medication orders to determine that the resident's orders represent optimal therapy for that individual: A written diagnosis or indication supports each medication order. As-needed (PRN) orders include indications for use. Indications for use and therapeutic goals are consistent with current medical literature and clinical practice guidelines.The duration of therapy is indicated and is appropriate for the resident .Evaluating response to drug therapy to assure that each resident receives optimal drug therapy: The resident's response to drug treatment is evaluated through the use of laboratory data, physical assessment, medication administration record, and other data to determine if therapeutic goals are achieved. The use of a medication without identifiable evidence of adequate indications for use, such as, the use of a medication to treat a clinical condition without identifiable evidence that safer alternatives or more clinically appropriate medications have been considered.Medical condition and response to drug therapy are used to evaluate the drug regimen for unnecessary medications.The pharmacist's review considers factors such as: Whether the physician and staff have documented objective findings, diagnoses, symptom(s), and/or resident goals and preferences to support indications for use.Whether the medication dose, frequency, route of administration, and duration are consistent with the resident's condition, manufacturer's recommendations, and applicable standards of practice. Whether the physician and staff have documented progress towards, decline from, or maintenance of the resident's goal(s) for the medication therapy.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and a review of the facility's Resident Assessment Instrument policy, facility staff failed to identify and document a skin tear injury on the comprehensive Minimum Data Set (MDS) for one (1) of three (3) residents reviewed for skin integrity (Resident #18). The findings include:Resident #18 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease, type 2 diabetes mellitus, vascular dementia without behavior, and encephalopathy.Review of the comprehensive Minimum Data Set (MDS) dated [DATE] revealed Resident #18's skin was intact without notation of skin tears, abrasions, or open wounds/injuries. During an observation and interview on 07/29/25 at 2:41 PM, Resident #18 sat in his room in a recliner chair with both legs elevated engaging with his sister. The skin on his lower legs was dry with dark pin-head size scabs and a two-centimeter redden/open and moist skin tear was visible on his lower left leg/shin.During an interview on 07/30/25 at 1:00 PM, the MDS Coordinator confirmed the MDS assessment reflected Resident #18's was intact and that she was not aware of the skin tear injury. Review of Resident #18's medical records, progress notes, wound assessment, and physician notes revealed no documented evidence of doctor/nurse treatment orders or acknowledgment of injury. During an interview on 07/30/25 at 10:05 AM, Registered Wound Care Nurse (RN) #1 confirmed weekly skin assessments are completed but she was not aware and did not document the skin tear. Review of the facility's Resident Assessment policy revised 01/18/24 read, The MDS Coordinator (or designee) is responsible for ensuring that the Interdisciplinary Care Plan Team conducts timely resident assessments. (Facility Name) will use a variety of other sources, including communication with licensed and unlicensed staff members on all shifts, discussion with the physician, family members. Data entered in Section GG will be a collaboration of clinical assessments completed by licensed health care clinicians.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the facility's policy titled Pre-admission Screening and Resident Review (PASRR), the facility failed to complete the Preadmission Screening and Resident Review (PASRR) Level II upon a new qualifying mental health diagnosis for one (1) out of two (2) residents sampled for PASRR Level II (Resident #4). The findings include:Resident #4 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure, obesity, and type 2 diabetes.Resident #4's quarterly Minimum Data Set (MDS) dated [DATE] revealed that he was cognitively intact, dependent with activities for daily living (ADLs) and required one person assist for transfers. Review of past MDS revealed a diagnosis of unspecified. psychosis not due to a substance or known physiological condition dated 2/19/2025 and Manic episode, unspecified dated 11/12/24.During an interview on 07/30/25 at 4:20 PM, Resident #4 denied any behavioral health or mental health concern. He reported his mood was stable and doesn't have the desire to talk to anyone regarding his mood. During an interview on 07/31/25 at 2:00 PM with Social Worker (SW) #1, she presented the Preadmission Screening and Resident Review (PASRR) Level I and stated that she was unaware of the reason why Resident #4 received a diagnosis of Psychosis on 02/19/25. SW #1 verified that resident# 4 was not referred for PASRR Level II.During a telephonic interview on 08/01/25 at 10:00 AM with the Minimum Data Set (MDS) coordinator, SW #1 and SW #2, the MDS coordinator verified Resident #4's medical record supported the diagnosis of bipolar. She stated the resident was prescribed Seroquel, an antipsychotic medication. SW #1 stated due to the current Behavioral Health referral process she was unaware Resident #4 received a new mental health diagnosis that indicated a significant change in his mental status that required a Level II PASRR referral. She verified that Resident #4 should have been referred for PASSR Level II.Review of the facility's policy titled (Facility Name) Admissions-Pre-admission Screening and Resident Review (PASRR) dated 10/08/24 read .Procedures:.4. A Level 1 screen remains valid unless there is a significant change in a resident's status that affects their mental health or IDD treatment needs. This means that if a resident is discovered to have SMI, IDD or RC after the Level 1 was performed, the facility must call the PASRR contractor to perform an updated Level 1.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the facility's policy titled Pre-admission Screening and Resident Review (PASRR), the facility failed to ensure the accurate completion of the Level I PASRR and referral for Level II PASRR for a resident with a mental health diagnosis for one (1) out of two (2) residents sampled for PASRR (Resident #5). The findings include:1. Resident #5 was admitted on [DATE] with diagnoses that included delusional disorders, history of left below the knee amputation, peripheral vascular disease, and diabetes.Review of Resident #5's PASRR Level I Assessment, dated 12/05/24, revealed .The individual does not meet the federal definition for mental illness/ mental retardation. No further PASRR screening is required unless a significant change occurs with the individual's status which. suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions.no qualifying mental health diagnosis.Review of Resident #5's medical record revealed prior to admission to the facility, a new diagnosis of delusional parasitosis disorder was documented on 12/20/24 and then referenced on 12/24/24 in the health care provider's notes.Review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/25 revealed a diagnosis of delusional disorders and the resident was not assessed for PASRR Level II.Review of the Resident #5's Physician's progress note dated 12/20/24 revealed . Delusional parasitosis: wife and patient are dealing with depression and delusional parasitosis. patient is not sleeping throughout the night. added on low dose Seroquel at 25mg q hs. May help with delusions as mentioned above.Review of the Resident #5's Physician's progress note dated 12/24/24 revealed . has dx of delusional parasitosis, detailed on inpat d/c summary as follows: wife and patient are dealing with depression and delusional parasitosis .During an interview and medical record review for Resident #5 on 07/31/25 at 3:35 PM with Social worker (SW) #1, she confirmed that the mental health diagnosis for Resident #5 of delusional parasitosis was received after completion of the PASRR Level I on 12/05/24 and prior to admission to the facility. She stated that with this new qualifying mental health diagnosis prior to admission, the resident would need an updated PASRR Level I and a PASRR Level II completed.Review of the facility's policy titled Pre-admission Screening and Review (PASRR), dated 10/08/24 read 4.A Level I screen remains valid unless there is a significant change in a resident's status that affects their mental health or IDD treatment needs. This means that if a resident is discovered to have SMI, IDD, or RC after the Level I was performed, the facility must call the PASRR contractor to perform an updated Level I .6. It is the responsibility of the referral source to initiate the PASRR process. The Social Worker or admission and Marketing Director or designee will be responsible for ensuring the PASRR level is obtained and documented. Evidence that the PASRR process was followed must be present in the medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews, and review of the facility's policies Resident Rights for Senior Services, Behavioral Health Services and Trauma-Informed Care, and Care Plans - Nursing Facility, the facility failed to ensure staff developed and/or implemented comprehensive care plans for three (3) of 23 sampled residents reviewed, that included person-centered interventions for behaviors (Resident #7), trauma informed care (Resident #8), and restorative services (Resident #45). The findings include: 1. Resident #7 was admitted to the facility 06/26/25 with diagnoses that included Parkinsonism and insomnia. Review of the admission Minimum Data Set, dated [DATE] revealed Resident #7 was moderately cognitively impaired; had verbal behavioral symptoms directed towards others, other behavioral symptoms not directed towards others, and rejected care one (1) to three (3) days during the seven (7) day look back period; and required substantial/maximal assistance with personal care and mobility. Review of the care plan for Resident #7 initiated 06/30/25, revealed, .I am resistive to care r/t [related to] adjustment to nursing home, Anxiety.Give clear explanation of all care activities prior to an [and] as they occur during each contact.I have a behavior problem r/t yelling out and yelling for help.Caregivers to provided [provide] opportunity for positive interaction, attention.Approach/Speak in a calm manner. Divert attention.Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Updates to the care plan included on 07/11/25, .I have impaired cognitive function or impaired thought processes r/t history of subdural hematoma which had significant impact to my cognitive ability.Ask yes/no questions in order to determine the resident's needs.Communication: Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences.Cue, reorient and supervise as needed.Engage the resident in simple, structured activities that avoid overly demanding tasks. And on 07/30/25, .I am at risk for aggressive behavior r/t attempting to choke a CNA [Certified Nurse Aide].Provide education about how aggression and violence are not appropriate ways to respond to others.Staff will approach me in a calm manner and explain what they are about to do. During an observation on 07/30/25 at 1:11 PM, Resident #7 was in his room with Certified Nurse Aide (CNA) #14. Resident #7 was in his recliner, trying to stand up, and CNA #14 was standing with a wheelchair between her and the resident. CNA #14 was talking to the resident in an argumentative tone and the resident was speaking too low to be heard. CNA #14 could be heard saying, .You can't keep calling me and asking me for help and then telling me you going to knock me out cause that doesn't make sense. Does that make sense? [Resident #7 with an inaudible response] I don't even know what that is. [Resident #7 with an inaudible response] Because I am not the nurse. I am not supposed to know your medicines that's not my job.Now I'm going to go find someone else that wants to talk to you so you can cuss someone else out because you're not going to cuss me out. I don't know what you want me to do. [Resident #7 with an inaudible response] Because you don't want me to touch you. Then I get close to you, and you say you are going to knock me out. CNA #14 exited the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and walking down the hall with CNA #16 and stated I don't know what he wants. During an interview on 07/30/25 at 1:28 PM, CNA #16 stated CNA #14 told her Resident #7 was debating between sitting in the recliner or wheelchair and not knowing what it was he wanted. Resident #7 had threatened to punch CNA #14, and CNA #16 told CNA #14 she should report the behaviors to the Administrator. CNA #16 stated she was not allowed to work with Resident #7 anymore because last night when she was trying to untangle the resident's oxygen tubing, the resident put his hands around her neck and started to choke her. The resident made it very clear that he did not want CNA #16 in his room. She said she handled the situation by moving back and saying, Please don't put your hands on me. Resident #7 told her to get out. She asked the resident if she could put his oxygen back on and he told her to get out. CNA #16 left the room and told another CNA that the resident's oxygen was off so they could go in and care for him. Later in the evening, a housekeeper told CNA #16 that Resident #7 was attempting to get up unassisted, so CNA #16 went back in to try and assist him, and he again told her to get out of his room and she did. CNA #16 would not be caring for Resident #7 anymore so as not to agitate him. CNA #16 stated when caring for a resident like Resident #7, it was best to try and de-escalate the situation and if you cannot, walk away and try to find someone else to assist. She stated she would not argue with a resident because it was their home and that was not appropriate. CNA #16 did not hear CNA #14 talking to Resident #7, but stated she would not have responded the way CNA #14 did because That is not very ethical. During an observation on 07/30/25 at 1:31 PM, Resident #7 was yelling out help me while attempting to get up out of a chair. A staff member entered the resident's room and asked Resident #7 what he was doing and if he wanted to get in his wheelchair. The resident was placed in his wheelchair and the resident was calm and cooperative. During an interview on 07/30/25 at 1:37 PM, CNA #14 stated she had been out of the facility for a week and a half and before she left, she had a good relationship with Resident #7. CNA #14 was shocked that he threatened to knock me out. The resident said, Bring it [the wheelchair] over here or I am going knock you out. CNA #14 stated every time she got close to him, he would shake and threaten her. During an interview on 07/31/25 at 10:50 AM, Licensed Practical Nurse (LPN) #5 stated Resident #7 had Parkinson's with behaviors and the providers were adjusting his medications to achieve a balance between managing his anxiety and behaviors, and not over sedating him. Resident # 7 told LPN #5 today that CNA #14 was in all of his business when he wanted to get in his wheelchair and the CNA asked him where he wanted to go. LPN #5 stated CNA #14 was an agency CNA, and the LPN was not aware of any issues with the CNA. LPN #5 confirmed the exchange between CNA #14 and Resident #7 overheard earlier was not appropriate and definitely not dignified. During an observation and interview on 07/31/25 from 3:30 – 3:39 PM, Resident #7 was in the unit dayroom sitting in his wheelchair with two (2) staff members. The resident was falling asleep in his wheelchair. CNA #15 took Resident #7 back to his room and put him to bed. During the process of putting him back to bed, CNA #15 explained everything she was going to do and asked the resident's permission before proceeding. Resident #7 was cooperative and went to bed without any problems. During an interview, CNA #15 stated she had never had any problems caring for Resident #7 and he had never had any behaviors with her. During an interview on 08/01/25 at 10:34 AM, the Director of Nursing confirmed CNA #14 failed to implement Resident #7's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Resident Rights for Senior Services Policy effective 10/30/24 read, .It is the policy of (Facility Name) to recognize that all residents have the right to a dignified existence, self determination, and access to persons and services inside and outside the facility. (Facility Name) will treat each resident with respect and dignity and will care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. (Facility Name) will protect and promote the rights of all residents. Review of the facility's policy titled Behavioral Health Services and Trauma-Informed Care Policy, effective 10/08/24 read, .(Facility Name) provides the necessary behavioral health care and services to residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being.Additionally, a resident who displays or is diagnosed with mental disorder or psychosocial disorder or has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being and to minimize triggers or re-traumatization.Ensuring that necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Ensuring that direct care teammates interact and communicate in a manner that promotes mental and psychosocial well-being, in addition to using approaches which are culturally competent and account for experiences and preferences.Providing an environment and atmosphere that is conducive to mental and psychosocial well-being.Anxiety and anxiety disorders include symptoms such as excessive fear and intense anxiety that can cause significant distress. Anxiety can be triggered by loss of function, changes in relationships, relocations, or medical illness. It may also be a symptom of other disorders, such as dementia.Additionally, all teammates are trained in the ability to communicate and interact with residents in a way that promotes meaningful engagement and psychosocial and emotional well-being.Teammates that support and provide care for residents will receive additional training on behavioral health, including trauma-informed care, during orientation and as required though the online learning program. Review of the facility's policy titled Care Plans – Nursing Facility last reviewed 01/18/24 read, (Facility Name) will develop a comprehensive care plan for each nursing facility resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Care plans are available to staff members who have responsibility for providing care and services to the resident. 2. Resident #8 was admitted to the facility 06/24/24 with diagnoses that included schizoaffective disorder, bipolar type; post-traumatic stress disorder (PTSD); depression and type 2 diabetes. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had mild cognitive impairment; a diagnosis of PTSD; no behaviors during seven-day (7) day look back period and is independent with activities of daily living (ADLS). Review of the care plan initiated 06/24/24 revealed, there were no specific interventions that addressed Resident #8's specific needs to related to her PTSD diagnosis to minimize triggers and to prevent re-traumatization of the resident while receiving care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/30/25 at 4:42 PM, Resident #8 was observed fully dressed; reclined in bed. The resident stated she was not aware of a behavioral health diagnosis and denied talking to anyone about her mood. She stated, sometimes I feel sad and would like to talk to someone. During an observation and interview on 07/31/25 at 11:00 AM, Resident #8 was observed in room dressed and playing music. The resident stated, I'm getting ready to go walking. She denied any concerns. During an interview on 7/31/25 at 11:30 am, with Social Worker (SW) #1 regarding Resident #8's PTSD diagnosis and specific interventions, she denied completing a social history or trauma assessment. She stated, I know the resident personally; I live on the same street as her mother. SW #1 reported resident was a registered sex offender; has a history of sexual molestation and was triggered by men that she does not know. She confirmed Resident #8 was recently triggered by a new male CNA. She did inform the Director of Nursing so that the resident would not be assigned the CNA. SW #1 confirmed that this information was not listed in the resident's care plan. She agreed that the care plan should be completed with information and resident specific interventions that would assist the facility staff to provide trauma-informed care for the resident. Review of the facility policy titled (Facility Name) Social Services-Behavioral Health Services and Trauma-Informed Care Policy dated 10/08/24 read, . Trauma informed care. Procedure:. 4. Care Planning to Address Past Trauma: The facility collaborates with resident trauma survivors, and as appropriate, the resident's family and any other health care professionals.to develop and implement individualized interventions. If the trauma survivor is reluctant to share their history, teammates will try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize effect of the rigger on the resident .5. Additionally, trauma-specific interventions should recognize the interrelation between trauma and symptoms of trauma.Trauma- specific interventions recognize the survivors need to be respected, informed, connected, and hopeful regarding their recovery . 3. Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) following unspecified cerebrovascular disease affecting the left non-dominate side, morbid obesity, spinal stenosis and chronic respiratory failure. Review of the Comprehensive Minimum Data Set (MDS) dated [DATE] revealed the Resident #45's cognition was moderately impaired. The resident was dependent on staff for assistance with activities of daily living (ADLs), and substantial assistance for bed mobility and transfers. Review of Resident #45's comprehensive care plan revised, 07/21/25 revealed no focus, goals, or resident-centered interventions to address the maintenance and/or prevention of decreased ROM and bed mobility related to the resident's hemiplegia/hemiparesis (paralysis/weakness) diagnoses. On 07/31/25 at 10:30 AM, the Director of Nursing (DON) and RN #3 confirmed that staff was expected to ensure care plans are accurate and reflect the resident's care needs. Review of the facility's Restorative Nursing Care policy, dated 11/12/24, read The restorative nursing care program is designed to assist each resident in achieving and maintaining an optimal level of self-care and independence. A resident may be referred to the restorative nursing program. Functional decline or maintenance need identified at time of admission or during stay and resident is not appropriate for therapy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and review of Up To Date medical reference, the facility: 1. failed to ensure arrangements were made for a dermatology consult in accordance with a physician order for one (1) resident (Resident #27); 2. failed to ensure assessment and treatment for potential insect bites for one (1) resident (Resident #66); and 3. failed to ensure arrangements were made for a speech and language evaluation in accordance with an order for one (1) resident (Resident #21) of 23 sampled residents. The findings include: 1. Resident #27 was admitted to the facility 06/12/25 with diagnoses that included type 2 diabetes, major depressive disorder, anxiety disorder, and adjustment disorder with depressed mood. The resident was cognitively intact. During an interview on 07/28/25 at 5:35 PM, Resident #27 stated she was admitted [DATE] and the only complaint the resident had since being admitted was this itching that won't go away.from head to toe. The resident stated the itching made it hard to sleep at night. Resident #27 stated facility staff and providers told her the itching was due to anxiety, but she did not believe that was the problem and had suffered from the same itching before. Resident #27 wanted to see a dermatologist. Review of the physician Initial Assessment for Resident #27 dated 6/24/25 revealed .also has h/o [history of] itching in scalp and in throat.Episodic Problems .Itching of skin .no rashes.Review of physician's orders for Resident #27 revealed an order dated 07/01/25 for a dermatology consult for itching and a history of eczema and an order written 07/18/25 for cetirizine (medication for allergies) 10 milligrams (mg) for a diagnosis of pruritic (itching). Review of a nurse's note dated 07/19/25 at 5:34 AM, revealed, .Resident [#27] c/o [complaint of] itching all over. Resident having trouble sleeping d/t [due to] itching. N.O. [New Order] Cetirizine 10 mg tab, take one tablet daily.Resident is requesting an appointment with an allergist. Review of the medical record for Resident #27 revealed no documentation for an appointment with a dermatologist or allergist had been arranged or that the resident was seen by a dermatologist or allergist for the complaints of itching. During an interview on 07/31/25 at 10:36 AM, [NAME] Clerk #5 stated orders for consults were placed in a folder for transportation staff to arrange appointments. The orders did not get placed in the medical record until transportation had made the appointment and the resident had come back from the appointment. During an interview on 07/31/25 at 11:03 AM, Certified Medication Aide/Transportation (CMA) #13 stated she was responsible for scheduling appointments with outside physician's offices and specialists. CMA #13 stated the orders for outside consults were put in a folder at the nurse's station for her. She would then review the orders, make the appointments, and arrange transportation. She reviewed the medical record and confirmed there was an order written for a dermatology consult for Resident #27 and she was not aware of the order. CMA #13 stated she had not been given the order in her folder. CMA #13 confirmed she had not made an appointment for Resident #27 to see a dermatologist. During a follow up interview on 07/30/25 at 4:01 PM, Resident #27 stated the itching was awful and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed she had not seen a dermatologist since being in the facility. She did not know there was an order for a dermatology consult, but she would like to see the dermatologist. During a follow up interview on 08/01/25 at 8:31 AM, CMA #13 stated Resident #27 had been seen by a dermatologist when she resided at the nursing facility she transferred from. Resident #27 had oral and topical medications prescribed by the dermatologist and the facility was working on having the prescriptions transferred to their pharmacy. CMA #13 scheduled a dermatology appointment for Resident #27. During an interview on 08/01/25 at 10:32 AM, the Director of Nursing (DON) stated the order for the dermatology consult for Resident #27 should have been put in the folder for transportation and given to CMA #13 to arrange the appointment and transportation. 2. Resident #21 was admitted to the facility on [DATE] with a diagnosis of dysphagia. Review of Resident #21's Minimum Data Set (MDS) dated [DATE] revealed the resident was moderately cognitively impaired. During an interview with Resident #21 on 07/29/2025 at 11:27 AM, the resident stated that the facility's diet ordered for her was not appetizing. She did not like the consistency of the meat and that she was informed by the Registered Dietician (RD) that she would have an evaluation with the Speech Language Pathologist (SLP) in regard to changing her diet, but to date no one had changed her diet or followed up with her. Review of Resident #21's diet order revealed an order dated 08/28/24 for Regular diet, Mechanical Soft Ground texture, Regular consistency and an order dated 12/30/24 Resident requests to speak with SLP re her diet. Review of the RD note dated 12/30/24 revealed that .Resident continues to complain about her diet and request to speak to the SLP to downgrade her diet. Resident does not want her food ground up .Plan: request SLP to speak with resident re her diet . Review of Resident #21's medical record did not reveal any SLP documentation. During an interview with the NP on 07/31/25 at 3:14 PM, she stated that the expectation was for any changes in diet consistency, residents will need to have an order for an evaluation by the SLP. Based on the recommendations for the type of diet, the resident can decide to adhere to the diet or sign a waiver regarding their decision to eat whatever they want. The NP reviewed Resident #21's medical record and confirmed that the resident did not have any SLP documentation regarding an evaluation for change in diet nor did Resident #5 have a waiver. During an interview with the SLP on 08/01/25 at 8:57 AM, she confirmed that an order was placed for a SLP referral to evaluate the resident on 12/30/24 and that there was no documentation to support that the resident received a SLP evaluation. The expectation was that the resident was seen by SLP to evaluate the resident and determine if the diet preference was appropriate. During an interview with the DON on 08/01/25 at 9:39 AM, she stated that her expectation was that nursing staff ensure all orders written are completed and the appropriate referrals are made. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RD on 08/01/2025 at 10:25 AM, she stated that she wrote the order for SLP, due to the resident's concern regarding her diet and food choice. She stated that her expectation was that if an order was placed for a referral, then the staff should make the appropriate referrals. Review of the facility's policy Referrals to Outside Agencies Policy effective 06/23/25 read, The purpose of this Policy is to provide (Facility Name) teammates with guidelines for referrals are made timely and appropriately to meet the needs of the resident .This policy is a guideline for making timely and appropriate referrals to meet resident's routine and emergency needs while at (Facility Name) If the physician orders an outside referral, nursing staff should notify the social worker (or designee) of the referral. The social services teammate may collaborate with nursing or other pertinent disciplines to arrange for the services that have been ordered by the physician . 3. Resident #66 was admitted to the facility 11/14/24 with diagnoses that included unspecified atrial fibrillation, cerebrovascular disease, and moderate persistent asthma. The resident was cognitively intact. During an interview on 07/29/25 at 11:42 AM, Resident #66 stated approximately two and a half (2 1/2) weeks ago she woke up and there were ants all over her bed. The Certified Nurse Aide (CNA) and the housekeeper tried to get all the ants up, but they were in the mattress. Resident #66 stated she continued to see ants for seven (7) days. She got ant bites on her upper back and neck area and a few bites on her left arm. She stated the doctor said, Oh that's just a rash. Resident #66 stated, I'm not completely stupid. I know bug bites from a rash. Resident #66 reported that she was prescribed a cream, but the staff only applied the cream one time. Review of a nurse's note dated 07/17/25 at 10:20 PM revealed, Resident [#66] is noted to have a rash to back side of left shoulder. Resident complaints of itching, she is provided hydrocortisone cream to area and encouraged not to scratch at area. Area is noted red, and raised areas, no drainage or open areas noted. Review of a Skin/Wound Note for Resident #66 dated 07/18/25 at 3:33 PM, revealed .Report of rash to L [left] posterior shoulder/back. Small, slightly red papules are noted. Scattered cluster pattern noted. No apparent rash. No drainage or induration. Resident denies itching at present. Resident reports she believes this is related to bug bites. Site to be monitored for change in appearance or symptom. Review of a Nurse Practitioner (NP) note dated 07/18/25 at 3:33 PM, revealed, .[Resident #66] Has itchy rash on left shoulder; hydrocortisone cream applied. Under the Physical Exam portion of the note was documented, .Skin: No rashes. There was no other documentation in the notes regarding assessment or treatment of the area where Resident #66 stated she had gotten ant bites. During an interview on 07/31/25 at 9:56 AM, Housekeeper #1 stated about a week or two ago, the housekeeper saw ants in the room of Resident #66. Housekeeper #1 saw a trail of ants by the bathroom door area going across the room. It was little black ants, and the ants were on the resident's mattress. During an interview on 07/31/25 at 10:23 AM, CNA #12 stated there were ants in Resident #66's room. The ants were getting on the resident's mattress and staff wiped off the mattress and cleaned it, but the ants came back. CNA #12 stated Resident #66 showed the CNA an ant bite on the left arm. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with Resident #66's daughter on 07/31/25 at 11:36 AM, the daughter stated Resident #66 had called the daughter on 07/17/25 and reported that she had ants in her room. She talked to Resident #66 again on 07/24/25 and Resident #66 stated the ants were still in her room and in her bed and they were biting her. The facility physician saw Resident #66 on 07/24/25 and told her it was dermatitis. Resident #66 and the daughter did not believe the area to be dermatitis. The daughter had taken pictures of the area and shown them to her doctor who told her they looked like bug bites. The daughter provided photographs to show the area Resident #66 was complaining were bug bites. Review of the photographs showed many areas of distinct raised papules that were reddened and were scattered on the resident's upper back area, with a cluster of approximately 10 distinctly separate papules to the back of the left shoulder, one (1) very large raised papule to the back of the right shoulder, and one (1) large papule on the underside of the left upper arm. Two (2) papules to the upper back appeared to have small open areas in the center. Review of the medical record revealed no documentation of an assessment by the facility's physician. During an interview on 07/31/25 at 2:40 PM, the NP reviewed her notes and stated that she did not describe in detail the appearance of Resident #66's skin when she assessed her. From memory, she stated it was reddened area, slightly raised area, and she was responding well to hydrocortisone cream. I don't think it was a new rash. The NP stated she recalled a discussion at some point about whether there were ants in the resident's room as reported by the resident and whether the resident was having some cognitive, behavioral, or delirium symptoms. The NP stated that had she known about bugs being confirmed in the room, she may have evaluated her different. The NP was unable to describe what a bug bite looked like and said, I don't know because I have never had a patient with bug bites. During an interview on 07/31/25 at 3:00 PM, Registered Nurse (RN) #1 stated staff reported to her that Resident #66 thought she had insect bites. RN #1 assessed Resident #66 on 07/18/25 and saw papules on the left shoulder that appeared scattered and clustered and there was no evidence of scratching. Resident #66 reported that she thought it was ant bites. RN #1 stated by the appearance, it could have been bug bites. The Interdisciplinary Team met the next morning and discussed that ants had been seen in the room and the plan was to have pest control come to the facility and housekeeping did a deep cleaning of the room. RN #1 stated Resident #66 was cognitively intact, a reliable historian, and had never shown any signs of delirium or behaviors. RN #1 stated hydrocortisone cream was prescribed and confirmed it was documented as having only been administered one time and that was on 07/17/25. Review of the Up To Date reference article titled Insect and Other Arthropod Bites last updated 05/22/25, revealed, .The bites of insects and other arthropods may be a minor nuisance or may lead to serious medical problems, including transmission of insect-borne illnesses and severe allergic reactions .Most arthropods are insects, but the phylum Arthropoda also includes spiders, centipedes, and crustaceans .Insect bites may result in several types of local reactions, papular urticaria, or systemic allergic reactions. Rarely, other forms of systemic reactions occur, such as serum sickness .he normal reaction to an insect bite is an inflammatory reaction at the site of the punctured skin, which appears within minutes and consists of pruritic local erythema and edema. A single punctum may be visible .Local reactions are caused by irritant substances concentrated in insect saliva (eg, anticoagulants such as factor Xa inhibitors, digestive enzymes such as amylases and esterases, agglutinins, and mucopolysaccharides). In some cases, a local reaction is followed by a delayed skin reaction consisting of local swelling, itching, and redness .

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	345475	A. Building B. Wing	08/01/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy titled Restorative Nursing Care, the facility failed to initiate restorative care nursing services for Activities of Daily Living (ADL) for two (2) residents out six (6) residents sampled for ADL decline and rehabilitation and restorative care (Residents' #3 and #5). The findings include:1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of right hand, adult failure to thrive, and end stage renal disease (ESRD). Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact.During an interview on 07/29/25 at 10:50 AM with Resident #3, she stated that she was not getting any stronger and still weak. She stated she was informed that she would continue with exercises, but the facility staff had done nothing. Review of Resident #3's therapy note dated 07/08/25 revealed .Pt will be DC on Thursday and be placed on restorative.PTA assisted POC supervisor with restorative paperwork. Communicated with restorative aide regarding clarification on goals for pt. once on the restorative program. Paperwork completed and restorative aide is confident in completing goals.Review of Resident #3's therapy note dated 07/10/25 revealed Per previous notes, pt. will be d/c today from PT to restorative program. Maximum progress/potential has been met with PT. Patient in agreement with this plan.Review of Resident #3's care plan revealed a care plan for ADL self-care performance deficit related to activity intolerance, impaired balance, decreased safety awareness, and limited mobility with no restorative nursing care interventions.Review of Resident #3's medical record revealed no restorative assessment or notes in the chart.Review of the Restorative Nursing List revealed Resident #3's name was missing.During an interview on 07/31/25 at 12:15 PM with the Physical Therapy Assistant (PTA), she stated that Resident #3 was discharged to the restorative program on 07/10/25 and was no longer on the therapy schedule. 2. Resident #5 was admitted to the facility on [DATE] with diagnoses that included below the knee amputation of left lower leg, peripheral vascular disease, chronic obstructive pulmonary disease (COPD), and morbid obesity.Review of Resident #5's Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact.During an interview with Resident #5 on 07/31/25 at 2:38 PM, he stated facility staff had not provided restorative care and he was advised by the physical therapist that someone would provide those services after he completed therapy.Review of Resident #5's therapy note dated 07/01/25 revealed .Patient was informed of findings and given opportunity to ask questions throughout. At this time, patient would like to be placed in the restorative program to maintain current functional status. Patient in agreement with plan.Review of Resident #5's care plan revealed a care plan for ADL self-care performance deficit related to debility, left below the knee amputation, peripheral arterial disease, diabetes, obesity and impaired balance with no restorative nursing care interventions.Review of Resident #5's medical record revealed no restorative assessment or notes in the chart.Review of the Restorative Nursing List revealed Resident #5's was listed as never enrolled.During an interview on 07/31/25 at 12:02 PM with the PTA, she stated Resident #5 was referred to the restorative program on 07/01/25 and was no longer on the therapy schedule.During an interview on 70/31/25 at 3:00 PM with the Nurse Practitioner (NP), she stated that if a resident completed therapy and was referred to the restorative program, the expectation was that staff would follow the physical therapist orders. During an interview on 07/31/25 at 4:28 PM with the Restorative Nurse Program (RNP) Coordinator/MDS Coordinator, she stated the process was that a restorative referral form was completed by therapy staff who provide that information to the restorative aide. The therapy staff then train the restorative Certified Nurse Aide (CNA) with the residents to help them to understand the exercises and care goals. The RNP Coordinator confirmed that Resident #3 and Resident #5 restorative therapy program referrals were missed.During an (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 08/01/2025 at 9:34 AM with the Director of Nursing, she stated the expectation was that if a resident was referred to restorative nursing care, then a restorative nursing assessment form was completed, and the resident should receive those services.Review of the policy titled Restorative Nursing Care, effective 11/12/24, read The purpose of this Policy is to provide (Facility Name) teammates with guidelines for restorative nursing care assisting each resident in achieving and maintaining an optimal level of self-care and independence. Restorative nursing care is rehabilitative nursing care that does not require the use of a qualified professional therapist. A resident may be referred to the restorative nursing program due to: In conjunction with, or at discharge from, therapy [physical therapy (PT), occupational therapy (OT), speech therapy. After a triggering event (such as weight loss, pressure ulcer, choking). Functional decline or maintenance need identified at time of admission or during stay and resident is not appropriate for therapy.

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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** Based on record review, interview, and review of the facility policies titled Bathing and Dressing Policy and Activities of Daily Living (ADLs) Policy, the facility failed to ensure showers were provided at least twice a week as scheduled for one (1) resident of three (3) sampled residents for ADLs (Resident #66). The findings include:Resident #66 was admitted to the facility 11/14/24 with diagnoses that included unspecified atrial fibrillation, cerebrovascular disease, and moderate persistent asthma. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #66 was cognitively intact. Resident #66 did not exhibit any mood or behavior symptoms and did not resist or refuse care. The resident required partial/moderate assistance with showering/bathing. During an interview on 07/29/25 at 11:48 AM, Resident #66 stated that she had trouble getting showers twice a week, mostly on nights when there was a male and a female Certified Nurse Aide (CNA) scheduled to work. She stated sometimes the female CNA would not be available to assist her with a shower, or if the female CNA called in sick, then she would not get a shower at all because there was only the male CNA to assist with showers, and she preferred a female CNA. She stated it happens about once a week that someone calls in. Review of the ADL Bathing charting for May, June, and July 2025 revealed bathing occurred for Resident #66 on Friday 5/2, Friday 5/9 (7 days in between), Monday 5/12, Monday 5/19 (7 days in between), Friday 5/23, Monday 5/26, Friday 5/30, Friday 6/6 (7 days in between), Friday 6/13 (7 days in between), Monday 6/16, Monday 6/23 (7 days in between), Friday 6/27, Monday 6/30, Friday 6/4, Friday 7/4, Monday 7/7, Friday 7/11, Friday 7/18 (7 days in between), Friday 7/25 (7 days in between), and Monday 7/28. During an interview on 07/30/25 at 4:40 PM, CNA #1 stated Resident #66 was scheduled to receive showers on the night shift on Wednesdays and Saturdays. The CNA stated Resident #66 was particular about receiving her showers at night at a particular time and was particular about which CNAs assisted her with her showers. During an interview on 08/01/25 at 11:50 AM, the Director of Nursing (DON) stated Resident #66 was scheduled for showers every Thursday and Sunday night before bed. The DON stated that when there was a male CNA working, there was always a female scheduled with the male to provide showers and care to those female residents who preferred a female caregiver. If the female CNA called in, then the nurse could provide bathing assistance or the Certified Medication Aide (CMA) would convert to CNA duties, providing a female CNA for resident bathing. The DON stated there should always be a female available to provide bathing assistance. Review of the facility's policy titled Bathing and Dressing Policy effective 09/10/24 revealed, .(Facility Name) will honor the resident's choices regarding preferences for bathing and dressing. Residents have the right to refuse bathing and dressing. If this occurs, nursing teammates may come back at a later time or attempt to see if another nursing teammate or family member can encourage resident to be bathed or dressed. Frequent or consistent refusals should be documented in the medical record and interventions noted in the care plan. Review of the facility's policy titled Activities of Daily Living (ADLs) Policy effective 09/17/24 read, The purpose of this Policy is to provide (Facility Name) teammates with guidelines for maintaining residents' ability to perform activities of daily living (ADLs) through the provision of appropriate treatment and services.(Facility Name) ensures that each resident will receive the appropriate treatment and services to maintain their ability to perform ADLs.(Facility Name) monitors ADLs because they are key indicators of a person's level of independence and of their ability to maintain their own health and safety.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, and review of the facility's Wound Care and Dressing Change-Clinical Protocol policy, facility staff failed to identify, treat, and/or implement appropriate measures to prevent friction-related skin tear/injuries during showering or personal care, in accordance with professional standards of practice for one (1) of three (3) residents reviewed, with fragile skin susceptible to injury (Resident #18).The findings include:1. Resident #18 was admitted to the facility on [DATE] with diagnoses that included encephalopathy, type 2 diabetes mellitus, vascular dementia without behavioral, peripheral vascular disease and glaucoma. During an observation and interview on 07/29/25 at 2:41 PM, Resident #18 sat in his room in a recliner chair with both legs elevated engaging with his sister. The resident's ankles were swollen and the skin on his lower legs were dry with dark pin-head size scabs. There was a two-centimeter redden/open and moist area on his left lower leg/shin. The resident's sister stated, That is a skin tear that happened when they showered him after he got here. I told them that his skin was thin (fragile) and to keep from tearing his skin, I always pat his legs dry because rubbing them takes the skin right off. Review of Resident #18's wound assessments for July 2025 revealed no documented evidence or description of fragile/thin skin, skin tears, or other injuries to the lower legs. Review of Resident #18's progress notes and care plan revealed no evidence of care and interventions to prevent skin irritation, abrasions, or tears related to fragile skin or friction. Review of the nursing progress notes, dated 07/13/25 revealed, Resident has scabs on his lower extremities with different forms of healing. There was no indication of a wound treatment plan for healing or protection. During an interview on 07/31/25 at 10:05 AM, the Registered/Wound Care Nurse (RN) #2 confirmed weekly skin assessments had been completed on Resident #18; she was aware of the scabs and the healed scars from old injuries on the resident's lower legs but was not aware of the open/moist skin tear on his lower left leg/shin. RN #2 stated that she would reassess and treat and/or notify the doctor to confirm treatment orders, as needed. On 07/31/25 at 10:05 AM, the Director of Nursing (DON) acknowledged that she was aware the skin the resident's legs were fragile and subject to skin tears/friction related injuries, during care. The DON did not provide whether a plan to treat the open wound or to prevent worsening had been developed. Review of the facility's Wound Care and Dressing Change-Clinical Protocol, dated 11/25/24 read .Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress, and wound stage. Document pertinent information in the medical record, including wound appearance (wound bed, edges, presence of drainage). Report other information in accordance with facility policy and professional standards of practice.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, and review of the facility's Restorative Nursing Care, policy, facility staff failed to provide or re-evaluate appropriate restorative treatment and services to increase, maintain and/or prevent decrease in range of motion (ROM) and/or mobility for one (1) of three (3) residents reviewed for limited ROM and/or mobility (Resident #s 45).The findings include: Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) following unspecified cerebrovascular disease affecting the left non-dominate side, morbid obesity, spinal stenosis and chronic respiratory failure. Review of the Comprehensive Minimum Data Set (MDS) dated [DATE] revealed the Resident #45's cognition was moderately impaired. The resident was dependent on staff to assist with activities of daily living (ADLs), for substantial assistance for bed mobility and transfers. During an observation and interview on 07/29/25 at 11:08 AM, Resident #45 expressed that she was unable to assist the staff with repositioning due to weakness in her extremities. The resident stated, My arms and legs are weaker now than when I came in. I am supposed to have intensive physical therapy (PT) but I have not. I used to be able to get out of bed with the staff's help; but I can't turn myself and not they use a lift to get me up. PT came one time, when I was vomiting but they left and never came back. I want to be able to at least help to turn myself in bed. No one exercised my arms or legs, and I wasn't shown how to do bed exercise.Review of Resident #45's medical record revealed no physician or rehabilitation orders for physical therapy, occupational therapy, or restorative nurse program services (RNP) to promote, attain or maintain the resident's highest practicable range of motion (ROM) and bed mobility. Review of Resident #45's comprehensive care plan revised on 07/21/25 revealed there were no focus, goals, or resident-centered interventions that addressed restorative care/services to maintain and/or prevent decreased ROM and/or bed mobility. Review of the list of residents currently enrolled in the RNP program revealed Resident #45 was not enrolled. During an interview on 07/30/25 at 12:45 PM, Physical Therapy Aide (PTA) #1 confirmed Resident #45 had received/attempted 3-5 physical therapy visits but was discharged due to her refusal to participate. The PTA stated, The resident can benefit from rehab services. Resident #45 had not been referred to the RNP for restorative service . During an interview on 07/30/25 at 2:03 PM, Certified Nurse Aide (CNA) #1 verified Resident #45 had not received therapy. She stated, The restorative aide (RA) helps the resident with things like bed exercises, ROM, and walking. During an interview on 07/30/25 at 2:10 PM, Licensed Practical Nurse (LPN) #2 confirmed the RA provided restorative services.During an interview on 07/30/25 at 3:00 PM, the RNP Director acknowledged that based on the resident's hemiplegia/hemiparesis diagnoses, limited/decreased ROM/mobility, and having not received rehabilitation services, she may be a candidate for the RNP services. The RNP Director stated, We typically receive referrals from physical therapy, but anyone can make a referral to the RNP. Resident #45 was never referred to, evaluated by, or enrolled in the RNP.On 07/30/25 at 3:15 PM, the RA stated that since Resident #45 was not enrolled in the RNP, she doesn't provide any restorative services. Review of the facility's Restorative Nursing Care policy, dated 11/12/24, read, The restorative nursing care program is designed to assist each resident in achieving and maintaining an optimal level of self-care and independence. A resident may be referred to the restorative nursing program. Functional decline or maintenance need identified at time of admission or during stay and resident is not appropriate for therapy.

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F 0689 Level of Harm - Minimal harm or potential for 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 observations, interviews, record reviews, and review of the facility's policy titled Fall Risk Reduction and Management, the facility staff failed to ensure fall prevention interventions were resident-centered, practicable, consistently implemented, and that adequate supervision was provided to prevent falls for two (2) of two (2) residents reviewed with a history of multiple falls (Residents' #18 and #33). Additionally, staff failed to document its assessment and safety education for the use of smokeless (chewing) tobacco and offer nicotine cessation alternatives for one (1) of one (1) resident who used smokeless tobacco (Resident #71). The findings include: 1. Resident #18 was admitted to the facility on [DATE] with diagnoses that included encephalopathy, type 2 diabetes mellitus, vascular dementia without behavioral, peripheral vascular disease and glaucoma. Review of the comprehensive Minimum Data Assessment (MDS) dated [DATE] revealed Resident #18's cognition was severely impaired. The ambulated with a walker. had bilateral lower extremity impairment and required partial assistance from another person to complete activities. During an observation and interview on 07/29/25 at 2:37 PM, the resident reclined in the chair, next to the bed, with the legs raised and fully extended. The call light was in the middle of the bed; where the resident attempted to reach it but could not. There was no fall mat observed in the room. The resident was pleasantly confused but engaging with his sister. He lowered the recliner's foot rest without assistance and stated, I can get up by myself and go to the bathroom. The resident's sister reminded him to use his call bell for help when he wants to get up. The walker was 15-feet across the room and was not within the resident's reach. The resident's sister stated, He tries to get up by himself even though his walker is often across the room, where he can't reach it, when come to visit. We have been called and told that he'd fallen three or four times in the short time he's been here-once in the bathroom and twice in his room.Review of the resident's care plan revised 07/21/25 revealed, Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The residents need prompt response to all requests for assistance.Review of medical records and the post fall Briggs Fall Risk report, dated 07/19/25 revealed Resident #18 had no falls within the past three months. No admission fall assessment was observed. Review of the facility's Incident by Incident Type report for the period between 02/28/25 to 07/29/25 revealed the resident fell on [DATE] at 1:58 AM, 07/02/25 at 7:10 AM and 07/19/25 at 7:20 PM.During an interview on 07/30/25 Certified Nurse Aide (CNA) #1 confirmed the resident was mobile with a walker and had fallen multiple times. She stated, The resident tries to get up by himself and we have to remind him to remind him to use his call light. During an interview on 07/31/25 at 10:05 AM, the Director of Nursing (DON) confirmed the resident had fallen three times in the three weeks since admission. The Registered Nurse Manager (RNM) #3 stated, We are aware of the multiple resident falls. A root cause analysis was conducted after each fall and the care plan updated. The DON and RNM confirmed the call light and the resident's walker should have been within reach and easily accessible. The DON also stated, A sign that reminds the resident to call for help should have been on the resident's bedside table.During an observation on 07/31/25 at 10:56 AM, Resident #18 sat in his recliner chair with his feet in a dependent position on the floor. The resident's walker was across the room approximately 5-feet from where he sat. An 11 x 8.5-inch white laminated sheet with PLEASE USE YOUR CALL BELL FOR ASSISTANCE was on the window bench, propped against the wall. The resident looked in the direction of the sign and stated that he was not sure what it was. Review of the facility's policy titled Fall Risk Reduction and Management revised 09/10/24 read, 6. When managing the risks for falls, the hourly needs for the 4 Ps should be considered: Position; Personal needs (toileting); Pain; and Placement (bed height and belongings, call light within reach). If the resident continues to fall, the teammates will re-evaluate the situation to determine whether it is appropriate to continue or change (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions. As needed, the Provider will help the teammates reconsider possible causes of falls that may not previously have been identified. 2. Resident #33 was admitted to the facility on [DATE] with diagnoses that included other abnormalities of gait and mobility and hallucinations, unspecified. Review of the quarterly MDS dated [DATE] revealed Resident #33's cognition was intact. The resident is ambulatory and required partial assistance from another person to complete activities.During an observation and interview on 07/29/25 at 3:26 PM Resident #33 stated that she had fallen several times since admission. She stated, I sometimes hallucinate and try to go get the animals I see. The bed was not in the lowest position; there was no fall mat next to the bed; and no precaution reminder signs about the room. Review of the Incident by Incident Type report for the period between 02/28/25 to 07/29/25 revealed the resident had four (4) unwitnessed falls within two months on 05/11/25 at 7:30 AM, 06/11/25 at 2:20 AM, 06/19/25 at 11:10 AM, and 06/05/25 at 10:30 PM. During an interview on 07/30/25, CNA #3 confirmed the resident had a history of falling; and the bed was not in the lowest position. She stated, The resident's bed should be in the lowest position and if care planned for it, a fall mat should be next to the bed. I'm not sure why there is no mat in the room. We also remind the resident not to get out of bed by herself and to use the call bell when she needs help. During an observation on 07/30/25 at 1:37 PM, Resident #33 was lying in bed with no fall mat next to the bed or visible in the room, the bed was raised two (2) feet off the floor, and the bed was not in the lowest position. During an interview on 07/31/25 at 10:03 AM, the DON and RNM stated that staff was expected to ensure the resident's bed was in the lowest position and the fall prevention mat was in place when the resident was in bed. The RNM confirmed the bed was not in the lowest position at 2-feet from the floor. On 07/31/25 at 2:00 PM, Resident #33 lay in bed awake and alert. The fall mat was not in place next to the resident's bed or observed in the resident's room. During an interview on 07/31/25 at 2:15 PM, Licensed Practical Nurse (LPN) #1 confirmed there was no fall mat next to Resident #33's bed or in the room. She stated, I checked the orders, and one should be there. I have ordered one for her. 3. Resident #71 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillations, gastro-esophageal reflux disease, atherosclerotic heart disease, cardiac arrythmias, and essential hypertension. During an observation and interview on 07/29/25 at 4:45 PM, the resident sat in her wheelchair, alert and responded appropriately to questions. The resident was extremely hard of hearing and was visually impaired. The resident's natural teeth were badly stained. She stated that she had not seen the dentist and had not asked. On 07/30/25 at 1:30 PM, a 3-5 centimeter (cm) sized dark brown chunk of chewing tobacco looking substance was observed in a 1-ounce plastic medicine cup on top of a table in the [NAME] neighborhood's day room. LPN #2 and CNA #3 confirmed the substance was previously chewed tobacco that belonged to Resident #71. Review of medical records revealed no smoking evaluation to determine the safe use of tobacco products. During an interview on 07/31/25 at 10:15 AM, the DON confirmed that she was aware the resident used chewing tobacco that she kept at her bedside. She stated, We can't do anything about it. This is a non-smoking facility, so the resident was not evaluated for safe use of tobacco products.

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	345475	A. Building B. Wing	08/01/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy titled Dialysis Services and the Nursing Home Dialysis Transfer Agreement, the facility failed to ensure one (1) of one (1) sampled residents reviewed for dialysis services had coordinated care with the dialysis center to include communication between both facilities regarding the assessment of the resident pre and post dialysis for any changes in condition and/or for any complications and providing updates to the health care provider and dialysis center regarding missed dialysis visits to ensure appropriate interventions were developed and followed (Resident #3) . The findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD) requiring hemodialysis three days per week, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of right hand, and adult failure to thrive. Review of the Medication Administration Records (MAR) for July 2025 revealed Resident #3's pre and post dialysis weights, vital signs, and/or vascular assessment were not documented on 07/16/25, 07/21/25, and 07/30/25. In addition, the July 2025 Dialysis/SNF Hand-Off communication Reports were incomplete and/or not completed on 07/09/25, 07/14/25, 07/18/25, 07/21/25, 07/23/25, 07/25/25, 07/28/25, and 07/30/25. Review of the July 2025 nurse's notes revealed there was no documentation on 07/11/25 and 07/16/25 to indicate the reason for Resident #3 missing dialysis, no documentation of communication with the dialysis center, and no indication that the physician was notified of missed the dialysis visits. During an interview on 08/01/25 at 8:50 AM with Licensed Practical Nurse (LPN) #4, he stated that prior to dialysis, the assigned nurse would assess the resident and obtain vital signs which included a weight and then complete the dialysis communication form. LPN #4 stated that he did not take resident's vital signs or weight upon return from dialysis. He would take them from the dialysis communication section completed by the dialysis center staff. During an interview with the Director of Nursing (DON) on 08/01/25 at 9:30 AM, she stated that according to the blank MAR dates of 07/11/25 and 07/16/25, Resident #3 did not go to dialysis and there was no documentation in the medical record to indicate the missed visit or that the physician or dialysis center was notified. She stated that her expectation was that nursing staff perform an assessment which included pre and post dialysis vital signs, dialysis access checks, and weights. The DON further stated that the nursing staff was expected to contact the provider for any missed dialysis visits, communicate with the dialysis center, and document any missed dialysis visits in the resident's chart. Review of the facility's policy titled Dialysis Services, reviewed 09/10/24 read . 5. (Facility Name) nursing teammates provide ongoing assessment of the resident's condition, including monitoring for complications before and after treatments received at a certified dialysis facility.7. (Facility Name) nursing teammates are trained in the assessment of dialysis access sites including arterial venous (AV) grafts and fistulas, and in appropriate infection control measures. nursing teammates provide immediate monitoring and documentation of the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications.11. The nephrologist\ dialysis team and the resident's Provider must be notified of a canceled or postponed dialysis treatment, and responses to the change in treatment must be documented in the resident's medical record. If dialysis is canceled or postponed, the nursing home and dialysis staff should provide or obtain ongoing monitoring and medical management for changes such as fluid gain, respiratory issues, review of relevant lab results, and any other complications that occur until dialysis can be rescheduled based on resident assessment, stability, and need. Review of the Nursing Home Dialysis Transfer Agreement, read .6.Facility will provide for the interchange of information useful or necessary for the care of the Designated Resident and will inform Center of a contact person at the Facility whose responsibilities include oversight of provision of dialysis services by Center to the Designated Residents of Facility.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy titled Social Services-Behavioral Health Services and Trauma-Informed Care, the facility failed to assess the needs of a resident with a history of post-traumatic stress disorder (PTSD) for one (1) of twenty-three (23) sampled residents (Resident# 8).The findings include:Resident #8 was admitted to the facility 06/24/24 with diagnoses that included schizoaffective disorder, bipolar type; post-traumatic stress disorder (PTSD); depression and type 2 diabetes.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had mild cognitive impairment and a diagnosis of PTSD; no behaviors during seven-day (7) day look back period and was independent with activities of daily living (ADLS).Review of the medical record revealed, there were no specific assessment that addressed Resident #8's specific needs to related to the PTSD diagnosis to minimize triggers and to prevent re-traumatization of the resident.During observation and interview on 07/30/25 at 4:42 PM, Resident #8 was observed fully dressed and reclined in supine position. The resident said she was not aware of her behavioral health diagnosis and denied talking to anyone about her mood. She stated, Sometimes I feel sad and would like to talk to someone.During observation and interview on 07/31/25 at 11:00 AM Resident #8 was observed in the room dressed and playing music. The resident stated, I'm getting ready to go walking. She denied any concerns.During an interview on 07/31/25 at 11:30 am with Social Worker (SW) #1 regarding Resident's #8 PTSD diagnosis and specific cultural or trauma focused assessment, she denied completing a social history or trauma assessment. She stated, I know the resident personally; I live on the same street as her mother. SW #1 reported the resident had a history of sexual trauma and the resident was triggered by men that she did not know. She confirmed Resident #8 was recently triggered by a new male Certified Nurse Aide (CNA). She did inform the Director of Nursing (DON) so that the resident was not assigned the male CNA. SW #1 confirmed that this information was not listed in the resident's medical record. She agreed that an assessment should be completed with information that would assist facility staff to provide person-centered, trauma-informed care.Review of the facility's policy titled (Facility Name) Social Services-Behavioral Health Services and Trauma-Informed Care dated 10/8/24 read, . Trauma informed care. Procedure:.2. Individual Assessment: Upon admission, Resident admitted with such disorders or who have a history of PTSD will receive appropriate person-centered treatment and services to meet their assessed needs. Facilities use a multi-pronged approach to identify a resident's history of trauma as well as their cultural preferences. This includes asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and a review of the facility's Referrals to Outside Agencies policy, facility staff failed to assess residents' dental care needs and did not assist with coordinating, scheduling, or rescheduling routine or emergency dental evaluations for two (2) of three (3) residents reviewed. This included one resident with a missing upper denture (Resident #45) and another with broken and decayed teeth (Resident #70). The findings include: 1.Resident #70 was admitted to the facility 10/07/24 with diagnoses that included acute osteomyelitis left ankle and foot, heart failure, and Alzheimer's disease, chronic diastolic (congestive) heart failure. Review of the significant change in status Minimum Data Set (MDS) dated [DATE] revealed Resident #70 had moderately impaired cognition, required partial/moderate assistance with eating and substantial/maximal assistance with oral hygiene, had obvious or likely cavities or broken natural teeth, and had not lost weight. During observations and interviews on 07/29/25 at 10:25 AM, 07/30/25 at 3:20 PM, and 08/01/25 at 8:30 AM, Resident #70 was observed to have no upper teeth and his bottom teeth included broken teeth, darkly colored teeth, and appeared to have caries. Resident #70 stated he had upper dentures that he did not wear and confirmed he had poor bottom teeth. During an interview on 08/01/25 at 9:05 AM, Certified Nurse Aide (CNA) #9 stated Resident #70 had upper dentures, but he would not wear them. CNA #9 confirmed Resident #70 had dental caries on the bottom row of teeth, but he did not complain of pain or have trouble eating. CNA #9 was unaware of Resident #70 being seen by a dentist. During an interview on 08/01/25 at 9:50 AM, Licensed Practical Nurse (LPN) #6, the nurse for Resident #70, stated she did not know how residents were scheduled for dental appointments or how to ensure a resident was seen by a dentist. During an interview on 08/01/25 at 10:41 AM, the Director of Nursing (DON) stated the nurses were responsible for writing the orders for a resident to have a dental appointment. The DON reviewed the medical record and confirmed Resident #70 had not been seen by a dentist. 2. Resident #45 was admitted to the facility on [DATE] . During an observation and interview on 07/29/25 at 11:17 AM, Resident #45 stated, I lost my dentures during the transfer her. I need replacement top dentures. I have trouble eating without my upper plate. They took me to the dentist but told me he could not see me because I was in a wheelchair. During an interview on 07/30/25 at 10:00 AM, Social Worker (SW) #1 confirmed the resident had requested assistance with replacing her upper denture plate. SW #1 deferred to Scheduling Coordinator (SC) #1, who stated, The resident was transported to the Affordable Dentures office, but we were told that she could not be seen because she was unable to get out of the wheelchair. We tried other dental service providers but because the resident's payor source is Medicaid, we are (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited. We have been working on this for a while. Review of the nursing progress notes, dated 06/03/25 revealed, Took the resident to Affordable Dentures in Asheville. After getting there, the dentist told us that they couldn't see the resident because she was unable to transfer from her wheelchair for an X-ray, and that the other dentist who usually sees patients in wheelchairs was out this week. On 07/31/25 at 3:30 PM, SW #1 confirmed the unsuccessful appointment and stated, We should have rescheduled an appointment with the dentist that usually sees patients in wheelchairs at Affordable Dentures. The facility did not provide a dental service policy. Review of the facility's policy Referrals to Outside Agencies Policy effective 06/23/25 read, The purpose of this Policy is to provide (Facility Name) teammates with guidelines for referrals are made timely and appropriately to meet the needs of the resident .This policy is a guideline for making timely and appropriate referrals to meet resident's routine and emergency needs while at (Facility Name) If the physician orders an outside referral, nursing staff should notify the social worker (or designee) of the referral. The social services teammate may collaborate with nursing or other pertinent disciplines to arrange for the services that have been ordered by the physician .