STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to honor a resident's request for a shower to be stopped when the resident told Nursing Assistant (NA) #3 to stop because he was man handling him. Resident #13 stated he was fearful of NA #3 and felt like no one was listening to him when he told staff about the incident. Additionally, the facility failed to maintain a resident's dignity by not placing a privacy/ dignity cover over his urine collection bag exposing his urine which was visible from the hallway to other residents, staff and visitors. This occurred for 2 of 3 residents reviewed for dignity (Resident #13 and Resident #3).The findings included: 1. Resident #13 was admitted to the facility on [DATE] with diagnoses that included chronic pain and dementia. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was moderately cognitively impaired. The MDS documented the resident as having behavioral symptoms not directed towards others for 4-6 days during the look back period. Resident #13 was also documented as being dependent on staff for toileting and bathing. Resident #13's active care plan edited on 10/28/25 revealed resident needed extensive to dependent assistance with most activities of daily living. The goal for Resident #13 was that he would have safe transfers. The interventions included encourage participation with activities of daily living, do not rush resident, provide extensive assistance as needed. Resident #13 was interviewed on 12/8/25 at 4:18pm. Resident #13 discussed NA #3 was rough with him a couple of months ago. Resident #13 stated it started when NA #3 transferred him from his wheelchair onto the shower chair. He stated NA #3 handled him roughly. Resident #13 explained he told NA #3 to stop being rough with him, but the NA did not listen. He stated throughout his shower NA #3 was man handling and being rough. He stated he told NA #3 to stop because he was hurting him, but NA #3 did not stop or say anything. Resident #13 explained once he was back in his room, he told people what happened (could not remember who) but no one was listening to him. He stated he was fearful of NA #3 and upset no one was listening. Resident #13 stated NA #3 had not been assigned to him since the incident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with NA #3 on 12/11/25 at 8:44am, NA #3 confirmed he had been assigned to Resident #13 on 10/2/25 and provided Resident #13 with a shower. NA #3 described the incident saying as soon as he began to transfer Resident #13 from his wheelchair to the shower chair, Resident #13 began yelling telling him to stop and saying NA #3 was man handling him. NA #3 stated he proceeded to take Resident #13 to the shower and once the water was adjusted right, he put soap on the washcloth and began washing Resident #13. NA #3 explained Resident #13 began telling him to stop and saying NA #3 was being too rough. NA #3 stated he rinsed Resident #13 off, got him dressed, and returned him to his room. NA #3 stated he never told a staff member or his supervisor what had occurred with Resident #13. He also stated he did not stop when the resident asked because he was not man handling him or being rough. The Director of Nursing (DON) was interviewed on 12/12/25 at 2:14pm. The DON stated she would have wanted to know what happened between Resident #13 and NA #3 when it happened, not later. She also stated NA #3 should have stopped when Resident #13 had requested NA #3 to stop and treated the resident in a dignified manner. The DON confirmed the facility had removed Resident #13 from NA #3's assignment. The Administrator was interviewed on 12/12/25 at 2:58pm. The Administrator stated NA #3 should have stopped when requested by Resident #13 and reported the incident to the nurse. 2. Resident #3 readmitted to the facility on [DATE]. Resident #3's significant change Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #3 was severely cognitively impaired and had an indwelling catheter in place. Resident #3's care plan dated 11/05/2025 revealed he was at risk for rehospitalization related to recent hospital stay for urinary tract infection (UTI) and has an indwelling catheter in place. Interventions included staff to provide catheter care as ordered and staff to change catheter as ordered. An observation from the hallway was completed of Resident #3 on 12/09/2025 at 10:55 AM. Resident #3 was observed in bed resting. His bed was in a low position, and his urine collection bag was observed from the hallway. The urine collection bag was observed to be one fourth full of amber colored urine. Visitors, nursing staff (nurses and nurse aides), residents, and other staff (housekeepers) were observed passing Resident #3's room. An observation from the hallway was completed of Resident #3 during lunch meal service on 12/09/2025 at 1:41 PM. Resident #3 was observed in his bed, watching television, and eating his lunch meal. His urine collection bag was observed from the hallway with amber colored urine. The urine collection bag was one fourth full. Visitors, nursing staff (nurses and nurse aides), residents, and other staff (housekeepers) were observed passing Resident #3's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse Aide (NA) #13 was completed on 12/09/2025 at 2:37 PM. NA #13 stated she has worked at the facility since October of 2025. NA #13 explained she had 2 residents with catheters, and she was responsible for emptying the urine collection bag when needed. She explained she generally emptied the urine collection bags on her assignment at the end of her shift (7:00 AM to 3:00 PM) to report to the nurse the resident's urinary output. NA #13 further stated she emptied the urine collection bags as needed as well. An observation of Resident #3 was completed with NA #13 at 2:42 PM. NA #13 stated she had just emptied Resident #3's urine collection bag and reported the urinary output to Nurse #9. NA #13 verbalized she had not noticed Resident #1's catheter bag not having a privacy/ dignity cover in place and his urine being visible from the hallway. NA #13 stated Resident #3 needed a privacy/ dignity cover, and she would inform Nurse #9. An interview was completed with Nurse #9 regarding Resident #3 on 12/09/2025 at 2:48 PM. Nurse #9 stated Resident #3 had a catheter in place and required a catheter bag for urine collection. Nurse #9 and this writer made an observation of Resident #3 from the hallway at 2:50 PM. Nurse #9 verbalized that Resident #3 did not have a privacy/ dignity cover on his urine collection bag. Light yellow colored urine was visible from the hallway in the urine collection bag. Nurse #9 explained Resident #3 had a recent procedure at the urology office and his catheter was changed while out of the facility. Nurse #9 continued to explain when Resident #3 returned from this procedure, staff should have made sure the privacy/ dignity cover was in place on his urine collection bag. Nurse #9 voiced the privacy/ dignity cover was important to maintain the resident's dignity and privacy. An interview was completed with Nurse #17 on 12/09/2025 at 2:55 PM who stated nurses were trained on dignity and ensuring Resident's privacy/ dignity was maintained when having a catheter with a urine collection bag was in place. Nurse #17 explained Resident #3 slipped through the cracks when he returned from his urology appointment. Nurse #17 stated Resident #3 would have a privacy/ dignity cover for his urine collection bag in place immediately. An interview was completed with Resident #3's Family Member via telephone call on 12/09/2025 at 3:47 PM. Resident #3's Family Member stated he (Resident #3) would not appreciate others being able to see his urine from the hallway. The Family Member stated they would prefer his urine collection bag to be covered to maintain his privacy/ dignity. The Family Member indicated they visited 2 to 3 times per month as their health allowed and could not recall if Resident #3's urine collection bag had been covered or not when they visited. An observation and interview was completed with the Director of Nursing (DON) on 12/10/2025 at 8:50 AM. Resident #3's urine collection bag remained uncovered and Resident #3's urine remained visible from the hallway. The DON stated nurses and nurse aides should check to make sure that privacy/ dignity covers on the urine collection bags were in place to maintain the resident's privacy/ dignity throughout their shift. Staff were trained on dignity inclusive of ensuring privacy/ dignity covers were in place for those residents that have urine collection bags. Staff were trained annually and upon hire on dignity and catheter care inclusive of ensuring the privacy/ dignity covers were in place. If a privacy/ dignity cover was missing from the urine collection bag, nurses and nurse aides should go to the supply room to obtain a replacement cover. The DON was not certain why Resident #3 did not have a privacy/ dignity cover in place after his procedure and return to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Based on observations and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all required state agencies and advocacy groups, including the State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. These observations occurred on 4 of the 5 days of the onsite recertification survey.The findings included: An observation completed on 12/08/2025 at 10:51 AM of the front hallway bulletin board revealed no signage in place for the State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An observation completed on 12/09/2025 at 11:43 AM of the front hallway bulletin board revealed no signage in place for State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An observation completed on 12/10/2025 at 9:55 AM of the front hallway bulletin board revealed no signage in place for State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An observation completed on 12/11/2025 at 8:30 AM of the front hallway bulletin board revealed no signage in place for State Survey Agency, Adult Protective Services, State Long-Term Care Ombudsman Program, and the Resident Advocacy Network, Home and Community Based Service Programs, or Medicaid Fraud Control Unit information. The first-floor nurses station wall had a Resident Rights poster with the current local Ombudsman's contact information. The second-floor nurses station wall had a Resident Rights poster with the previous local Ombudsman's contact information. No other postings were observed. An interview with the Recreation Director completed on 12/11/2025 at 9:17 AM revealed she put up Resident Rights posters with the local Ombudsman's contact information in the front lobby hall bulletin board and at each nurse's station. She explained she changed the local Ombudsman's contact information when a new person started earlier this year. She did not mention why the second-floor poster information hadn't been changed. The Recreation Director stated she didn't have anything to do with the other signs on the main bulletin board and wasn't sure who did but thought it might be the Social Worker. An interview with the Social Worker completed on 12/11/2025 at 9:26 AM revealed she wasn't the person who put the posting signs up on the front hallway bulletin board and didn't know if they were up to date. She stated the Administrator would know if any posting signs needed to be changed. An interview and walking tour was completed with Administrator on 12/11/2025 at 9:35 AM who explained the Recreation Director kept Resident's Rights and Ombudsman's information up to date in the front hallway bulletin board and at the two nurses' stations. The Administrator stated he thought current postings on the front hallway bulletin board had included what had been required but he would investigate it. The Administrator revealed the information for State Survey Agency, Adult Protective Services, State Long Term Care Ombudsman, and the Resident Advocacy Network, Home and Community Based Services Program, and Medicaid Fraud Control hadn't been posted since he had been the Administrator for over three years. He further explained there were also Resident Rights posters with the local Ombudsman's contact information on the upstairs and downstairs resident halls. He stated if something had changed, he would have let the social worker or someone know to make sure the updated information had been posted and hadn't realized the local Ombudsman's information hadn't been updated on the second-floor Resident Rights poster. During a follow up interview on 12/11/2025 at 4:15 PM, the Administrator stated it was important for residents, families and visitors to have access to information in the required postings in case they had any questions or concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Consultant Pharmacist and Physician interviews, the facility failed to ensure Resident #2 had a diagnosis for the use of antipsychotic medication and the as needed (PRN) antipsychotic medication, Haldol, used to regulate mood, behaviors, and thoughts, had a stop date of 14 days. The facility also failed to ensure Resident #1 had a diagnosis for the use of antipsychotic medication and antidepressant medication. This occurred for 2 of 5 residents reviewed for unnecessary medications (Resident #2, and Resident #1).The findings included:1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included mild dementia with agitation, brief psychotic disorder and anxiety. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was severely cognitively impaired. The MDS documented Resident #2 had physical behavioral symptoms directed towards others for 1 to 3 days during a 7-day period. The resident was not documented as receiving an antipsychotic medication.Physician order dated 11/3/25 revealed Resident #2 was ordered Haldol lactate solution (antipsychotic) 5 milligrams (mg)/1 milliliter (ml), administer 2mg intramuscular (IM) every 4 hours PRN for agitation. The end date was 1/3/26.Resident #2's active care plan revised on 11/20/25 revealed a problem with mood state. The goals for Resident #2 included he would not exhibit signs of drug related sedation, hypotension, or anticholinergic symptoms. The interventions included resident was on hospice, administering medications as ordered, following pharmacy recommendations, and pharmacy consult review monthly.Pharmacy review dated 12/5/25 read per hospice, haloperidol 2mg IM every 4 hours PRN agitation for 60 days.During an interview with the Physician Assistant (PA) and Physician on 12/10/25 at 3:15pm, the PA stated she and the hospice Physician wrote the Haldol order together for Resident #2. She stated the end date was written for 60 days because Resident #2 had behaviors and was non-compliant with oral medications. The PA also stated Resident #2's diagnosis of brief psychotic disorder was the mental health diagnosis justifying the use of Haldol and was unaware the Haldol order was written for agitation. The PA stated she was unaware antipsychotic PRN medication could only be written for 14 days.The Consultant Pharmacist was interviewed by telephone on 12/10/25 at 3:52pm. The Consultant Pharmacist discussed during her monthly medication reviews, she reviewed all the medications, ensured there was a diagnosis for the medication and that the stop dates, if needed, were correct. She confirmed Resident #2's PRN Haldol was written for 60 days but was unaware, since the resident was on hospice, that a diagnosis of agitation could not be used. The Consultant Pharmacist stated the PRN Haldol should be written for 14 days and stated she did not question the order because the order came from the hospice Physician.An interview with the Director of Nursing (DON) conducted on 12/12/25 at 2:27pm revealed the facility relied on the pharmacy's review to check medication orders. She explained the facility did not have staff verify medication orders for accuracy. The DON stated no one was aware until recently (12/10/25) that there were time frames for PRN antipsychotic medications.The Administrator was interviewed on 12/12/25 at 3:03pm and stated he had nothing to add.2. Resident #1 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral or psychotic disturbances. There were no mental health diagnoses.The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was cognitively intact with no behaviors. The MDS also documented Resident #1 was on antipsychotic and antidepressant medication.Physician order dated 10/8/25 for olanzapine (antipsychotic) 5 milligrams (mg) at bedtime for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Physician order dated 10/9/25 for sertraline (antidepressant) 50mg once a day for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #1's active care plan dated 10/20/25 revealed a problem with mood state. The goal for Resident #1 was he would not exhibit signs of drug related sedation, hypotension, or anticholinergic symptoms. The interventions included administer medication as ordered, assessing/record effectiveness, follow up on pharmacy recommendations, and pharmacy consult review monthly.Physician order dated 12/3/25 olanzapine 5mg at bedtime for unspecified dementia without behavioral and/or psychotic disturbances.Physician order dated 12/3/25 sertraline 50mg once a day for unspecified dementia without behavioral/mood/anxiety disturbances.Progress notes reviewed from 11/9/25 through 12/9/25 revealed no documentation of Resident #1 having behaviors other than yelling out for help instead of using his call light.An interview occurred with the Physician Assistant (PA) and the Physician on 12/10/25 at 3:15pm. The PA confirmed there were no diagnosis of depression or psychosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, and resident, Resident Representative, Physician Assistant, and Psychiatric Nurse Practitioner interviews, the facility failed to follow and implement their abuse policy and procedures in the areas of protecting and reporting to the Administrator for 1 of 3 residents reviewed for abuse (Resident #13). Resident #13 told Nursing Assistant (NA) #3 that the NA was treating him roughly and man handling him and to stop care. NA #3 did not stop the care. NA #9 heard Resident #13 state that NA #3 treated him roughly and was man handling him during his shower. Neither NA #3 or NA #9 reported the incident to administration or the charge nurse on duty allowing NA #3 to finish his shift and to return to work the next day. This failure resulted in a lack of protection for other residents. The findings included:The facility's policy Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property reviewed on 12/7/22 stated any allegation, suspicion, or identified occurrences involving patient abuse should be immediately reported to the Administrator. The policy also documented that all staff involved were required to cooperate with internal/external investigative procedures and the provider was responsible for safeguarding the patient and preventing a reoccurrence.Resident #13 was admitted to the facility on [DATE] with multiple diagnoses that included unspecified dementia, chronic obstructive pulmonary disease, and chronic pain.Resident #13 was interviewed on 12/8/25 at 4:18pm. Resident #13 discussed NA #3 was rough with him a couple of months ago. Resident #13 stated it started when NA #3 transferred him from his wheelchair onto the shower chair. He stated NA #3 handled him roughly. Resident #13 explained he told NA #3 to stop being rough with him, but the NA did not listen. He stated throughout his shower NA #3 was man handling and being rough. He stated he told NA #3 to stop because he was hurting him, but NA #3 did not stop or say anything. Resident #13 explained once he was back in his room, he told staff what happened (could not remember who) but no one was listening to him. He stated he was fearful of NA #3 and upset no one was listening. Resident #13 stated NA #3 had not been assigned to him since the incident.Review of the facility's schedules for 10/2/25 revealed NA #3 was assigned to Resident #13 and NA #3 completed his whole shift (7:00am to 3:00pm) on 10/2/25.During a telephone interview with NA #3 on 12/11/25 at 8:44am, NA #3 confirmed he had been assigned to Resident #13 on 10/2/25 and provided Resident #13 with a shower. NA #3 described the incident saying as soon as he began to transfer Resident #13 from his wheelchair to the shower chair, Resident #13 began yelling telling him to stop and saying NA #3 was man handling him. NA #3 stated he proceeded to take Resident #13 to the shower and once the water was adjusted right, he put soap on the washcloth and began washing Resident #13. NA #3 explained Resident #13 began telling him to stop and saying NA #3 was being too rough. NA #3 stated he rinsed Resident #13 off, got him dressed, and returned him to his room. NA #3 stated he never told a staff member or his supervisor what had occurred with Resident #13. He also stated he did not stop when the resident asked because he was not man handling him or being rough. NA #3 confirmed he finished his shift on 10/2/25 and that he worked on 10/3/25 and was assigned to the 2nd floor, not to Resident #13 on 10/3/25. He stated on 10/5/25 he received a call from the Director of Nursing (DON) telling him he was suspended during the investigation. NA #3 stated he was suspended for a week and then returned to work. He stated once he returned to work, he was not assigned to Resident #13.Review of the facility's schedules for 10/3/25 revealed NA #3 had worked that day and was assigned to the 2nd floor, not with Resident #13. NA #9 was interviewed on 12/11/25 at 9:24am. NA #9 discussed working on the same hall as NA #3 on 10/2/25 but was not assigned to Resident #13. She stated she was on the hall when NA #3 brought Resident #13 back from the shower and heard Resident #13 stating that he was man handled and treated rough while in the shower. NA #9 explained that she did not report the allegation by Resident #13 because, I didn't know what was going on. NA #9 went on to explain she was in the dining room shortly after lunch with Resident #13 when NA #3 came to take Resident #13 to be changed. She stated she heard Resident #13 state, please don't be rough with me again like you were in the shower. NA #9 stated she reported the incident to Nurse #15 and then stated, everyone knew what the resident said.A telephone interview occurred with Nurse #15 on 12/11/25 at 9:43am. Nurse #15 confirmed she had been working in the same hall as NA #3 and NA #9 and was assigned to Resident #13 on 10/2/25. The nurse stated she did not remember any staff member telling her that Resident #13 felt he was man handled in the shower. Nurse #15 explained if she had been told a resident was being man handled she would have reported it right away to management.A telephone interview occurred with Resident #13's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and physician interviews, the facility failed to administer lidocaine 4% external pain patches per the Physician order for 1 of 6 residents reviewed for medication regimen review (Resident #34).The findings included:Resident #34 was admitted to the facility on [DATE] with diagnoses of pain in right hip and low back pain.A review of Resident #34's physician orders revealed an order dated 08/13/2025 for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily.A review of Resident #34's Medication Administration Record (MAR) revealed Nurse #8 signed the MAR for the four Lidocaine patch administration on 12/11/2025. The MAR specified for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily.A record review and interview with Nurse #6 on 12/11/2025 at 11:00 am revealed that she had only placed two lidocaine patches on Resident #34 for all of the dates she worked in November, which included November 2nd, 12th, 15th, 18th, 19th, 20th, 24th, 25th, 26th, 27th, and 29th of 2025. Nurse #6 stated she had placed the two patches either on Resident #34's low back or on her hips, but not both. Nurse #6 confirmed the order had not been changed but verbalized in her opinion Resident #34 no longer needed to have four patches, so she did not apply the four patches per the physician's order. Nurse #6 voiced she could have requested a new order from the physician, but she did not. A record review and interview with Nurse #8 on 12/11/2025 at 10:50 am revealed she had not ever placed four patches on Resident #34 when she provided her medications in the past. When reviewing the MARs for the dates that she worked in September, October, and November of 2025, Nurse #8 explained she had only placed one lidocaine patch on Resident #34 for those dates, which included September 7th, 9th, 15th, 16th, 21st, 24th, 25th, 29th, and 30th of 2025; October 2nd, 4th, 5th, 8th, 9th, 16th, 19th, 21st, 27th, and 30th, of 2025; and November 1st, 5th, 6th, 7th, 10th, 11th, 13th, 22nd, and 30th of 2025. Nurse #8 stated she understood the order stated to place four lidocaine patches on Resident #34. Nurse #8 could not say why she did not follow the order. Nurse #8 expressed that she did not request a new order or clarification of the existing order from the physician.During an interview with the Physician on 12/10/2025 at 3:15 pm he stated he read the lidocaine order for Resident #34 to indicate that four lidocaine patches should be provided to Resident #34 daily but stated he believed staff were only providing 2 patches to Resident #34. He explained no one contacted him for clarification or to have the order changed and that he would rewrite the order so it would be written more clearly. He further explained the nurses should have asked for clarification if an order was not clearly written or if they had questions.During an interview on 12/11/2025 at 2:05 pm with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON stated the nurses providing the lidocaine patches to Resident #34 should have followed the physician's order or clarified the order with the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 record review, and resident and staff interviews, the facility failed to complete a smoking safety screen in August 2025 for 1 of 1 resident reviewed for smoking (Resident # 48).The findings included:An undated facility policy titled, Tobacco, Vapes, and Alcohol Use in the North Carolina State Veterans Home, stated Staff will evaluate each resident's ability to safely use cigarette lighters, lit cigarettes, cigars, pipes, and Vape devices to determine if a resident can be permitted to use these without direct supervision (independently) or if the resident must be directly supervised in order to safely use them. Resident #48 was admitted to the facility on [DATE] with diagnoses which included tobacco use, cerebral vascular accident, and vascular dementia.A review of Resident #48's Nursing Quarterly Assessment that included the smoking safety screen dated 5/19/25 indicated the resident was a supervised smoker and did not have the ability to hold his own cigarette or extinguish it.Review of Resident #48's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired and coded for tobacco use.Review of Resident #48's medical record revealed the August 2025 Nursing Quarterly Assessment did not include a smoking safety screen. Review of Resident #48's care plan revised on 11/3/25 revealed Resident #48 had a history of smoking. The goal for Resident #48 was to be compliant with the smoking policy. The interventions included supervision of the resident when smoking, assisting the resident to the smoking area at assigned times as needed, educating resident and family on the smoking policy, educating the resident on smoking times and location, and utilizing a smoking apron.Resident #48 was interviewed on 12/08/2025 at 12:58 PM. Resident #48 discussed being a smoker and going out to smoke during the designated times. He explained he did not go all the time, but when he felt well, he enjoyed going out to smoke.The Director of Nursing (DON) was interviewed on 12/10/25 10:12 AM. She stated residents must have a quarterly smoking safety screen completed in their medical records.During a follow up interview on 12/10/25 at 12:00 PM, the DON stated the staff nurses were responsible for completing the Nursing Quarterly Assessment, which included the smoking safety screen. She confirmed the smoking safety screens must be done quarterly. When asked, the DON was able to provide Resident #48's Nursing Quarterly Assessment for May 2025, but she did not provide any other assessments. She stated the facility did not have a system in place to ensure the assessments were completed. The DON stated that she would be the party responsible for ensuring the assessments were completed by the assigned due date and specific for each resident. The DON indicated she expected the assessments to be completed accurately and by the date they were due to be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff, and Physician Assistant interviews, the facility failed to keep a urinary catheter collection bag from touching the floor to reduce the risk of infection for 1 of 3 residents reviewed for urinary catheters (Resident #51).The findings included:Resident #51 was admitted to the facility on [DATE] with diagnoses which included stage four kidney disease, and obstructive and reflux urinary disease.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. Resident #51 was coded for an indwelling urinary catheter.Resident #51's care plan revised 11/21/2025 indicated Resident #51 had a goal that she would not develop any complications or injury associated with urinary catheter usage.An initial observation was conducted on 12/08/2025 at 9:19 am of Resident #51 while she was sitting up in her chair in the dining area. Her urinary catheter collection bag was observed to be laying on the floor under her chair. It had a privacy cover on it so urine was not visible.An additional observation on12/9/2025 at 9:49 am revealed Resident #51 laying in her bed, resting with her eyes closed and her urinary catheter collection bag was lying on the floor. It had a privacy cover on it so urine was not visible.An interview on 12/10/2025 at 10:40 am with Nursing Assistant (NA) #6 who worked with Resident #51 on 12/08/2025 revealed she had not seen the urinary catheter collection bag lying on the floor. She stated that Hospice staff had been there that day and explained on the days Hospice worked with Resident #51, NA #6 didn't do any care for Resident #51. NA #6 stated that if Resident #51 had a bowel movement before Hospice arrived, she would have cleaned her up, but otherwise on those days, she didn't provide any care to Resident #51. NA #6 added that the urinary catheter collection bag should not have been on the floor and had she noticed it, she would have picked it up and hung it back on the bed.During an interview with NA #4 on 12/10/2025 at 4:24 pm who worked with Resident #51 on 12/09/2025, she stated the urinary catheter collection bag always needed to be hung up off the floor. NA #4 said she had not seen it on the floor on 12/09/2025 and she would have picked it up and hung it up off the floor if she had. An interview on 12/10/2025 at 10:27 am with Nurse #6 who was the nurse working with Resident #51 on 12/09/2025 revealed that the urinary catheter collection bag should hang below the level of the bladder and should not be touching the floor. She stated if she saw the urinary collection bag on the floor, she would have picked it up and placed it back on the bed frame. Nurse #6 stated she did not see Resident #51's urinary catheter collection bag on the floor on 12/09/2025.During an interview with Assistant Director of Nursing on 12/10/2025 at 3:15 pm she stated that it was never acceptable for the urinary catheter collection bag to be on the floor and she would have changed the bag immediately if she had found it lying on the floor.An interview with the Physician's Assistant on 12/10/2025 at 3:20 pm revealed that the urinary catheter collection bags should be hung up off the floor and below the bladder. The Physician Assistant stated it was never acceptable for the urinary catheter collection bag to be on the floor and that being placed on the floor could increase the risk for urinary infections.An interview and record review was conducted on 12/12/2025 at 1:12 pm with the Director of Nursing and Senior Nurse Consultant. The Director of Nursing stated that all nursing staff including all nurses and nurse aides received training on urinary catheters at the annual skills fair last held on 09/16/2025. The Director of Nursing stated that the nurses were trained in the insertion of indwelling catheters, and the nursing aides were trained on how to provide catheter care for individuals with indwelling catheters. The Senior Nurse Consultant provided a printout from their electronic education platform titled Clinical Procedure: Urinary Catheter Care dated 2025 and stated that was the education that would have been covered at the skills fair as well. The printout did not address where the urinary drainage bag should or should not have been placed. The Senior Nurse Consultant stated that knowing where the urinary catheter collection bag should have been hung was CNA (certified nursing assistant)101 and they all knew where it was supposed to be hung. The Director of Nursing added that the urinary catheter collection bag should never be found on the floor as this would increase the risk of the resident getting an infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Consultant Pharmacist, and the Physician Assistant, the Consultant Pharmacist failed to identify drug irregularities related to the indicated use and scheduled stop date of an as needed (PRN) antipsychotic, and the indicated use of an antidepressant for 2 of 5 residents (Resident #2 and Resident #1) reviewed for drug regimen review.The findings included:1. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses that included mild dementia with agitation, brief psychotic disorder and anxiety. A physician order dated 11/3/25 revealed Resident #2 was ordered Haldol lactate solution (antipsychotic) 5 milligrams (mg)/1 milliliter (ml), administer 2 mg intramuscular (IM) every 4 hours PRN for agitation. The order indicated the end date was 1/3/26.A monthly pharmacist Medication Regimen Review (MRR) dated 12/5/25 read per hospice, haloperidol 2 mg IM every 4 hours PRN agitation for 60 days. The pharmacist review did not document any recommendations or irregularities.During an interview with the Physician Assistant (PA) on 12/10/25 at 3:15 pm, the PA stated she and the hospice Physician wrote the Haldol order together for Resident #2. The PA stated the end date was written for 60 days because Resident #2 had behaviors and was non-compliant with oral medications. The PA also stated Resident #2's diagnosis of brief psychotic disorder was the mental health diagnosis justifying the use of Haldol and was unaware the Haldol was written for Resident #2's dementia with agitation. The PA stated she was unaware antipsychotic PRN antipsychotic medication could only be written for 14 days.The Consultant Pharmacist was interviewed by telephone on 12/10/25 at 3:52 pm. The Consultant Pharmacist discussed during her monthly medication reviews, she reviewed all the medications, ensured there was a diagnosis for the medication and that the stop dates, if needed, were correct. The Consultant Pharmacist confirmed Resident #2's PRN Haldol was written for 60 days. She explained she thought since the resident was on hospice, the diagnosis of dementia with agitation was ok. The Consultant Pharmacist stated the PRN Haldol should be written for 14 days and stated she did not question the order because the order came from the hospice Physician.The Assistant Director of Nursing (ADON) was interviewed on 12/11/25 at 3:01pm. The ADON confirmed she had entered the Haldol order into Resident #2's medical record on 11/3/25. She stated she wrote the reason for the Haldol was dementia with agitation because that was how hospice wanted the order written and she did not think she could question the hospice Physician. The ADON explained when she audited a resident's medical record and saw a medication had been entered with a wrong diagnosis, she would call the PA and have it changed. The ADON stated she audited resident medical records daily which included any new Physician orders for medications.During an interview with the Director of Nursing (DON) on 12/12/25 at 2:27 pm, the DON explained medication orders were only checked by the Consultant Pharmacist on a monthly basis. She confirmed she had not received any recommendations from the Consulting Pharmacist regarding Resident #2's PRN Haldol stop date or a need for Resident #2's indication for use to change. The DON also stated the facility had just learned from the PA on 12/10/25 that PRN antipsychotic medications needed a 14 day stop date.2. Resident #1 was readmitted to the facility on [DATE] with multiple diagnoses that included unspecified dementia without behavioral or psychotic disturbances. There were no mental health diagnoses. A physician order dated 10/8/25 read; olanzapine (antipsychotic) 5 milligrams (mg) at bedtime for unspecified dementia without behavioral and/or psychotic disturbances.Review of Resident #1's Medication Administration Record for November and December 2025 revealed Resident #1 received olanzapine 5 mg daily at bedtime. A physician order dated 10/9/25 read; sertraline (antidepressant) 50 mg once a day for unspecified dementia without behavioral/mood/anxiety disturbances.Review of Resident #1's MAR for November and December 2025 revealed Resident #1 received sertraline daily at 9:00 am. The initial pharmacist Medication Regimen Review (MRR) dated 11/4/25 revealed Olanzapine 5 mg at bedtime for dementia with behaviors and sertraline 50 mg daily for dementia with behaviors. The pharmacist review did not have any documentation for recommendations or irregularities. The monthly pharmacist Medication Regimen Review (MRR) dated 12/5/25 revealed medical record was reviewed but did not document anything related to Resident #1's antipsychotic or antidepressant. The pharmacist review did not have any documentation for recommendations or irregularities.An interview occurred with the Physician Assistant (PA) on 12/10/25 at 3:15 pm. The PA confirmed there were no diagnosis of depression or psychosis currently for Resident #1. The PA stated she had seen these diagnoses in past medical records. She presented a record from a neurologist dated 8/26/25 where Resident #1 had been diagnosed with Alzheimer's dementia with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and interviews, the facility failed to maintain an accurate medical record related to documentation of medication administration for 1 of 2 residents reviewed for accurate medical records (Resident #34).The findings included:Resident #34 was admitted to the facility on [DATE] with diagnoses of pain in right hip and low back pain. A review of Resident #34's physician orders revealed an order dated 08/13/2025 for Lidocaine (an over-the-counter pain reliever) adhesive patch, medicated; 4%; amount: 4; apply to skin. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily. a. An observation and interview with Nurse #6 and Resident #34 on 12/10/25 at 12:00 pm revealed Nurse #6 had two lidocaine patches in her hand. Nurse #6 proceeded into Resident #34's room and when she returned from the room, she said that she had placed the two patches on Resident #34's low back and no patches were placed to Resident's bilateral hips. A review of Resident #34's Medication Administration Record (MAR) revealed that Nurse #6 had signed the MAR for the four lidocaine patches on 12/10/2025 for the 9:00 am administration time. The MAR specified for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily.A record review and interview with Nurse #6 on 12/11/2025 at 11:00 am revealed that she had only placed two lidocaine patches on Resident #34 for all of the dates she worked in November, which included November 2nd, 12th, 15th, 18th, 19th, 20th, 24th, 25th, 26th, 27th, and 29th of 2025. Nurse #6 said she had placed the two patches either on Resident #34's low back or on her hips, but never both. Nurse #6 confirmed the order had not been changed but said in her opinion the resident no longer needed to have four patches, so she did not apply her four patches. Nurse #6 acknowledged that this would have been incorrect documentation of the MAR.b. A review of Resident #34's MAR revealed Nurse #8 signed the MAR for the four Lidocaine patch administration on 12/11/2025. The MAR specified for four (4) 4% Lidocaine adhesive patches to the skin daily. Special Instructions on order read: Apply to bilateral hips/ bilateral lower back daily.A record review and interview with Nurse #8 on 12/11/25 at 10:50 revealed she had never placed four patches on Resident #34 when she had provided her medications in the past. When reviewing the MARs for the dates that she worked in September, October, and November, she said that she had only ever placed one lidocaine patch on Resident #34 for those dates, which included September 7th, 9th, 15th, 16th, 21st, 24th, 25th, 29th, and 30th of 2025; October 2nd, 4th, 5th, 8th, 9th, 16th, 19th, 21st, 27th, and 30th, of 2025; and November 1st, 5th, 6th, 7th, 10th, 11th, 13th, 22nd, and 30th of 2025. Nurse #8 said that she understood that the order stated to place four lidocaine patches on Resident #34 and Nurse #8 could not say why she did not follow the order. Nurse #8 stated that she signed the MAR indicating the four patches were applied but she did not apply four patches which would have been inaccurate documentation. She said she would place one patch wherever Resident #34 indicated she wanted it. These locations included left or right lower back or left or right hip. During an interview on 12/11/2025 at 2:05 pm with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON said that the nurses providing the lidocaine patches to Resident #34 should have clarified the order if they were not providing what the order stated. She said if the order indicated they were to provide Resident #34 with four patches; the nurses should have been providing her with four patches. Both DON and ADON agreed this wound not have been accurate documentation of the MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident representatives and staff, the facility failed to explain the arbitration agreement to a resident's representative prior to having them sign the agreement. This occurred for 2 of 5 residents reviewed for arbitration (Resident #1 and Resident #66).The findings included:A review of the facility's undated arbitration agreement read that the residents or resident representatives acknowledge they had read and understood the agreement and that it had been explained in plain language.a. Review of Resident #1's arbitration agreement dated 10/7/25 revealed neither box was checked indicating if the resident/resident Representative accepted or declined the agreement. The agreement was signed by Resident #1's Representative.Resident #1 was admitted to the facility on [DATE].Resident #1's Representative was interviewed by telephone on 12/11/25 at 5:00pm. The Representative discussed sitting next to the facility's admission Coordinator during Resident #1's pre-admission meeting on 10/7/25. She stated the Admissions Coordinator did not explain any of the forms. The Representative explained that the Admissions Coordinator just pointed out where to sign. Resident #1's Representative stated she did not have the arbitration agreement explained to her.b. Resident #66 was admitted to the facility on [DATE].Review of the arbitration agreement for Resident #66 dated 11/19/25 revealed the form was signed by Resident #66's Representative through an electronic signing platform that indicated the representative read and understood the agreement and the agreement had been adequately explained. A telephone interview occurred with Resident #66's Representative on 12/11/25 at 4:00pm. The Representative explained the admission paperwork was sent to her by email with a note to sign the paperwork. She stated she lived in Alaska and had to figure out the paperwork on her own. The Representative stated she did not have any verbal communication with the Admissions Coordinator. Once the agreement was explained to the Representative by the surveyor, she asked the surveyor if the agreement could be rescinded. Education was provided by the surveyor on whom to contact to discuss the matter.During a telephone interview with the Admissions Coordinator on 12/12/25 at 9:18am, the Admissions Coordinator discussed that the facility was now using an electronic signing platform. She explained the forms were sent to the resident's representative by email. The Admissions Coordinator stated she did not explain any of the forms to the representatives but wrote in the email if they had questions, they could call her. She stated, with Resident #1's Representative, she sat next to the Representative and explained all the forms, including the arbitration agreement, and the Representative did not ask any questions. The Admissions Coordinator stated she never spoke with Resident #66's Representative.The Director of Nursing (DON) was interviewed on 12/12/25 at 2:40pm. The DON confirmed she knew what the arbitration agreement was and stated any form the resident or resident Representative did not understand should be explained to them prior to signing.The Administrator was interviewed on 12/12/25 at 2:56pm. The Administrator stated he had nothing to add.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, record review, and interviews with staff and the Physician's Assistant (PA), facility staff used a shared blood glucose meter located in the medication cart without cleaning and disinfecting it before and after each use. This occurred while there were two residents identified with a known bloodborne pathogen in the facility with 1 of the 2 residents requiring blood glucose monitoring. Shared blood glucose meters can be contaminated with blood and must be disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer's instructions to disinfect a shared blood glucose meter has a high likelihood of exposing residents to the spread of blood borne infections. This deficient practice affected 2 of 2 residents who were observed to have their blood glucose checked (Resident #26 and #37) and involved 2 of 2 nurses observed performing blood glucose checks (Nurse #2 and the Assistant Director of Nurses [ADON]). Immediate jeopardy began on 12/09/2025 when Nurse #2 was observed to use a shared blood glucose monitor for Resident #26 without disinfecting the meter. Immediate jeopardy was removed on 12/11/2025 when the facility implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity level D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective to correct the deficient practice. Findings included:The facility's policy and procedure titled Infection Control: Glucometer (blood glucose meter) Cleaning and Disinfecting dated 09/01/2019 stated under E. Cleaning and Disinfection Step 1. Clean and disinfect glucose meter before and after each resident use. Step 4. Clean and disinfect the meter by using the EPA approved germicidal and disinfectant wipes. Wipe all external areas of the meter including both front and back surfaces until visibly clean. Step 5. Ensure that the surface of the meter remains wet at room temperature for the contact time listed on the wipe's directions for use. Allow to air dry. The manufacturer's instructions for cleaning and disinfecting the blood glucose meter used at the facility were summarized in the manufacturer's Blood Glucose Monitoring System User's Guide revised 07/2016. The instruction on page 46 titled, Cleaning and Disinfecting Procedures for the Meter stated, The Meter should be cleaned and disinfected between each patient. The manufacturer listed several products approved for use. Important Safety Instructions included: The blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed.The manufacturer's user's guide Revised 07/2016, for the blood glucose meter listed the disinfectant wipes used at the facility as one of the EPA-registered wipes recommended to clean and disinfect the blood glucose meter. Specific instructions for use: Contact time for a disinfectant is the amount of time a surface must remain wet with the product to achieve disinfection. Special instructions for cleaning and decontamination against human immunodeficiency virus (HIV), hepatitis B and hepatitis C indicated, Allow surfaces to remain wet for one minute, let air dry. For all other organisms, see directions for contact time. A continuous observation and interview from 4:30 pm to 4:53 pm occurred on 12/09/2025 in the 2C hallway. The observation revealed Nurse #2 removed a blood glucose meter from his medication cart. He wiped it down with an alcohol pad and then took it into Resident #26's room and advised he was going to check Resident #26's blood sugar. He held the blood glucose meter (with the test strip already in the machine) to the resident's finger obtaining his blood sugar. Nurse #2 was observed walking out of the resident's room and placed the blood glucose meter on top of the medication cart. The blood glucose meter was observed to not be labeled with a resident's name. At 4:40pm, Nurse #2 was observed to wipe the blood glucose meter with an alcohol wipe and place the blood glucose meter in the drawer of the medication cart without disinfecting it per the disinfectant wipe's instructions, despite there being a container of disinfecting wipes present on his medication cart. Nurse #2 was observed for another ten minutes with no other residents receiving blood sugar checks. Nurse #2 stated that he did not have any other blood sugars to check until bedtime. He explained that he was trained to clean and disinfect the blood glucose meter using alcohol. When asked about the facility policy regarding disinfection, Nurse #2 responded that it also recommended using alcohol. He confirmed that the manufacturer likewise recommended alcohol for disinfecting the blood glucose meter.A continuous observation of the Assistant Director of Nursing, working on 1B Hallway, on 12/09/2025 from 5:15 pm until 5:30 pm revealed she took an unlabeled blood glucose meter out of her medication cart. The ADON did not clean or disinfect the blood glucose meter. She proceeded to enter Resident #37's room. ADON told Resident #37 that she was going to do his blood sugar and proceeded to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home - Salisbury	1601 Brenner Ave., Building #10 Salisbury, NC 28145

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to (1) document that education of the influenza vaccine was provided for Resident #20 and (2) failed to obtain Resident #72's signature on the influenza vaccine consent/refusal form prior to administering the influenza vaccine. This occurred for 2 of 5 residents reviewed for immunizations.Findings included:1. Resident #20 was re-admitted to the facility on [DATE].Review of the facility's document titled, Resident Influenza (Flu) Vaccine Consent/Refusal Form, revealed Resident #20 consented to receive the influenza vaccine and signed the form on 6/12/25. A Vaccine Information Statement (VIS) form for the influenza vaccine was not attached to the consent form.The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #20 was cognitively intact.Review of Resident #20's electronic medical record (EMR) revealed Resident #20 received the influenza vaccine at the facility on 11/4/25. The vaccine education section did not indicate education was or was not provided to Resident #20 or Resident #20's Representative.The facility was unable to provide written documentation that Resident #20 or Resident #20's Representative had received education prior to consenting to the influenza vaccine.During an interview with the Infection Preventionist on 12/11/25 at 2:16 PM, Resident #20's signed vaccination consent form was reviewed. It was noted the form did not have a signed VIS attached to the vaccine consent form. She stated obtaining a signature on the VIS form was most important when a resident or resident representative refuses a vaccine because there would be documentation that they were educated on the risks of refusing the vaccine. The Infection Preventionist stated the VIS forms did not have to be provided or signed for a resident to receive a vaccine. She was unable to locate this information within the Influenza Vaccine policy. Further discussion revealed the Infection Preventionist did not always bring a VIS form when she met with a resident or resident representative to discuss vaccination. She stated a resident or resident representative did not have to sign the Vaccine Information Sheet if they accepted the vaccine and Resident #20 did not sign the form because he accepted the vaccine. The Infection Preventionist stated vaccine education was documented in the resident's EMR. She reviewed Resident #20's EMR and noted the EMR did not indicate education for the influenza vaccine was or was not provided to Resident #20 or Resident #20's representative. The Infection Preventionist confirmed she was responsible for the immunization program for the facility and responsible for obtaining the resident or resident representative's signature for the vaccination consent and VIS forms.An interview with the Director of Nursing (DON) and Administrator was conducted on 12/12/25 at 11:45 AM. Resident #20's influenza vaccine consent form was reviewed, and the missing VIS form was noted. The DON stated providing the Vaccination Information Statement form was not required when a resident or resident representative refused a vaccination. The Administrator stated education was documented in the EMR. Page three of the Influenza (Flu) Vaccinations for Health Care Center Residents policy was reviewed. Item #3 stated Prior to administering the vaccine, the resident or legal representative will be provided the vaccine information statement (VIS). Item #3 further stated education regarding the benefits and side effects of the influenza vaccine shall be documented in the resident's record. Item #5 stated the resident or legal representative may refuse vaccination and the reason for the refusal should be documented in the resident's medical record or Electronic Health Record (EHR). The DON stated the VIS form did not need to be provided to a resident or resident representative when a vaccine was refused because Item #3 began with Prior to administering the vaccine. The DON and the Administrator reviewed Resident #20's EMR and were unable to give a reason for why the Vaccination Information Statement was not provided to Resident #20 and why vaccine education was not documented in Resident #20's EMR.2. Resident #72 was admitted on [DATE].The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 had moderate cognitive impairment. The MDS indicated Resident #72's hearing and vision were adequate, speech was clear, was able to understand, and was able to be understood. The MDS further indicated Resident #72 had no functional impairment to upper and lower extremities with range of motion and had the ability to use suitable utensils to bring food to his mouth.The facility document titled Resident Influenza (Flu) Vaccine Consent/Refusal Form for Resident #72 revealed the form was marked for consenting to receive the influenza vaccine. The consent form did not have Resident #72's signature or a signature for Resident #72's Representative. The vaccine consent form dated 7/24/25 was witnessed by the Infection Preventionist and Nurse #18. The vaccine consent further revealed the influenza vaccine was administered on 10/24/25 by Nurse #13. An influenza VIS form was attached to the consent form with two