STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Foley Center at Chestnut Ridge	621 Chestnut Ridge Parkway Blowing Rock, NC 28605

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with the Medical Director and staff, the facility failed to prevent a medication error when Nurse #2 administered a medication to a resident without a physician's order. On 6/21/25, Resident #92 received a 300 milligram (mg) dose of gabapentin (nerve pain medication) that was left in a medication cup labeled with Resident #94's last name. The deficient practice occurred for 1 of 6 residents reviewed for unnecessary medications (Resident #92). Findings included: Resident #92 was admitted to the facility on [DATE] with diagnoses including volvulus (abnormal twisting of intestine) and aftercare following digestive system surgery, and chronic pain. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92's cognition was moderately impaired. A review of Resident #92's active physician order summary as of 6/21/25 revealed no order was in place for the administration of gabapentin. Resident #94 was admitted to the facility on [DATE] with diagnoses including fibromyalgia (a chronic disorder causing pain) and Parkinson's disease. A review of Resident #94's MAR revealed a physician's order for gabapentin 300 mg give one capsule three times a day was scheduled to be administered at 9:00 AM, 2:00 PM, and 9:00 PM. A review of the medication error incident report documented by Nurse #2 revealed on 6/21/25 at approximately 6:00 PM, Resident #92 received gabapentin 300 mg that was intended for Resident #94. The error report indicated Resident #92's family member was in the room and questioned Nurse # 2 if gabapentin was a new order. Nurse #2 administered the gabapentin and afterwards the family member presented Resident #92's order summary that did not include gabapentin. Nurse #2 reviewed Resident #92's MAR and medical chart and confirmed gabapentin 300 mg was administered in error and was ordered for Resident #94. The report indicated the immediate action taken by Nurse #2 was to call the Assistant Director of Nursing (ADON) and instructed to call the on-call physician and report the medication error to the on-coming nurse. Nurse #2 left two messages for the on-call physician, obtained vital signs, and checked neurological status and noted Resident #92 was at baseline. Nurse #2 made a note in the physician's communication folder and notified the family member of the medication error. A review of Nurse #2's progress note documented on 6/21/25 at 8:44 PM revealed gabapentin 300 mg was given to Resident #92 instead of Resident #94. After reviewing the medical chart and MAR, Nurse #2 notified the ADON of the medication error and was instructed by the ADON to notify the on-call physician for orders. Nurse #2 noted Resident #92's vital signs and neurological status were at baseline and would continue to monitor for changes. An interview was conducted on 7/30/25 at 2:26 PM with Nurse #2. Nurse #2 revealed she had removed Resident #94's gabapentin from the medication package and went to administer the dose scheduled at 2:00 PM on 6/21/25. Nurse #2 recalled Resident #94 was either not in the room or in bathroom and stated she was unable to administer the gabapentin. She went back to the medication cart and wrote Resident #94's last name on a medication cup and put it in the medication cart to give later. She started administering medications to the other residents and when she got to Resident #92 saw the medication cup with the gabapentin and thought it was Resident #92's name on the cup because the last names were similar. She reviewed Resident #92's MAR for medication that was scheduled and added it to the cup with the gabapentin. Resident #92's family member was in the room and Nurse #2 stated she explained what each pill was to Resident #92 and when she named gabapentin the family member questioned if Resident #92 got gabapentin, then stated, maybe it was started at the hospital, Nurse #2 revealed she administered the gabapentin and did not check the physician orders to confirm gabapentin was listed. Nurse #2 revealed Resident #92 did not question the medications and took the gabapentin at approximately 5:30 or 6:00 PM on 6/21/24. Nurse #2 revealed it was approximately 15 to 30 minutes later when Resident #92's family member informed her gabapentin was not on the list of medications and that was when she recalled the gabapentin was for Resident #94. Nurse #2 revealed she called the ADON and was told to notify the on-call physician and let them know what happened and provide guidance and get vital signs. Nurse #2 described Resident #2 was alert and oriented at her baseline and had no abnormal vital signs. She left two messages for on-call physician and wrote a note in the physician's communication book, confirmed with the family member gabapentin was given in error, and informed the oncoming nurse what happened. Nurse #2 stated she did not observe Resident #92 was over sedated from the time the gabapentin was administered till the end of her shift around 8:00 PM. A review of Resident #92's vital signs revealed the following: - 6/21/25 at 7:46 PM heart rate 70 (normal 60 to 100) beats per minute (bpm); blood pressure 120/68 (normal 120/80); respiratory

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to secure an opened tube of antifungal ointment and an opened tube of zinc oxide cream for 1 of 1 resident reviewed for medication storage (Resident #80). Resident #80 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #80 with intact cognition. A review of Resident #80's medical records revealed he had never been assessed for self-administration of medication. During an observation conducted on 07/28/25 at 12:59 PM, one opened tube of Miconazole nitrate cream (an over-the-counter antifungal medication used to treat fungal infections of the skin, such as athlete's foot, jock itch, and ringworm) with the concentration of 2%, and an opened tube of Zinc oxide (a topical cream used to treat and prevent diaper rash) with the concentration of 20% were observed left unattended on top of the window sill in Resident #80's room and ready to be used. An interview was conducted with Resident #80 on 07/28/25 at 1:02 PM. He stated both medications had been sitting on the window sill since he moved into the room. He added both medications did not belong to him and denied he had ever used any of the topical medication so far. During a joint observation and subsequent interview with Nurse #1 and Medication Aide #1 (MA) on 07/28/25 at 1:06 PM, MA #1 stated she saw both medications in Resident #80's room for a few days but was not sure they had to be secured in the medication cart. Nurse #1 stated it was her second day working in the facility. She oversaw MA #1, but she was working at the adjacent 200 Hall. She did not know there were medications left unattended in Resident 80's room and added both medications should be kept in the medication cart. An interview was conducted with the Assistant Director of Nursing (ADON) on 07/28/25 at 1:18 PM. She stated both medications should be kept in the medication cart. It was her expectation for the facility to remain free of unattended medications. During an interview conducted on 07/28/25 at 1:23 PM, the Administrator stated both medications should be kept in the medication cart. She expected the staff to be more attentive when providing care or conducting medication pass to ensure the facility was free of unattended medications. An interview was conducted with the Medical Director on 07/31/25 at 1:00 PM. He stated all the medications should be kept securely in medication carts or medication storage rooms. It was his expectation for the facility to remain free of unattended medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to label and date leftover food and failed to discard food items by the expiration or used by date for 1 of 3 nourishment room refrigerators (300/400 hall) reviewed for food storage. This practice had the potential to cause foodborne illnesses.Findings included:An observation and interview were conducted on 07/28/25 at 10:50 AM with the Certified Dietary Manager (CDM) for review of the nourishment room refrigerator. The following were observed in the nourishment room refrigerator designated for the 300 and 400 hall used to store food brought into the facility for residents: a. A 12-ounce unopened container of egg salad with a use by date of 7/19/25. The CDM stated the date on the egg salad container indicated it should have been discarded on 7/19/25.b. A 10-ounce opened container of orange juice with a use by date of 6/25/25. The container did not have a resident name. The CDM revealed the orange juice should have been discarded on 6/25/25 as indicated on the container use by date and labeled with the resident's name. c. A opened reusable plastic storage container of soup with a handwritten date of 7/16/25. The container was half full and did not include the name of the resident it was for. The CDM stated the container of soup should have the name of the resident, the date it was purchased/made, and a used by date. The CDM stated soup was good for 7 days and should have been discarded on 7/23/25.During an interview on 07/30/25 at 5:49 PM, the CDM revealed dietary staff restocked the nourishment room refrigerators daily and were expected to discard expired and out of date items including food brought in for residents. The CDM revealed typically the nurse or Nurse Aide (NA) received food brought in for residents and expected to label the item with the name of the resident, the date it was received, and the use by date. The CDM stated it was a team effort between dietary and nursing staff to ensure out of date food was discarded. An interview was conducted on 07/31/25 at 2:59 PM with Nurse Aide (NA) #1. NA #1 revealed typically the nurse or the NA on the hall were given food brought in for residents and responsible for labeling the resident's name and the date the food was placed in the nourishment room refrigerator. NA #1 revealed residents' food was good for 3 days when stored in nourishment room refrigerator and if she observed items pass the use by date or expired food, she discarded it.During an interview on 07/31/25 at 3:59 PM, the Administrator stated dietary staff were responsible for checking the expiration and use by dates on food items being stored in the nourishment room refrigerators and to discard if out of date. The Administrator revealed food brought in the facility was labeled with the resident's name and discarded according to the use by date.