STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hibriten Mountain Nursing and Rehabilitation	**2030 Harper Avenue NW , Lenoir, North Carolina, 28645**

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F0000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 07/16/25 through 07/17/25. Additional information was obtained offsite on 07/22/25, therefore, the exit date was changed to 07/22/25. Event ID# 1D1725-H1. The following intakes were investigated: 833949, 833947, 833946, 833950, 833951, 833952, and 833953. 6 of the 13 allegations resulted in a deficiency. Past noncompliance was identified at: 483.25 at tag F689 at scope and severity J. Tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted. Immediate Jeopardy began on 07/11/25 and was removed on 07/15/25. On 08/20/25 the 000 tag was amended to show a correct IJ removal date of 07/15/25. 2567 reposted to facility.	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a	F0580	The following Plan of Correction (POC) is submitted in response to the deficiencies cited during the recent survey conducted by the Agency. This POC is intended solely as a statement of the actions the facility has taken or will take to address the cited deficiencies and to achieve compliance with applicable federal and/or state regulations. This submission does not constitute an admission by Facility that the deficiencies cited are accurate, nor does it imply agreement with the findings or conclusions of the survey. The facility reserves all rights to contest or appeal any findings through appropriate legal or administrative channels. The corrective actions described herein are implemented in good faith to ensure the health, safety, and well-being of our residents/patients, and to maintain compliance with regulatory standards. The facility remains committed to continuous quality improvement and excellence in care delivery.	08/07/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0580 SS = D	Continued from page 1 need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the resident's responsible party and staff, the facility failed to notify the responsible party of elopement for 1 of 3 residents reviewed for notification of change (Resident # 1). The findings included: Resident #1 was admitted to the facility on 3/6/25 with diagnoses that included dementia.	F0580	Continued from page 1 Resident #1 Responsible Party (RP) was not notified of elopement on 07/12/2025 at the time of the incident, RP was notified of elopement by Administrator on 07/13/2025. Starting on 08/04/2025, the Director of Nursing reviewed incidents from the last 30 days to ensure that the responsible party has been notified. This will be completed on 08/05/2025. Starting on 08/04/2025 to 08/06/2025, the Director of Nursing and Assistant Director of Nursing provided education to the licensed nursing staff on notifying responsible party of all changes with residents. Newly hired licensed nurses will receive this education upon hire. Starting on 08/06/2025, the Director of Nursing and/or Nursing Designee will complete a random audit on 5 residents weekly for 12 weeks to ensure that the responsible party was notified of changes. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 08/05/2025. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Compliance 08/07/2025	

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F0580 SS = D	Continued from page 2 The significant change in status Minimum Data Set assessment dated 5/5/25 indicated Resident #1 was severely cognitively impaired. A review of Resident #1's medical record indicated a late entry nursing progress note dated 7/12/25 at 3:29 PM by Nurse #1 which read, in part: Nurse Aide (NA) #1 and NA #2 witnessed Resident #1 outside, walking past the C hall door at approximately 7:45 PM. NA #1 immediately ran outside to assist him back into the building while NA #2 came and alerted Nurse #1. Nurse #1 assisted NA #1 with guiding Resident #1 back into the building via C hall door. NA #2 went to find Resident #1's wheelchair, finding it in the dining room just outside the door going into the kitchen. Once Resident #1 was assessed, Nurse #1 checked the doors and found all doors to be closed and locked. When NA #2 checked the kitchen door, she found it to be unlocked. Apparently, Resident #1 went through the unlocked kitchen door and outside through the back door of the kitchen. Nurse #1 notified the Director of Nursing as well as the Administrator who came to the facility shortly thereafter. An interview with Resident #1's responsible party (RP) on 7/16/25 at 11:01 AM revealed Resident #1 had gotten out of the facility on the evening of 7/11/25 around 8:00 PM. Resident #1's RP stated that from what was reported to her, Resident #1 had wheeled himself into the dining room, opened the door to the kitchen, which was left unlocked, and went outside through another door inside the kitchen. Resident #1's RP stated that she didn't find out about the incident until the next day, and it had upset her. She further stated that a resident first told her about Resident #1 getting outside the facility as she was walking up the sidewalk towards the facility on 7/12/25. The RP also stated that the nurse who was supposed to call her on the evening of 7/11/25 had called her since and apologized to her. A phone interview with Nurse #1 on 7/18/25 at 7:50 PM revealed she had thought the Administrator was going to call Resident #1's RP on the evening of 7/11/25. Nurse #1 stated that she knew it was her responsibility to notify Resident #1's RP about the incident, but she had gotten behind, had tried to get her medication pass started, and had forgotten about calling his RP that night. Nurse #1 further stated she called Resident #1's RP on 7/14/25 to apologize. An interview with the Unit Manager (UM) on 7/16/25 at 2:22 PM revealed whenever Nurse #1 did the assessment on Resident #1 after he was brought back inside the	F0580		

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F0580 SS = D	Continued from page 3 facility, he had assumed that she had taken the responsibility of notifying his RP. The UM stated that she heard Nurse #1 talking on the phone, and he thought she was calling his RP. The UM also shared that he worked day shift on 7/12/25, and he found out that Resident #1's RP was not called from the night before, but he knew Nurse #1 called her later to apologize. An interview with the Director of Nursing (DON) on 7/17/25 at 11:04 AM revealed that attempts were made to call Resident #1's RP on the evening of 7/11/25, but the phone number they had in his medical record was not correct. The DON stated that the RP was told about the incident on 7/12/25 when she came into the facility. A follow-up interview with Resident #1's RP on 7/17/25 at 11:15 AM revealed the Administrator told her that they called the phone number listed in Resident #1's medical record and it was inaccurate. The RP stated she looked at Resident #1's medical record and they had two phone numbers listed, but one of them was correct. She asked them why they didn't call both numbers listed but she didn't get a clear answer. She stated that Nurse #1 had called her at 6:30 AM on 7/14/25 to tell her that it was her responsibility to call her on the evening of 7/11/25 and she didn't, and she apologized. An interview with the Administrator on 7/17/25 at 1:34 PM revealed she did not call Resident #1's RP to notify her about the elopement because she thought Nurse #1 would call her as it was part of the incident report. The Administrator stated that there were two phone numbers listed in Resident #1's medical record, but one of them was correct, and that the nurse should have called both numbers to try to get in touch with Resident #1's RP.	F0580		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0600	"Past Noncompliance - no plan of correction required"	08/06/2025

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F0600 SS = D	Continued from page 4 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to protect a resident's right to be free from abuse when Resident #4 attacked Resident #5 which resulted in cuts above the right eye, bruising around the nose, and bleeding from his gums and required an Emergency Room visit. This was for 1 of 3 residents reviewed for resident-to-resident abuse (Resident #4). The findings included: Resident #4 was admitted to the facility on 10/01/24 with diagnoses that included Alzheimer's disease, anxiety, and major depressive disorder. Review of Resident #4's care plan, last revised on 03/31/25 revealed no care plan areas for aggressive behaviors. Review of Resident #4's quarterly Minimum Data Set assessment dated 06/30/25 revealed he was severely cognitively impaired with no delusions, behaviors, rejection of care, or instances of wandering. Resident #4 was independent with mobility and was able to ambulate on his own. Resident #5 was admitted to the facility on 10/27/23 with diagnoses of dementia without behaviors, unspecified mood disorder, psychosis, stroke, muscle weakness and atrophy, and need for assistance with personal hygiene. Review of Resident #5's most recent quarterly Minimum Data Set assessment dated 06/06/25 revealed he was severely impaired with no delusions, behaviors, rejection of care, or instances of wandering. Resident #5 was coded as dependent on others for the completion of his Activities of Daily Living (ADL). Review of the facility's Reportable Incidents revealed an incident dated 07/08/25. Review of the facility's investigation revealed Resident #4 was observed with one hand near the throat of another resident (Resident #5) and tried putting a hair comb in Resident #5's mouth with the other. Per the investigation report, Resident #4 and Resident #5 were separated by nurse aides (NA) NA #4, NA #5 and NA #6 and assessed by the	F0600		

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F0600 SS = D	Continued from page 5 nurse (Nurse #3). Resident #5 was observed to have cuts above his right eye and was bruised around his nose. There were no noted injuries to Resident #4. The investigation reported that both residents were sent to the emergency department for further evaluation and were returned to the facility a few hours later. Per the investigation report, Resident #4 was moved to another room by himself and was placed on one-on-one supervision. The investigation report indicated there was no lingering effects from the altercation with Resident #5 not experiencing fear or feelings of intimidation from Resident #4. An interview with NA #4 via telephone on 07/17/25 at 2:03 PM revealed she was familiar with the altercation and verified that she responded to the event on 07/08/25. NA #4 reported she was at the nurse's station when she heard shouting coming from Resident #4 and Resident #5's room. She reported she ran down the hall and when she entered the room, she observed Resident#4 with one hand on Resident #5's neck and the other hand with a comb and it appeared as though Resident #4 was attempting to put the comb in Resident #5's mouth. She stated she called for more assistance and pulled Resident #4 away from Resident #5. She took Resident #4 into the hallway, left him with NA #5 and went in to check on Resident #5. She reported by this time, NA #6 had arrived, and he went in the room as well to check on Resident #5. She reported she observed several small cuts above Resident #5's right eye, some redness around Resident #5's left eye, and some scant bleeding from Resident #5's gums. She reported Resident #4 was taken by NA #5 and NA #6 up to the nurse's station and reported the incident to Nurse #4. She stated Nurse #4 assessed both residents and notified administration and the Director of Nursing arrived at the facility in about 20 minutes. She reported both residents ended up being sent out to the emergency department. NA #4 stated that prior to the altercation, Resident #4 had a quiet evening with no noted agitation or aggression. She reported when she asked Resident #4 why he had attacked Resident #5, all he would say was "he was calling me out all night". NA #4 reported, to her knowledge, there had been no previous incidents between Resident #4 and Resident #5. An interview via telephone with NA #5 on 07/17/25 at 9:18 AM revealed she was one of the staff who responded to the altercation. She reported she was at the nurse's station when she heard yelling. She reported when she entered the room, Resident #4 was standing over Resident #5 with one hand on Resident #5's neck and he was using the other hand to put a comb in Resident #5's mouth. She reported Resident #4 was separated from	F0600		

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F0600 SS = D	Continued from page 6 Resident #5 and was taken to the hallway. She stated it appeared as though Resident #5 had cuts above his right eye, had redness on his cheek and appeared to have some cuts on his gums. She stated she overheard Resident #5 asking “why did he do that?” Resident #4 was taken down the hall to the nurse’s station and was asked why he attacked Resident #5, and he would only respond with “he was asking for it” and would not say anything else. NA #5 reported administration was called, and both residents ultimately were sent to the emergency department for further evaluation. An interview via telephone with NA #6 on 07/17/25 at 11:28 AM revealed he was clocking out from his shift when he heard a commotion and heard NA #4 calling for assistance. He reported when he got to the room, NA #4 and NA #5 were already there and both residents had been separated. Stated he observed Resident #5 to have redness around his eyes and appeared to be bleeding from his gums. He reported he assisted Resident #5 in getting into a wheelchair and Nurse #4 had come to the room. He reported Nurse #4 assessed both residents and Resident #4 was taken to the nurses’ station. NA #6 stated administration was called and both residents were sent to the emergency room. NA #6 reported that Resident #4 had seemed to be at his baseline that night and reported he had not been made aware of any aggressive behaviors prior to this incident. Multiple attempts to reach Nurse #4 via telephone calls were unsuccessful. Review of a skin assessment for Resident #4 dated 07/08/25 at 10:00 AM revealed the following: “No injuries noted, denies pain, no mental distress noted.” Review of a skin assessment for Resident #5 dated 07/08/25 at 11:00 AM revealed the following: “mild swelling to right eye/under eye, along cheek bone, scratch to right side of nose. Denies pain, denies any needs, no mental distress or anguish noted.” Review of Resident #5’s emergency room provider notes revealed he was seen on 07/08/25 and was treated for cuts above his right eye and returned to the facility the same day. An interview with Resident #5 on 07/17/25 at 8:26 AM revealed he had no recollection of the altercation, had no knowledge of Resident #5 and reported no residents or staff members had ever harmed or assaulted him. Multiple attempts to interview Resident #4 throughout the investigation were unsuccessful. When he was	F0600		

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F0600 SS = D	Continued from page 7 approached in his room, he turned his head away, closed his eyes, and became nonresponsive. An interview with the Director of Nursing on 07/17/25 at 10:54 AM revealed she was aware of the incident between Resident #4 and Resident #5. She reported Resident #4 had a previous altercation with another roommate several weeks prior and they had moved Resident #4's roommate to another room. She reported after that incident, the facility started looking at all the residents and roommate compatibility. She reported during this time, they felt that Resident #4 and Resident #5 would be compatible roommates as Resident #5 was a quieter resident and both gentlemen liked the room warm. She reported she was unsure how long Resident #4 and Resident #5 were roommates but reported it had not been a long time. She stated on 07/08/25 she was contacted around 3:45 AM about an altercation between Resident #4 and Resident #5. She reported she was informed that NA #4, NA #5, and NA #6 had gone into the residents' room and observed Resident #4 trying to shove a comb into Resident #5's mouth. The Director of Nursing stated she informed the staff to keep the men separated and to put Resident #4 on one-to-one supervision. She reported Nurse #4 advised that both men should be sent to the emergency department for further evaluation, so they received the order from the on-call physician and both men were sent. She continued, stating when both residents returned from the emergency department, Resident #5 had some minor swelling under his right eye but no other apparent injuries. She reported Resident #4 and Resident #5 were closely observed the rest of the day and reported by the end of the day, the swelling to Resident #5's eye had subsided. She reported Resident #4 continued on one-to-one supervision and was moved to an empty hall in a private room. The Director of Nursing stated that when both men returned from the emergency department, she completed a full body skin assessment on both residents. An interview with the Administrator on 07/17/25 at 1:18 PM revealed she was aware of the altercation between Resident #4 and Resident #5. She stated several weeks prior to that incident, Resident #4 had gotten into another altercation with another resident, who was his roommate at the time. She reported after the initial altercation by Resident #4, the administrative team discussed roommate compatibility and felt that Resident #4 and Resident #5 would have been a good fit to room together. She reported when they moved Resident #5 into the room with Resident #4, they had no initial concerns about them rooming together. She reported it was reported to her that Resident #5 was observed trying to	F0600		

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F0600 SS = D	Continued from page 8 “shove a comb” into Resident #5’s mouth. She reported that both residents were separated, and the Director of Nursing was called. She reported she was notified by the Director of Nursing of the altercation. The Administrator reported that both men were sent to the emergency department for further evaluation. She stated when Resident #4 and Resident #5 returned from the emergency department, both residents were moved to new rooms, with Resident #4 being moved to an empty hall, in a room by himself, and was placed on one-to -one supervision for about a week. She stated when she went to speak with each resident, neither resident could recall the altercation in detail. The Administrator indicated she could not recall what injuries Resident #5 sustained because of the altercation. The facility provided the following corrective action plan with a compliance date of 07/12/25. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 07/08/2025 at 3:45 AM Director of Clinical Services was notified of allegations of resident to resident abuse involving residents listed above. Staff report that Resident #4 had some skin tears and swelling to his eyes/nose area. Resident #5 without injuries. Residents were immediately separated with Resident #5 being placed on 1:1 supervision. Both residents were sent to the ER per on call provider. Director of Clinical Services notified Administrator. On 07/08/2025, Initial reportable was filed; Lenoir Police Department and Adult Protective Services (APS) were notified by the Administrator. On 07/08/2025, Medical Director was notified by the Director of Clinical Services. On 07/08/2025 Skin assessments were completed on residents listed above by the Director of Clinical Services. Resident #4 mild swelling noted under right eye and scratch noted along right side of nose. Resident is talkative and pleasant; denies pain at this time. No signs of mental distress noted. Resident #5 no negative findings noted. Resident denies pain at this time. No signs of mental distress noted. Resident is talkative per his normal behavior. 07/08/2025, Resident #4 was placed in a private room with 1:1 supervision by Certified Nursing Assistants. 07/08/2025 Care Plans were reviewed on both residents	F0600		

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F0600 SS = D	Continued from page 9 with updates being made as warranted by the MDS Nurse. 07/09/2025 Nurse Practitioner with psychiatric services notified of incident by the Director of Clinical Services . States that he will be in later today. Resident #5 is pending consents, Nurse Practitioner made recommendations to facility Nurse Practitioner. Depakote (an antiepileptic medication that can be used to treat bipolar disorder) was added. 07/10/2025 Follow up assessments completed on both residents by Director of Clinical Services with no changes noted from previous assessments. Resident #4 continues to deny pain, no signs of mental distress noted. 2 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 07/08/2025 Skin Assessments were completed by the Director of Clinical Services for all residents with a BIMS (Brief Interview for Mental Status) of 9 and below. No negative findings were noted. On 07/08/2025 Resident interviews were completed by the Director of Social Services for all residents with a BIMS of 10 and above. As part of the resident interviews, roommate compatibility questions were also looked at. No negative findings were noted. On 07/08/2025, Director of Clinical Services and the Administrator reviewed incident log for the past 30 days looking for trends in resident and resident incidents. At this time it was noted that Resident #5, does not do well with a room mate and at this time would be better suited to remain in a private room. A3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 07/08/2025 to 07/11/2025 Staff were provided education on abuse, neglect and misappropriation based on the facility's policy by the Director of Clinical Services and the Administrator. Education was provided in person and via the telephone for staff that were not working during these dates by the Director of Clinical Services. Education focused on staff intervening early on during situations or conflicts that could potentially escalate along with notifying the Director of Clinical Services and/or Director of Social Services of all roommate incompatibility issues. At the time of education, there was a period for questions and answers	F0600		

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F0600 SS = D	Continued from page 10 to review information provided. I4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Ad Hoc Quality Assurance and Performance Meeting held on 07/12/2025 with the Administrator, Director of Clinical Services and Medical Director to accept and approve of the plan. Director of Nursing/ or designee to complete random audits weekly of 5 residents with a BIMS of 10 and higher, to inquire about abuse while also looking at roommate compatibility. Immediate action to be taken for any positive findings. The Director of Nursing Services will bring results of these audits/interviews before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. In the monthly Quality Assurance and Performance Improvement Meeting, the Interdisciplinary Team will review all allegations of abuse to ensure appropriate interventions are in place and care plan updated x8 weeks. QAPI Committee will determine the need for further intervention and auditing beyond three months to assure compliance is sustained ongoing. Compliance date: 07/13/2025 The corrective action plan was validated on 07/17/25. Review of the facility provided monitoring tools revealed the facility had ongoing monitoring to ensure that no residents were subject to acts of abuse from any source. There was evidence of in-services with sign-in sheets, audits, and other interventions that were mentioned in the corrective action plan. Interviews with staff revealed they were able to verbalize the education regarding abuse policies and procedures. The staff interviewed were able to verbalize the steps needed to take in the event that they observed aggressive behaviors and concerns regarding the compatibility of roommates. The interviewed staff also were able to verbalize the steps they should take if they observe an altercation between residents. The completion date of 07/13/25 was validated.	F0600		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689	"Past Noncompliance - no plan of correction required"	08/06/2025

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F0689 SS = SQC-J	Continued from page 11 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews with the resident's responsible party, staff, and the Medical Director, the facility failed to supervise a severely cognitively impaired resident who demonstrated wandering behaviors in the facility and prevent him from entering into an unlocked kitchen door and then exiting the facility through the kitchen's exterior door for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 who had a diagnosis of dementia exited from the facility without staff's knowledge for an undetermined length of time on the evening of 7/11/25 and was observed by staff through the door at the end of C hall standing by the facility's transport van parked outside the facility in the back parking lot in socked feet. There was the high likelihood of a serious adverse outcome for Resident #1, who had a diagnosis of dementia, when he entered the unlocked kitchen and walked through the kitchen and exited the facility through the kitchen's exterior door. Resident #1 could have wandered into and been entrapped in the walk-in freezer or walk-in cooler, been injured by contact with kitchen equipment, or experienced a fall or serious injury if he had wandered into the nearby wooded area or the 4-lane main highway. The findings included: Resident #1 was admitted to the facility on 3/6/25 with diagnoses that included left femur fracture, abnormalities of gait and mobility, muscle weakness, and dementia. A review of the Elopement Risk Evaluation for Resident #1 dated 3/19/25 indicated Resident #1 had potential risk factors for elopement that included cognitive impairment, poor decision-making skills and ability to exit the facility, but he had no exit-seeking behaviors so Resident #1 was not considered at risk for elopement.	F0689		

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F0689 SS = SQC-J	Continued from page 12 The significant change in status Minimum Data Set assessment dated 5/5/25 indicated Resident #1 was severely cognitively impaired, but did not exhibit wandering behaviors during the assessment period. Resident #1 had range of motion impairment on one side of the lower extremities, used a wheelchair, and required substantial/maximal assistance with most activities of daily living including walking 10 feet. Resident #1 had one fall with no injury and one fall with minor injury since admission or prior assessment. Resident #1 did not have a care plan for wandering behaviors or risk for elopement prior to 7/11/25. A review of an Incident Report for Elopement dated 7/11/25 at 7:45 PM prepared by Nurse #1 indicated the nurse aide witnessed Resident #1 outside walking past C hall door. The nurse aide ran outside and assisted Resident #1 back inside the building. Nurse #1 assessed Resident #1 for any type of injury. There were none (injuries) to be found. A review of Resident #1's medical record indicated a late entry nursing progress note dated 7/12/25 at 3:29 PM by Nurse #1 which read, in part: Nurse Aide (NA) #1 and NA #2 witnessed Resident #1 outside, walking past the C hall door at approximately 7:45 PM. NA #1 immediately ran outside to assist him back into the building while NA #2 came and alerted Nurse #1. Nurse #1 assisted NA #1 with guiding Resident #1 back into the building via C hall door. NA #2 went to find Resident #1's wheelchair, finding it in the dining room just outside the door going into the kitchen. Once Resident #1 was assessed, Nurse #1 checked the doors and found all doors to be closed and locked. When NA #2 checked the kitchen door, she found it to be unlocked. Apparently, Resident #1 went through the unlocked kitchen door and outside through the back door of the kitchen. Nurse #1 notified the Director of Nursing as well as the Administrator who came to the facility shortly thereafter. A phone interview with NA #1 on 7/16/25 at 12:05 PM revealed she was talking to NA #2 when she noticed Resident #1 outside the facility through the door at the end of C hall on 7/11/25. Resident #1 was standing and holding onto the facility's transport van which was parked in the back parking lot. NA #1 stated that she immediately went out the C hall door to get Resident #1 while NA #2 alerted Nurse #1 who helped her walk Resident #1 back into the building. NA #1 stated Resident #1 was wearing long sleeves and pants, and she noticed that his face was red from being outside. NA #1 stated that she observed Resident #1 pulling on the van	F0689		

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F0689 SS = SQC-J	Continued from page 13 door, and she thought he was trying to get in the van. NA #1 asked Resident #1 what he was doing, and he just shrugged his shoulders at her, and did not say anything. NA #1 stated that Resident #1 moved around on his own in his wheelchair both by rolling his wheelchair and sometimes standing up and walking while pushing his wheelchair. NA #1 further stated that she wasn't assigned to Resident #1 on 7/11/25, and had not seen Resident #1 prior to him being outside. She shared that NA #3 and NA #4 were assigned to Resident #1, but they were doing their rounds when NA #1 saw Resident #1 outside the facility. NA #1 further shared that when NA #2 looked for Resident #1's wheelchair, she found it right at the interior kitchen door from the dining room which was unlocked, and they suspected he had gotten out through the exterior kitchen door on the left side close to the dishwasher because he had grass all over his socks, and that he must have walked through the grass outside that door. NA #1 stated that nobody was in the kitchen at that time because all dietary staff had already left for the day. An interview with NA #2 on 7/16/25 at 3:47 PM revealed she was talking to NA #1 when NA #1 saw Resident #1 outside the C hall door. NA #1 took off running to get Resident #1, and hollered to everyone that Resident #1 was outside. NA #2 stated that she observed Resident #1 standing by the facility's transport van, which was parked at the back parking lot, but his wheelchair was not out there. NA #2 stated she went back into the facility to get Resident #1's wheelchair and on the way to his room, NA #2 alerted Nurse #1 that Resident #1 was outside. NA #2 further stated that she checked Resident #1's room but his wheelchair was not there. NA #2 said that she found Resident #1's wheelchair in the dining room parked right by the interior kitchen door which was unlocked. NA #2 stated that the interior kitchen door from the dining room was normally locked and could not be accessed unless a code was entered on the door. NA #2 shared that only the dietary staff knew the code to the interior kitchen door. NA #2 shared that she walked into the kitchen and observed an unlocked exterior door on the left side close to the dishwasher leading to the outside. NA #2 further shared that she suspected Resident #1 walked out through this door because his socks were covered with grass, and they were wet. A phone interview with Nurse #1 on 7/18/25 at 7:50 PM revealed the elopement incident involving Resident #1 must have happened between 7:55 PM and 8:00 PM on 7/11/25, and she had been in the facility for about an hour. Nurse #1 stated that she last saw Resident #1 around 7:30 PM, and he was propelling himself in his	F0689		

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F0689 SS = SQC-J	Continued from page 14 wheelchair around the nurses' station. Nurse #1 stated that NA #1 and NA #2 both saw Resident #1 through the end of the C hall door. She further stated that she and NA #1 both ran to get Resident #1 while NA #2 looked for his wheelchair. Nurse #1 shared that Resident #1 was wearing long sleeves, pull-on pants, and socks. She said that Resident #1 was strong, but he couldn't stand upright well. As they were walking Resident #1 back inside, he was trying to pull away from them, and he acted like he did not want to sit down. While NA #2 was looking for Resident #1's wheelchair, they sat him down in the chair by the nurses' station so Nurse #1 could assess him. Nurse #1 stated she checked his skin to look for any signs of injuries and she found none. She checked his vital signs which were normal. Nurse #1 stated Resident #1 had grass on his socks which led them to believe he had gotten out through the exterior kitchen door leading to the back parking lot. Nurse #1 stated she called the Administrator and the Director of Nursing to notify them about the incident. An interview with NA #3 on 7/16/25 at 3:25 PM revealed she came in to work on 7/11/25 at 7:15 PM, and she was assigned to Resident #1's hall. NA #3 stated she saw Resident #1 in the dining room at 7:15 PM sitting in his wheelchair. NA #3 further stated as soon as she got to the facility, she was advised that all the nurse aides had to split D hall, so she and NA #4 went ahead and assisted a resident into bed on D hall. NA #3 stated that when they went down to Resident #1's hall and got ready to start their round, NA #4 heard another employee say that Resident #1 had gotten out of the facility. NA #3 stated that after staff got Resident #1 back into the facility, she put him in his recliner in his room, and then about 20 minutes before 9:00 PM, she assisted him to bed. NA #3 stated that she was glad NA #1 and NA #2 had turned around and saw Resident #1 through the door at the end of C hall. NA #3 stated that all staff had to lay eyes on Resident #1, because he liked to go to doors and mash on them. NA #3 added that she would often try to redirect Resident #1 whenever she saw him mashing on the hall doors. NA #3 shared that Resident #1 usually sat by the doors, and liked to look outside. She further shared that he normally wore non-skid socks, long-sleeve shirt, and pants. She said that Resident #1 was always confused, and she asked him what he was doing outside, but he did not answer her and just looked at her. A phone interview with NA #4 on 7/16/25 at 12:59 PM revealed when she walked in to work around 7:00 PM on 7/11/25, she saw Resident #1 in his wheelchair propelling himself around by the nurses' station. NA #4 stated that she was getting ready to do rounds on	F0689		

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F0689 SS = SQC-J	Continued from page 15 Resident #1's hall when she walked up to the nurses' station and NA #1 and NA #2 told her that they had found Resident #1 wandering by the facility van which was parked in the back parking lot. NA #4 stated the incident must have happened around 7:30 PM because it was not long after she had been in the facility. NA #4 stated that Resident #1 had wandering behaviors, and he was always walking or propelling around in his wheelchair. NA #4 stated that she had seen him near the doors at the end of A hall and C hall, and he often tried to push them open, but these doors wouldn't open. NA #4 shared that the interior kitchen door was supposed to be locked, and that there was a code to get in it. NA #4 stated that from what she heard, the interior kitchen door was left open and didn't close all the way. An interview with the Unit Manager (UM) on 7/16/25 at 2:22 PM revealed he was in the conference room between 7:00 PM and 8:00 PM on 7/11/25 when he heard commotion from staff. The UM stated he came out of the conference room and observed staff walking Resident #1 back into the facility. The UM stated that they brought Resident #1 into the nurses' station and Nurse #1 obtained his vital signs and did a skin assessment. The UM shared that he was assigned to two other halls that evening, and had seen Resident #1 occasionally wheeling himself around, but he couldn't remember the time he had seen him. An interview with the Dietary Manager (DM) on 7/16/25 at 1:24 PM revealed she had a cook and two dietary aides who worked the supper service on 7/11/25, and all of them left at 7:00 PM. The DM stated that they all reported that they locked all the doors to the kitchen before they left. The DM shared that there was one interior kitchen door coming from the dining room, and two exterior doors leading to the outside, and her staff said they made sure they locked all the interior and exterior kitchen doors. The DM stated that the interior kitchen door was locked through a code, while the two exterior doors were locked through a knob. She shared that her staff locked the exterior doors with a key from the outside, but it was easy to open from the inside just by turning the doorknob. An observation inside the kitchen on 7/16/25 at 1:15 PM revealed an industrial gas range with turn knobs, a sink and a dishwasher which were around 50 feet from the interior kitchen door. There were several cabinets and countertops with various kitchen gadgets, a walk-in freezer, a walk-in cooler, reach-in refrigerators, and multiple meal carts.	F0689		

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F0689 SS = SQC-J	Continued from page 16 An observation was made on 7/16/25 at 1:34 PM of the outside area from the kitchen door on the left side right by the dishwasher. Right outside the exterior door was approximately 50 feet of grassy area before reaching the side walk on the left side of the exterior door. The back parking lot and the end of the C hall door was approximately 85 feet from the exterior kitchen door. The 4-lane main road with a posted speed limit of 45 miles per hour (mph) was approximately 150 feet from the back parking lot at the end of the C hall door where Resident #1 was observed. There was a wooded area approximately 200 feet towards the right side from the exterior door. Behind the wooded area was ditch approximately three feet deep with a sharp incline. A review of the weather conditions per Weather Underground website revealed the following data for Lenoir, North Carolina on 7/11/25 at 7:54 PM: 76 degrees Fahrenheit with no precipitation, Southeast wind speed at 3 mph. An interview with Resident #1's responsible party (RP) on 7/16/25 at 11:01 AM revealed Resident #1 had gotten out of the facility on the evening of 7/11/25 around 8:00 PM. Resident #1's RP stated that from what was reported to her, Resident #1 had wheeled himself into the dining room, opened the interior door to the kitchen, which was left unlocked, and went outside through an exterior door inside the kitchen. Resident #1's RP stated nobody knew how long Resident #1 was inside the kitchen or outside of the facility. The nurse and the nurse aides brought Resident #1 back in after they had seen him through a hall door. Resident #1's RP stated that she didn't find out about the incident until the next day, and it had upset her. She further stated that it scared her because something bad could have happened to Resident #1. She added that Resident #1 could have gotten hurt while he was unsupervised in the kitchen, as well as while he was outside by himself because the facility was right by a busy road. During the RP interview, an attempt was made to interview Resident #1, but he did not answer any questions. He was observed sitting in a wheelchair while facing the door at the end of A hall. Resident #1's RP stated that Resident #1 recognized her but did not talk much to her either. During an interview with the Maintenance Director on 7/16/25 at 2:17 PM, an observation of the interior kitchen door revealed he had removed the latch or the locking mechanism at the back of it. The Maintenance Director stated that it had been reported to him that on the evening of 7/11/25, the latch at the back of the interior kitchen door had been kept unlocked and this	F0689		

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F0689 SS = SQC-J	Continued from page 17 prevented it from requiring a code to unlock it. He stated that removing the latch prevented staff from keeping the interior kitchen door unlocked without having to enter a code on the keypad. He also stated that he had changed the code to the interior kitchen door on 7/15/25 and again on 7/16/25, because he found out that some nurse aides knew about the code to the interior kitchen door. The Maintenance Director stated that the nurse aides were not supposed to have the code to the kitchen, and that only kitchen staff should have access to the interior kitchen door. He also pointed out that he had removed the door stop to the interior kitchen door to prevent staff from propping it open during meal service. An interview with a Physical Therapist (PT) on 7/17/25 at 9:30 AM revealed physical therapy had worked with Resident #1 from 3/6/25 to 4/17/25 following repair of his left femur fracture. The PT stated that when Resident #1 was discharged from physical therapy, his mobility depended on the day, but he had walked up to 300 feet with contact guard which meant a staff member held onto a gait belt while he walked. The PT stated Resident #1 always had to have assistance with walking, but his dementia prevented him from remembering that it was unsafe for him to walk unassisted. The PT further stated that it was not safe for Resident #1 to walk on grass at the time of discharge from therapy. She also shared that Resident #1 always wore gripper socks because wearing shoes caused him to trip more, and he had better traction with gripper socks. A phone interview with the Medical Director (MD) on 7/17/25 at 9:37 AM revealed he was informed about Resident #1's elopement shortly after it had happened when he received a text message letting him know about Resident #1 getting outside the facility through an unlocked kitchen door. The Medical Director stated that it was an unfortunate coincidence that Resident #1 made it through a kitchen door to the outside of the facility. The Medical Director stated that it was not safe for Resident #1 to be outside unassisted. The Medical Director further stated that he could go on and on about the dangers of a resident with dementia being outside unsupervised, and that this caused a potential for serious harm. An interview with the Director of Nursing (DON) on 7/16/25 at 4:22 PM revealed she received a phone call from Nurse #1 that Resident #1 had gotten out of the building on 7/11/25. A nurse aide saw him outside and brought him back in. They assessed him and checked him for any signs of injuries, and he didn't have any. The DON stated that staff told her that Resident #1 exited	F0689		

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F0689 SS = SQC-J	Continued from page 18 through the kitchen because his wheelchair was found right at the interior kitchen door which was unlocked. The DON shared that NA #2 observed that the interior kitchen door was unlocked because the door latch had been unlocked from the inside. An interview with the Administrator on 7/17/25 at 1:34 PM revealed Nurse #1 texted her at 8:04 PM on 7/11/25 about Resident #1 being found outside the facility. She stated that she got to the facility about 10 to 15 minutes later. The Administrator stated that as soon as she arrived at the facility, she made sure Resident #1 was alright, and he was already back in his room. She said she tried to interview him, but he was staring at the television in his room with his hands behind his head, and he didn't say anything to her after she asked him what he was doing outside the facility. The Administrator further stated that she checked all the doors to make sure they were all locked. She shared that every door was locked except the exterior kitchen door leading to the outside close to the dishwasher, so she locked it back. The Administrator also stated that she texted the Medical Director to notify him about the incident, and she started talking to staff about what to do when someone eloped. The Administrator was informed of immediate jeopardy on 7/17/25 at 11:48 AM. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 07/11/2025 at approximately 8 PM Director of Clinical Services was notified by nurse at the facility that resident had exited the building and was seen walking in the back parking lot. Nurse stated that resident was assisted back into the building by staff without incident. Wheelchair was located in the dining room by the door that leads into the kitchen. Door was closed at this time and secured, requiring key pad to open the door. Director of Clinical Services notified the Administrator along with the Vice President of Clinical Services and Regional Vice President. On 07/11/2025 the Administrator walked perimeter of building checking all exit doors, all were secure. On 07/11/2025 a complete assessment including a skin assessment was completed by the nurse assigned to resident with no negative findings. Resident's vital	F0689		

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(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
F0689 SS = SQC-J	Continued from page 19 signs were within normal limits/baseline, with temperature being 98.4. The temperature outside at this time was between 79-81 degrees. On 07/11/2025 15 minute checks were initiated by the Director of Clinical Services on resident. The Director of Clinical Services provided this instruction to the nurse assigned to resident and it would be on-going until further notice. The 15 minute checks are documented on the monitoring form with the nurses verbally reporting confirmation of the completion of the 15 minute checks for resident shift to shift. On 07/11/2025 the Director of Clinical Services verified using the census from electronic medical record that every resident was accounted for. All residents were present and accounted for. On 07/12/25 the Unit Manager completed an elopement risk evaluation in electronic medical record which was used to update the Elopement Book to include the resident that eloped and any residents at high risk for elopement. The Elopement Book is maintained at the sole nurses station which is behind a secured entrance in which all visitors must be assisted in or out by a facility staff member. On 07/12/2025 the nurse assigned to the resident completed a skin assessment on resident with no negative findings noted. On 07/13/2025 Skin assessment was completed on resident by the Director of Clinical Services, no changes noted. No negative findings noted. On 07/13/2025 the Director of Clinical of services updated the care plan to include exit seeking behaviors. Interventions included: alert/call resident's wife to sit with resident as needed, facility to attempt to look for a more secure facility for resident with responsible party permission, include resident in activities that are ongoing in the facility, and to monitor resident's whereabouts more frequently. Kardex was updated at this time to reflect the current interventions added to the care plan for nursing staff to be aware. Care plan updates and Kardex updates were included in the education that was provided to facility staff. On 07/13/2025 BIMS assessment was completed on resident by the Director of Clinical Services. Previous BIMS was a 3, with current BIMS a 2, thus validating no changes in cognitive ability.	F0689		

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F0689 SS = SQC-J	Continued from page 20 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 07/11/2025 once the resident was back inside the building, the Certified Nursing Assistant noted resident's wheelchair sitting at the kitchen door where the lock was manually unlocked and immediately locked the door. Administrator obtained statements from current staff working at time of elopement. After review of statements a root cause was found to be the kitchen door was unlocked and not secured. From 07/11/2025 all exterior doors along with the door leading from the dining room into the kitchen have been checked by the Administrator and/or Maintenance. All doors have been closed and secured. On 07/12/2025 the locking knob for the kitchen door keypad was removed by the Maintenance Director. This removal has made the keypad an automatic locking door. The kitchen staff have the code and must use the keypad each time to open the door. On 07/12/2025 to 07/13/2025 Elopement Risk Assessments were completed on current residents in the facility by the Unit Manager and the Director of Clinical Services. Any residents triggering for elopement risk were updated in the Elopement Book that is placed at the nurses station and their care plans were updated accordingly. Elopement Risk Assessments are completed by the nursing staff upon admission, quarterly and as deemed necessary. Staff are made aware of care plan updates through education. On 07/13/2025 and 07/14/2025 Elopement Drills were conducted on all three shifts by the Administrator and/or Maintenance Personnel. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 07/11/2025 – 07/13/2025 Director of Clinical Services provided education on elopement and ensuring doors are closed and locked to current staff. Education was conducted via text messaging and/or email via scheduling portal immediately. Upon start of staff's next working shift, education was reviewed with staff signing acknowledgment of education and understanding. On 07/13/2025, Administrator and Director of Clinical Services continued to provide one on one education and answered any questions to nursing department, therapy department, dietary department, housekeeping	F0689		

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F0689 SS = SQC-J	Continued from page 21 department, and management team with validation of education via question and answer time. Education focused on residents at high risk for elopement (Elopement Book which is located at the nurses station), what to do in the event of a missing resident, and when to notify Director of Clinical Services and Administrator. Effectiveness of education will be measured by conduction of elopement drills one time per week for 4 weeks alternating between shifts, then monthly thereafter for 2 months to ensure understanding of elopement procedure. The Executive Director will bring the results of the elopement drills to the Quality Assurance Performance Improvement meetings. On 07/12/2025 Dietary staff were provided education by the Administrator pertaining to making sure that kitchen is secure upon leaving at night and that the door from the kitchen to the dining room is not propped open. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 07/13/2025 the Administrator held an Ad Hoc Quality Assurance Performance Improvement with the Medical Director and Director of Clinical Services to approve the plan. Starting on 07/14/2025 Maintenance and/ or designee to complete audits 2 times/day 7 days/week at random times for 4 weeks then daily for 4 weeks to ensure that all exterior doors are secure and the door leading from the dining room into the kitchen is closed. Immediate action to be taken for any positive findings. The Director of Clinical Services will bring results of these audits before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. In the monthly Quality Assurance and Performance Improvement Meeting, the Interdisciplinary Team will review all elopements to ensure appropriate interventions are in place and care plan updated x8 weeks QAPI Committee will determine the need for further intervention and auditing beyond three months to assure compliance is sustained ongoing. Alleged date of IJ removal date: 7/15/2025 Validation of the facility's corrective action plan was conducted on 7/17/24 through record review and staff	F0689		

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F0689 SS = SQC-J	Continued from page 22 interviews. A review of the 15-minute check sheets indicated Resident #1 was monitored every 15 minutes by staff from 7/11/25 at 8:00 PM to 7/15/25 at 8:00 PM. The Elopement Book included residents at high risk for elopement, and it was maintained at the nurses' station. A review of the Elopement Drill sign-in sheets indicated elopement drills were conducted on 7/13/25 at 2:19 PM and 7/14/25 at 5:16 AM to cover staff on all three shifts. A review of the facility's monitoring audits conducted on 7/14/25 through 7/16/25 indicated all outside doors were locked and secured, including the door leading from the dining room to the kitchen, and all door alarms were active. Interviews were conducted with nursing, therapy, dietary, and housekeeping staff which indicated they received education on the facility's elopement policy and ensuring doors were closed and locked. The staff revealed the education included residents at high risk for elopement, what to do in the event of a missing resident, and when to notify the DON and the Administrator. Interviews with dietary staff revealed they received education related to making sure that the kitchen was secure upon leaving at night and that the door from the kitchen to the dining room was not propped open. The corrective action plan completion date and IJ removal date of 7/15/25 was validated.	F0689		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and interviews with staff and the Medical Director, the facility failed to maintain a medication error rate of less than 5% as evidenced by the administration of a wrong dosage and failure to have the resident rinse their mouth after being given a steroid inhaler (2 medication errors out of 31 opportunities), resulting in a medication error rate of 6.45% for 2 of 4 residents observed during medication pass (Resident #2 and Resident #3).	F0759	Resident #2 orders were reviewed on 7/17/2025 with the provider and they provided a one-time order for the Vitamin D 20 mcg dose and Resident #2 Vitamin D 25 mcg PO daily will continue per discussion with provider on 07/17/2025. Resident #3 orders were reviewed on 7/17/2025 by the provider to include rinse and spit with current inhaler. Nurse #2 was immediately educated on following physicians orders. Starting on 7/17/2025, the Director of Nursing and Assistant Director of Nursing reviewed current resident orders for Vitamin D for the correct dose and inhalers with directions to rinse and spit to verify physician order is being followed. Any issues identified were corrected. This will be completed by 7/21/2025. Starting on 7/17/2025 to 7/21/2025, the Director of Nursing and Assistant Director of Nursing provided education to the licensed nursing staff on following physician orders to include directions set by the physicians. Newly hired licensed nurses will receive this education upon hire.	07/23/2025

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F0759 SS = D	Continued from page 23 The findings included: 1. Resident #2 was admitted to the facility on 9/13/19 with diagnoses that included vitamin D deficiency. The Physician's Orders in Resident #2's electronic medical record indicated an active order dated 7/1/20 for Vitamin D3 tablet 25 micrograms (1000 units) (Cholecalciferol) – give 1 tablet by mouth one time a day related to vitamin D deficiency. On 7/16/25 at 9:19 AM, Nurse #2 was observed as he prepared and administered Resident #2's medications. Nurse #2 administered one tablet of Vitamin D 10 micrograms (400 units) to Resident #2. A phone interview with Nurse #2 on 7/17/25 at 10:03 AM revealed he didn't notice the formulation or label on the Vitamin D bottle before he administered the medication to Resident #2. Nurse #2 stated that he should slow down and look at the medication label to make sure the dosage was accurate. An interview with the Unit Manager (UM) and observation of the medication cart on 7/17/25 at 2:31 PM revealed Vitamin D was only available in the 10-microgram formulation. The UM stated he wasn't sure about the other medication carts, but Nurse #2 could have given Resident #2 two and half tablets from the Vitamin D bottle for the correct dose. An interview with the Director of Nursing on 7/16/25 at 4:22 PM revealed the nurse should have given the correct dose of Vitamin D to Resident #2. 2. Resident #3 was admitted to the facility on 2/25/25 with diagnoses that included chronic obstructive pulmonary disease (COPD). The Physician's Orders in Resident #3's electronic medical record indicated an active order dated 3/22/25 for Trelegy Ellipta inhalation aerosol powder breath activated 100-62.5-25 micrograms/actuation (Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally one time a day for COPD. A review of the manufacturer's recommendations indicated to rinse mouth with water after taking a dose of the medicine and spit the water out. Do not swallow the water. This is important to prevent the development of oral thrush, a fungal infection that can occur due to the presence of corticosteroids in the inhaler. On 7/16/25 at 9:27 AM, Nurse #2 was observed as he	F0759	Continued from page 23 Starting on 7/22/25, the Director of Nursing and/or Nursing Designee will complete a med pass observation on 5 residents 3 times a week times 4 weeks, then 1 time a week times 8 weeks on varying shifts to ensure all three shifts are monitored and to ensure licensed nursing staff are following physician orders with directions set by the physician order. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 7/21/2025. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. 5. Completion Date: 7/23/2025	

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F0759 SS = D	Continued from page 24 administered Resident #3's medications. Nurse #2 activated Resident #3's Trelegy inhaler and handed it to Resident #3 who took a deep breath while inhaling into the inhaler. Resident #3 handed the inhaler back to Nurse #2 who handed Resident #3 her other medications. Resident #3 swallowed her pill medications and took a sip of water through a straw. An interview with Nurse #2 on 7/16/25 at 9:49 AM revealed he had thought about instructing Resident #3 to rinse her mouth after he gave her the inhaler, but it was too late because she had already reached for her pills. Nurse #2 stated that he should have asked her to rinse her mouth and spit the water out. A phone interview with the Medical Director on 7/17/25 at 9:37 AM revealed it was part of the facility's policy that the nurses were supposed to have the residents rinse their mouths and spit out the water after giving them a Trelegy inhaler. The Medical Director stated that the reason for this was that the effects of the medication could stay in the oral mucosa and cause irritation. An interview with the Director of Nursing on 7/16/25 at 4:22 PM revealed the nurse should have instructed Resident #3 to rinse her mouth and spit the water out after the administration of the inhaler.	F0759		