STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 02/12/2025

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SALISBURY REHABILITATION AND NURSING CENTER	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted from 1/29/2025 through 1/30/2025. The survey was reopened on 2/12/25 to obtain additional information and interviews offsite. Therefore, the exit date was changed to 2/12/25. Event ID # 65Y111. The following intakes were ivestigated: NC00226425, NC00226452, NC00226285, and NC00225027. 1 of 12 complaint allegations resulted in a deficiency.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff, Resident, Pharmacy Consultant and Nurse Practitioner interviews, the facility failed to administer pain medication as ordered for 1 of 3 residents (Resident #2) reviewed for pain management. Findings included: Review of Resident #2's hospital record indicated she had a right ankle Computed Tomography (CT) Scan on 12/23/2024 which showed a new minimally displaced fracture involving the right ankle and a knee x-ray that showed a mildly displaced fracture involving the distal femur which	F 697	F697 Pain Management 1) On 1/29/25, the Unit Manager (UM) completed an audit of Resident #2□s pain medication orders to ensure medications were readily available for administration as ordered. All pain medications are available and will continue to be available as ordered for administration. 2) On 1/30/25, the Unit Manager□s (UM□s) completed an audit of residents admitted in the past thirty days (12/31/24 - 1/20/25) to ensure that all pain medications were readily available and administered as ordered. No additional	3/7/25

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

Electronically Signed | 02/28/2025

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F 697	Continued From page 1 forms the knee joint. The hospital record also indicated Resident #2 had surgical repair of the right ankle on 1/25/2025. Resident #2 was admitted to the facility on 1/8/2025 with fractures to her left knee and right ankle. An admission Minimum Data Set assessment dated 1/15/2025 indicated Resident #2 was cognitively intact and had moderate pain frequently. A Physician's Order dated 1/8/2025 at 8:00 pm indicated Resident #2 should receive Oxycodone Hydrochloride (a narcotic pain medication) 10 milligrams two times a day for pain beginning 1/8/2026 and would be discontinued on 1/10/2025. Resident #2's Medication Administration Record for 1/2025 indicated Resident #2 did not receive Oxycodone HCl 10 milligrams on 1/8/2025 at 8:00 pm or 1/9/2025 at 8:00 am. The Medication Administration Record for 1/2025 indicated Resident #2 received Acetaminophen 1000 milligrams as needed for pain on 1/9/2025 at 7:22 am and on 1/13/2025 at 10:45 am. Further review of Resident #2's Medication Administration Record for 1/2025 indicated she rated her pain at a "0" on a scale of 1 to 10 (with 1 being the least amount of pain and 10 being the worst amount of pain) on 1/8/2025 and 1/9/2025. On 1/29/2025 at 1:35 pm Resident #2 was interviewed and stated she was admitted on 1/8/2025 and did not receive the narcotic pain medication she needed for pain from fractures in both legs until the next day. Resident #2 stated	F 697	concerns identified. 3) Effective 2/25/25, the Staff Development Coordinator (SDC) educated current facility and agency licensed nurses (LN□s) and medication aides (MA□s) on effective pain management and on obtaining controlled substance pain medications as ordered during the admission process. Education included the process of obtaining a prescription for controlled substances and the process for routine, STAT and after-hours pharmacy orders and utilizing the back-up emergency kit or designated back-up pharmacy to obtain pain medications for residents as necessary. Newly hired facility and agency LN□s and MA□s and those not receiving education by 2/25/25 will receive education prior to first shift worked. Education will be provided by the SDC and/or Director of Nursing (DON) and tracked by the SDC for completion. 4) The DON and/or UM will monitor admission orders for newly admitted and readmitted residents to ensure timely availability and administration of pain medications as ordered. Monitoring will be completed twice weekly for eight (8) weeks then monthly for two (2) months. The DON will report the findings of audits to the Quality Assurance Process Improvement (QAPI) committee monthly for three (3) months and will make changes to the corrective plan as necessary to maintain compliance with resident pain management.	

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F 697	Continued From page 2	F 697	Completion Date: 2/25/25	

the nurses did give her Acetaminophen which did not relieve her pain, and she rated her pain at an 8 or 9 (on a scale of 1 to 10) from the time she was admitted until she received the ordered medication on the evening of 1/9/2025.

Nurse Aide #2 stated she worked 7:00 am to 3:00 pm shift on 1/8/2025 and was assigned to Resident #2 when she was admitted. Nurse Aide #2 stated Resident #2 did complain of pain when she arrived, and she notified the Unit Manager of Resident #2's pain in both legs.

An interview was conducted with Unit Manager #1 on 1/29/2025 at 1:15 pm and she stated Resident #2 admitted around 3:00 pm on 1/8/2025 and when she came from the hospital, they did not send a prescription with her for the Oxycodone Hydrochloride (a narcotic pain medication). Unit Manager #1 stated she did get an order for Acetaminophen 1000 milligrams every 6 hours as needed for pain. Unit Manager #1 stated Resident #2 rated her pain at a 7 on a scale of 1 to 10 (one being the least amount of pain and 10 being the worst pain) and she gave her the Acetaminophen and she later rated her pain at a 3 about an hour later.

During an interview with Nurse Aide #3 on 1/29/2025 at 2:15 pm she stated she worked on the 3:00 pm to 11:00 pm shift on 1/8/2025 and Resident #2 did not complain of pain to her during her shift. Nurse Aide #3 stated she checked on her every 2 hours and when she turned her call light on. Nurse Aide #3 stated Nurse #1 did give her pain medication that night, but she did not know what she was given.

Nurse #1 was interviewed on 1/29/2025 at 2:05

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F 697	Continued From page 3	F 697		

pm and stated she cared for Resident #2 on 1/8/2025 on the 7:00 pm to 7:00 am shift and she gave her Acetaminophen that evening and checked on her an hour later and she said her pain was a 2 on a scale of 1 to 10. Nurse #1 stated she must have forgotten to document the Acetaminophen she gave Resident #2 on the Medication Administration Record.

The Pharmacy Consultant was interviewed by phone on 1/30/2025 at 2:30 pm and stated Resident #2 would need narcotic pain medications as ordered for fractures in both legs. She stated the ordered narcotic would have been beneficial in managing Resident #2's pain. The Pharmacy Consultant stated the facility should have obtained a prescription, signed by the provider, and faxed it to the pharmacy and then the pharmacy would have released Resident #2's narcotic pain medication when she was admitted to the facility.

The Director of Nursing was interviewed on 1/29/2025 at 3:53 pm and she stated Unit Manager #1 was not able to get a prescription for Resident #2's pain medication on the evening she was admitted to the facility. She stated Unit Manager #1 did get an order for Acetaminophen and Resident #2 was documented by Unit Manager #1 and Nurse #1 as not having pain during the evening or night. The Director of Nursing stated the on-call service the facility contracts will not give a prescription for a narcotic if the prescription is not sent from the hospital. The Director of Nursing stated when the prescription is faxed to the pharmacy the medication is released from the electronic back-up medication system.

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F 697	Continued From page 4 During an interview with the Administrator on 1/29/2025 at 4:01 pm he stated the nursing staff should have reached out to the Physician or Nurse Practitioner to obtain a prescription for Resident #2's ordered pain medications so the medication could be dispensed from the facility's back-up medication system to ensure Resident #2 was comfortable.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner interviews, the facility failed to ensure a resident was transported to a scheduled urologist appointment on 1/2/2025 to have their suprapubic indwelling urinary catheter changed. The deficient practice occurred for 1 of 1 resident reviewed for medical related social services (Resident #3). Findings included: Resident #3 was admitted to the facility on 6/20/2023 with diagnoses of diabetes, obstructive uropathy and chronic kidney disease. Resident #3's quarterly Minimum Data Set assessment dated 10/28/2024 indicated she was severely cognitively impaired and required an indwelling urinary catheter. A Visit Summary from the Urologist dated	F 745	F745 Provision of Medically Related Social Services 1) On 1/29/25, Resident #3 was discharged from the hospital to another facility. 2) On 1/30/25, the Director of Nursing (DON) audited current facility residents with orders for outside medical appointments. The transportation clerk then audited the appointment transportation schedule to ensure all ordered medical appointments were scheduled for transport as ordered. No additional concerns identified. 3) On 1/30/25, the Staff Development Coordinator (SDC) provided education to current facility transportation clerks and the importance of rescheduling appointments and arranging transport, when necessary, in a timely manner to	3/7/25

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F 745	Continued From page 5 12/2/2024 stated Resident #3 was scheduled for a "31-day suprapubic catheter change" at the urologist's office on 1/2/2025. There was no evidence in the medical record that Resident #3 attended the urology appointment scheduled for 1/2/2025. During an interview with the Appointment Coordinator on 1/29/2025 at 3:40 pm he stated he called the Urology Clinic on 1/2/2025 to inquire about Resident #3's appointment to have her suprapubic catheter replaced and was told the appointment was cancelled but he stated they could not say who had cancelled the appointment. The Appointment Coordinator stated he had failed to reschedule Resident #3's appointment to have her suprapubic catheter changed. On 1/29/2025 at 3:48 pm the Urology Clinic's Scheduler was interviewed by phone, and she stated Resident #3's scheduled appointment on 1/2/2025 was not cancelled and the resident was not brought to the appointment. She stated no one had called to reschedule her appointment so her suprapubic catheter had not been changed within 31 days. An interview was conducted with the Director of Nursing on 1/29/2025 at 3:53 pm and she stated the Appointment Coordinator must not have ensured Resident #3's appointment for her suprapubic catheter change was put on the transportation schedule. She stated Resident #3 should have been taken to her appointment on 1/2/2025 and when it was missed it should have been rescheduled as soon as possible. The Director of Nursing stated Resident #3's	F 745	include any follow-up appointments or missed appointments as ordered. Newly hired facility transportation clerks and those not receiving education on 1/30/25 will receive education prior to first shift worked. Education will be provided by the SDC and/or Director of Nursing (DON) and tracked by the SDC for completion. 4) The DON/designee will audit residents with outside medical appointments to ensure proper scheduling, rescheduling and transport as ordered. Monitoring will be completed weekly for eight (8) weeks then monthly for two (2) months. The DON will report the findings of audits to the Quality Assurance Process Improvement (QAPI) committee monthly for three (3) months and will make changes to the corrective plan as necessary to maintain compliance with resident medical appointments. Completion Date: 2/25/25	

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F 745	Continued From page 6	F 745		

suprapubic urinary catheter was not changed at the facility because it was supposed to be changed at the urologist's office.

During an interview with the Administrator on 1/29/2025 at 4:01 pm he stated he thought on 1/2/2025 there was inclement weather, and they had cancelled all the scheduled appointments because of the weather. He stated he did not know why Resident #3's appointment had not been rescheduled, and it should have been rescheduled as soon as possible.

The weather conditions for the facility's geographical area where the facility was located were reviewed for 1/1/2024 and 1/2/2024, and historical weather conditions indicated there was no precipitation. The weather source was the Concord-Padgett Airport Weather Conditions.

During an interview by phone with Nurse #2 on 2/12/2025 at 2:41 pm she stated she cared for Resident #3 on the 7:00 pm to 7:00 am shift that began on 1/18/2025. Nurse #2 stated Resident #3 did not have any issues through the night. She stated she checked on Resident #3 throughout her shift and saw her around 6:30 am to 7:00 am that morning and she was responsive, and her urine was not dark and did not have a lot of sediment in it.

On 2/12/2025 at 3:12 pm an interview was conducted by phone with Nurse Aide #4 and she stated she cared for Resident #3 on 1/19/2025 on 1/19/2025. Nurse Aide #4 stated she gave Resident #3 a bed bath the morning of 1/19/2025 and she was not having any problems with her breathing, she was not lethargic, and her urine was not cloudy. Nurse Aide #4 stated Resident

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F 745	Continued From page 7	F 745		

#3 became lethargic after breakfast. She stated Nurse #1 checked on her and found her unresponsive and her blood pressure was low.

An interview was conducted by phone with Nurse #1 was interviewed by phone on 2/12/2025 at 2:29 pm and stated she cared for Resident #3 on 1/19/2025 and sent her to the hospital after breakfast when Resident #3 became lethargic, pale, and clammy shortly after breakfast. Nurse #1 stated she did not notice any sediment in Resident #3's catheter bag and her urine was not dark when she sent her to the hospital, but her blood pressure was low, and her breathing was labored. Nurse #1 stated she called the Physician and obtained orders to send Resident #3 to the hospital.

A review of Resident #3's vital signs on 1/19/2025 at 9:34 am revealed her blood pressure was 92/66, her pulse was 118 per minute, her respirations were 20 per minute, and her oxygen saturation level was 98%.

On 1/19/2025 Resident #3 was admitted to the hospital and an Emergency Department to Hospital Physician's Note stated her urine was thick and cloudy with a lot of sediment. The Hospital Physician's Note further stated they were unable to determine when the catheter was last changed because they were unable to obtain the information from the facility. The Hospital Physician's Note also stated Resident #3 was admitted with sepsis due to left lower lobe pneumonia and urinary tract infection and her suprapubic urinary catheter was changed in the hospital on 1/19/2025.

A Discharge Summary from the hospital dated

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F 745	Continued From page 8 1/28/2025 indicated Resident #3's sepsis was resolved and she was transferred to another facility with plans for palliative care. Nurse Practitioner #1 was interviewed by phone on 1/30/2025 at 10:51 am and she stated Resident #3's missed appointment to have her suprapubic urinary catheter changed on 1/2/2025 did not cause her decline or diagnosis of sepsis (a serious condition resulting from infection when bacteria is present a person's blood) when she went to the hospital on 1/19/2025. She stated Resident #3 had been declining due to her history of diabetes and kidney failure. Nurse Practitioner #1 stated she spoke with Resident #3's Responsible Party about a month ago and he understood Resident #3 had less than 6 months to live but had declined hospice services at the facility. Multiple attempts to contact the Urologist for interview were unsuccessful.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		3/7/25

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F 755	Continued From page 9 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Pharmacy Consultant, and resident interviews, the facility failed to ensure 1 of 1 resident (Resident #2) had pain medication available that was ordered on admission to the facility. Findings included: Review of Resident #2's hospital record indicated she had a right ankle Computed Tomography (CT) Scan on 12/23/2024 which showed a new minimally displaced fracture involving the right ankle and a knee x-ray that showed a mildly displaced fracture involving the distal femur which forms the knee joint. The hospital record also indicated Resident #2 had surgical repair of the right ankle on 1/25/2025.	F 755	F755 Pharmacy services/procedure/pharmacist/records 1) On 1/29/25, the Unit Manager (UM) completed an audit of Resident #2□s medication orders, including narcotic pain medication to ensure medications were readily available for administration as ordered. All medications are available and will continue to be available as ordered for administration. 2) On 1/30/25, the Unit Manager□s (UM□s) completed an audit of current facility residents to ensure that all medications are readily available on the medication cart for administration as ordered. The audit was completed by review of current physician orders and observation of medications for availability	

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F 755	Continued From page 10 Resident #2 was admitted to the facility on 1/8/2025 with fractures of her left knee and right ankle. A Physician's Order dated 1/8/2025 at 8:00 pm indicated Resident #2 should receive Oxycodone Hydrochloride (a narcotic pain medication) 10 milligrams (mg) two times a day for pain beginning 1/8/2026 and would be discontinued on 1/10/2025. Resident #2's Medication Administration Record for 1/2025 indicated Resident #2 did not receive Oxycodone HCl 10 mg on 1/8/2025 at 8:00 pm or 1/9/2025 at 8:00 am. The Medication Administration Record for 1/2025 indicated Resident #2 received Acetaminophen 1000 mg needed for pain on 1/9/2025 at 7:22 am and on 1/13/2025 at 10:45 am. Further review of Resident #2's Medication Administration Record for 1/2025 indicated she rated her pain at a "0" on a scale of 1 to 10 (with 1 being the least amount of pain and 10 being the worst amount of pain). On 1/29/2025 at 1:35 pm Resident #2 was interviewed and stated she was admitted on 1/8/2025 and did not receive the narcotic pain medication she needed for pain from fractures in both legs until the next evening. Resident #2 stated the nurses did give her Acetaminophen which did not relieve her pain, and she rated her pain at an 8 or 9 (on a scale of 1 to 10) from the time she was admitted until she received the ordered medication on the evening of 1/9/2025. On 1/29/2025 at 1:15 pm Unit Manager #1 was interviewed and stated she was assigned to Resident #2 on 1/8/2025 when she was admitted at approximately 3:00 pm. Unit Manager #1	F 755	on the medication cart and/or in the facility medication room. No additional concerns identified. 3) On 2/25/25, the contracted pharmacy representative provided education to facility and agency licensed nurses (LN□s) and medication aides (MA□s) on the pharmacy process for obtaining medications and providing prescriptions for controlled substances during routine hours, the after-hours STAT process and process for obtaining medications utilizing the facilities emergency back-up system, as well as a designated back-up pharmacy. The contracted pharmacy will provide additional education as needed upon facility request. Effective 2/25/25, the Staff Development Coordinator (SDC) educated current facility and agency licensed nurses (LN□s) and medication aides (MA□s) on pharmacy services and on the process for obtaining medications, including controlled substance pain medications as ordered. Education included the process of obtaining a prescription for controlled substances and the process for routine, STAT and after-hours pharmacy orders and utilizing the back-up emergency kit to obtain medications for residents as necessary. Newly hired facility and agency LN□s and MA□s and those not receiving education by 2/25/25 will receive education prior to first shift worked. Education will be provided by the SDC and/or Director of Nursing (DON) and tracked by the SDC for completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY REHABILITATION AND NURSING CENTER	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 11 stated Resident #2 came from the hospital without a prescription for her pain medication and she could not get her ordered pain medication from the electronic backup medication system until a prescription was faxed to the pharmacy. Unit Manager #1 stated the facilities on-call provider group will not give an order for a narcotic and she asked for Acetaminophen 500 mg two tablet every 6 hours as needed for pain. An interview was conducted with the Pharmacy Consultant on 1/30/2025 at 2:30 pm and she stated Resident #2 would need the narcotic pain medication that was ordered for her fractures, and the Acetaminophen would not have controlled her pain. The Pharmacy Consultant also stated the facility should have obtained a prescription and faxed it to the pharmacy and the pharmacy would have released the ordered narcotic pain medication from the facility's electronic emergency back-up medications. The Pharmacy Consultant stated the pharmacy cannot release narcotic medications until they have a prescription. On 1/29/2025 at 3:53 pm the Director of Nursing was interviewed and stated Unit Manager #1 was not able to get a written prescription of Resident #2 on 1/8/2025, when she was admitted, for Oxycodone 10 mg because the resident arrived after Nurse Practitioner #1 left for the day and the on-call provider started. The Director of Nursing stated their contracted on-call provider would not give orders for narcotic medications for a resident if the hospital failed to send a prescription with the resident. The Director of Nursing stated the pharmacy could not release the ordered narcotic pain medication from the electronic emergency back-up medications without the prescription.	F 755	4) The DON and/or UM will monitor newly admitted and readmitted residents to ensure timely availability and administration of medications, including controlled substance pain medications as ordered. Monitoring will be completed weekly for eight (8) weeks then monthly for two (2) months. The DON will report the findings of audits to the Quality Assurance Process Improvement (QAPI) committee monthly for three (3) months and will make changes to the corrective plan as necessary to maintain compliance with pharmacy services. Completion Date: 2/25/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 12 The Administrator was interviewed on 1/29/2025 at 4:01 pm and stated the nursing staff should have reached out to the physician or Nurse Practitioner and obtained a prescription for the ordered narcotic pain medication for Resident #2's ordered pain so that her pain medication could be released from the electronic back-up medications, when she was admitted to the facility to ensure her pain was controlled.	F 755		