STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. Building B. Wing	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Manor Nursing Center	410 Buckner Branch Road Bryson City, NC 28713

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 discard food with signs of spoilage and label and date food items in 1 of 1 walk-in cooler and maintain a clean and sanitary ice machine for 1 of 1 ice machine used to serve beverages to residents. These practices had the potential to affect food served to residents. Findings included: a. An observation of the walk-in cooler on 07/06/26 at 9:54 AM made with the Head [NAME] revealed the following:- A clear plastic container with a lid labeled tuna dated 6/21 with a useˆby date of 6/30,-A clear plastic pitcher with a lid labeled tomato soup with a useˆby date of 7/2,-A clear container with a lid labeled alfredo with a useˆby date of 6/28,-A clear plastic container with a lid labeled brown gravy with a useˆby date of 7/5,-A clear plastic container with an unsecured lid labeled cheezy rice with a useˆby date of 7/2,-A metal steam pan covered with plastic wrap with no label or date. The Head [NAME] was unable to identify the contents. It appeared to be grated cheese over pasta with a white creamy sauce on the bottom,-A clear plastic container with a lid labeled egg salad with a useˆby date of 7/3,-A clear plastic container with a lid labeled chicken noodle soup with no date,-An opened plastic bag labeled mozzarella cheese closed with a wire twist tie with no date,-An opened package of sliced American cheese with a received date of 05/28, with no opened on or useˆby date, left open to the air,-A sealed plastic bag labeled romaine dated 6/18, containing lettuce with brown discoloration and brown liquid in the bottom of the bag,-A sealed plastic bag labeled salad bag dated 6/18, containing lettuce with brown discoloration and brown liquid in the bottom of the bag.b. An observation of the ice machine in the kitchen on 07/06/26 at 10:08 AM made with the Head [NAME] revealed pink and brown substances scattered across the entire baffle (white plastic piece of the machine that helps manage ice flow) of the machine directly above the full trough of ice. An interview with the Head [NAME] on 07/06/26 during the initial observation revealed that he understood that items were not stored correctly and that the ice machine needed to be cleaned.An interview with the District Dietary Manager (filling in for the Food Service Manager) on 7/7/26 at 9:26 AM revealed that it was the Head Cook's or the Food Service Manager's responsibility to ensure all food coming in was labeled and dated, and that when packages were opened they were dated with an opened date and a useˆby date. The District Dietary Manager stated that all stored food should be checked daily for proper labeling and monitored for signs of spoilage. The District Dietary Manager also stated that the ice machine should be wiped down daily and the maintenance department should complete a deep clean monthly. An interview with the Administrator on 7/9/26 at 9:26 AM revealed that the Administrator expected all food to be labeled, dated, and stored correctly, and all spoiled food items to be discarded immediately. The Administrator stated that they expected the ice machine to be maintained and sanitized properly and for industry best practices to be followed.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of falls and Preadmission Screening and Resident Review (PASRR) for 7 of 22 residents reviewed for MDS accuracy (Resident #11, #20, #8, #9, #68, #10, and #76). Findings included: 1. Resident #11 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (inadequate oxygen levels) and fracture of the upper end left humerus (upper arm bone) with routine healing. The admission MDS assessment dated [DATE] coded Resident #11's fall history as having a fall in the last month and a fracture related to a fall prior to admission. Review of the nurse's progress note dated 04/22/26 revealed staff were alerted that Resident #11 was on the floor. The note indicated Resident #11 had rolled out of bed and landed on her buttocks. Resident #11 denied hitting her head or loss of consciousness and was noted to have no visible injury or complaints of pain with range of motion. Review of a nurse's progress note dated 05/13/26 revealed Resident #11 was found on the floor next to the bed. Resident #11 complained of right hip pain and was sent to the emergency room for further evaluation. A review of hospital discharge summary revealed Resident #11 was admitted on [DATE] after radiology imaging diagnosed an acute, comminuted (broken in 3 or more pieces) impacted (ends of the fractured bone are driven into each other) right intertrochanteric (involves the hip and thigh bones) fracture. A review of the discharge MDS assessment dated [DATE] coded for the number of falls since admission/entry or reentry or the prior assessment indicated Resident #11 had one fall with a major injury. During interviews on 07/07/26 at 11:55 AM and 07/09/26 at 2:39 PM, the MDS Coordinator revealed she had been in her position for approximately three months, and the discharge assessment dated [DATE] was completed by a traveling MDS Coordinator. She explained when coding the MDS assessment for falls she reviewed the resident's medical chart which included nurse progress notes. After review of the nurse progress notes dated 04/22/26 and 05/13/26, the MDS Coordinator stated Resident #11 had two falls since the prior assessment completed on 04/03/26. She stated the discharge MDS dated [DATE] should be coded to reflect one fall with no injury and one fall with major injury. During interviews on 07/07/26 at 12:15 PM and 07/09/26 at 3:07 PM, the Administrator confirmed previous MDS assessments were completed by a traveling MDS Coordinator and included Resident #11's discharge assessment dated [DATE]. She stated the discharge MDS dated [DATE] coding needed to be accurate and reflect Resident #11 had two falls since the prior assessment completed on 04/03/26. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #20 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder. A review of Resident #20's medical record revealed a Level II PASRR Determination Notification letter dated 04/21/26 indicated nursing home placement was appropriate and to follow-up with psychiatric services by a psychiatrist. A mental health Nurse Practitioner (NP) note dated 05/06/26 revealed Resident #20 was being evaluated for cognitive impairment and bipolar disorder and management of psychiatric medications. The NP noted the medications being reviewed included brexpiprazole (antipsychotic) 1 milligram (mg) every morning, mirtazapine (antidepressant) 75 mg at bedtime, trazodone (antidepressant) 100 mg at bedtime, and divalproex sodium (anticonvulsant) 250 mg three times a day. A review of the annual MDS assessment dated [DATE] noted Resident #20 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS list of active psychiatric/mood disorder diagnoses included bipolar disorder and depression. The MDS high risk medications listed Resident #20 was taking antipsychotic, antidepressant, and anticonvulsant medications. The antipsychotic medication was noted as being received on a routine basis. A review of the significant change in status MDS assessment dated [DATE] noted Resident #20 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS list of active psychiatric/mood disorder diagnoses included bipolar disorder, anxiety disorder, and depression. The MDS high risk medications listed Resident #20 was taking antipsychotic, antidepressant, and anticonvulsant medications. The antipsychotic medication was noted as being received on a routine basis. During interviews on 07/07/26 at 11:55 AM and 07/09/26 at 2:39 PM, the MDS Coordinator revealed she had been in her position for approximately three months, and Resident #20's annual MDS assessments dated 06/02/26 and the significant change in status dated 06/18/26 were done by a traveling MDS Coordinator. She explained when coding the MDS assessment for PASRR she reviewed the resident's medical chart or asked the Social Worker (SW). The MDS Coordinator confirmed Resident #20 was considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition and stated both the annual MDS assessment dated [DATE] and the significant change in status MDS assessment dated [DATE] were incorrectly coded and did not include the Level II PASRR information. During interviews on 07/07/26 at 12:15 PM and 07/09/26 at 3:07 PM, the Administrator confirmed previous MDS assessments were completed by a traveling MDS Coordinator and included Resident #20's annual MDS assessment dated [DATE] and the significant change in status MDS assessment dated [DATE]. She stated the MDS assessments dated 06/02/26 and 06/18/26 coding for PASRR needed to be accurate and reflect Resident #20's Level II PASRR information. 3. Resident #8 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder, unspecified dementia, unspecified severity with psychotic disturbances. A review of Resident # 8's medical record revealed a Level II PASRR Determination Notification letter dated 10/10/2018, with no expiration date, indicated nursing home placement was appropriate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the annual Minimum Data Set (MDS) assessment dated [DATE] noted Resident #8 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS list of active psychiatric/mood disorder diagnoses included bipolar disorder. The MDS high risk medications listed for Resident #8 was taking antipsychotic medication. The antipsychotic medication was noted as being received on a routine basis. During an interview on 07/09/26 at 8:52 AM, the MDS Coordinator revealed that Resident #8's annual MDS assessment dated [DATE] was completed by a traveling MDS Coordinator. She confirmed that Resident #8 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition and stated the annual MDS assessment dated [DATE] was incorrectly coded and did not include the Level II PASRR information. During an interview on 07/09/26 at 9:26 AM, the Administrator confirmed Resident #8's annual MDS assessment dated [DATE] was completed by a traveling MDS Coordinator. The Administrator stated the annual MDS assessment dated [DATE] coding for PASRR needed to be accurate and reflect Resident #8's current Level II PASRR information. 4. Resident #9 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder. A review of Resident #9's medical record revealed a Level II PASRR Determination Notification Letter dated 03/05/25, with no expiration date, indicated nursing home placement was appropriate. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] noted Resident #9 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS list of active psychiatric/mood disorder diagnoses included schizoaffective disorder. The MDS high risk medications listed for Resident #9 was taking antipsychotic medication. The antipsychotic medication was noted as being received on a routine basis. During an interview on 07/09/26 at 8:52 AM, the MDS Coordinator revealed that Resident #9's annual MDS assessment dated [DATE] was completed by a traveling MDS Coordinator. She confirmed that Resident #9 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition and stated the annual MDS assessment dated [DATE] was incorrectly coded and did not include the Level II PASRR information. During an interview on 07/09/26 at 9:26 AM, the Administrator confirmed Resident #9's annual MDS assessment dated [DATE] was completed by a traveling MDS Coordinator. The Administrator stated the annual MDS assessment dated [DATE] coding for PASRR needed to be accurate and reflect Resident #9's current Level II PASRR information. 5. Resident #68 was admitted to the facility on [DATE]. Review of Resident #68's medical record revealed a Pre-admission Screening and Resident Review (PASRR) Level II determination notification letter dated 04/21/26 with no expiration date. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #68 was not (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 07/07/26 at 11:55 PM, the MDS Coordinator revealed she had been in her position for approximately three months and Resident #68's annual MDS assessment dated [DATE] was completed by a traveling MDS Coordinator. She explained when coding the MDS assessment for PASRR, she reviewed the resident's medical record to see if they had a Level II PASRR or asked the Social Worker. The MDS Coordinator reviewed Resident #68's medical record and confirmed he had a Level II PASRR determination. The MDS Coordinator stated Resident #68's annual MDS assessment dated [DATE] was incorrectly coded and should have reflected he had a Level II PASRR. During an interview on 07/07/26 at 12:15 PM, the Administrator revealed previous MDS assessments were completed by a travelling MDS Coordinator. The Administrator stated the annual MDS assessment dated [DATE] should have accurately reflected Resident #68 had a Level II PASRR. 6. Resident #10 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder and major depressive disorder. A review of Resident #10's medical record revealed a Level II PASRR Determination Notification letter dated 02/09/26, which indicated Resident #10 had a Level II PASRR with an expiration date of 04/10/26, and that nursing home placement was appropriate. A review of the admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #10 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS list of active psychiatric/mood disorder diagnoses included anxiety disorder, depression, schizophrenia, and post-traumatic stress disorder. The MDS listed Resident #10 as having taken the following highˆrisk medications during the lookˆback period: antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. The antipsychotic medication was noted as having been received on a routine basis. An interview was conducted with the Social Worker (SW) on 07/07/26 at 11:03 AM. The SW confirmed Resident #10 was issued a Level II PASRR on 02/09/26. The SW stated that she attached the Level II PASRR Determination Notification letter to the resident's Electronic Medical Record (EMR) and that the MDS Coordinator was responsible for coding the PASRR on the MDS. During an interview on 07/07/26 at 11:22 AM, the MDS Coordinator stated she had been in her position for approximately three months, and that Resident #10's admission MDS assessment dated [DATE] was completed by a traveling MDS Coordinator. She stated that when coding the PASRR section of the MDS, she looked up the resident's Level II PASRR Determination Notification letter in the EMR and used that information to code the MDS PASRR section. The MDS Coordinator confirmed Resident #10 was not coded to have a Level II PASRR on the admission MDS dated [DATE] and after reviewing the Level II PASRR Determination Notification letter, Resident #10 was incorrectly coded and the MDS should have included the Level II PASRR information. 7. Resident #76 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder and major depressive disorder. A review of Resident #76's medical record revealed a Level II PASRR Determination Notification letter dated 03/03/25, which indicated nursing home placement was appropriate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the annual Minimum Data Set (MDS) assessment dated [DATE] noted Resident #76 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. An interview was conducted with the Social Worker (SW) on 07/07/26 at 11:03 AM. The SW confirmed Resident #76 was issued a Level II PASRR determination on 03/03/25. The SW stated that she attached the Level II PASRR Determination Notification letter to the resident's Electronic Medical Record (EMR) and that the MDS Coordinator was responsible for coding the PASRR on the MDS. During an interview on 07/07/26 at 11:22 AM, the MDS Coordinator stated she had been in her position for approximately three months, and Resident #76's annual MDS assessment dated [DATE] was completed by a traveling MDS Coordinator. The MDS Coordinator confirmed Resident #76 was not coded to have a Level II PASRR on the annual MDS assessment dated [DATE]. After reviewing the Level II PASRR Determination Notification letter she stated the MDS assessment had been incorrectly coded should have included the Level II PASRR information. During an interview on 07/07/26 at 11:43 AM, the Administrator stated MDS assessments should be accurate and correctly coded.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a discharge care plan for 1 of 2 sampled residents reviewed for discharge (Resident #83). Findings included:Resident #83 was admitted to the facility on [DATE]. Her cumulative diagnoses included obsessive-compulsive personality disorder (OCPD).A care plan meeting note dated 12/01/25 revealed a meeting was held with Resident #83's Family Member #1 and members of the facility's Interdisciplinary Team (IDT) that included the Business Office Manager, Social Worker (SW), Director of Nursing Services, and Administrator. It was noted that Resident #83 did not wish to attend. The plans discussed were for Resident #83 to remain at the facility short-term, receive psychiatric services prior to discharging home and there were no barriers to her discharge. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 had intact cognition. The MDS noted Resident #83's overall goal was to discharge to the community, there was no active discharge planning currently in place and Resident #83 did not want to be asked about returning to the community on all MDS assessments.A care plan meeting note dated 01/21/26 revealed a meeting was held with Resident #83's Family Member #1 and members of the facility's IDT that included the SW, Business Office Manager and nursing. It was noted that Resident #83 did not wish to attend. Resident #83's recent inpatient psychiatric admission to an acute hospital was discussed and Family Member #1 indicated they now wished for Resident #83 to be transferred to a long-term psychiatric facility for treatment.Review of Resident #83's comprehensive care plan, last reviewed/revised on 03/03/26, revealed no discharge care plan.A discharge-return not anticipated MDS assessment dated [DATE] revealed Resident #83 discharged to an inpatient psychiatric facility.During an interview on 07/09/26 at 2:30 PM, the SW revealed the discharge planning process begins upon a resident's admission which included conducting a 72-hour care plan meeting with the resident and/or their representative to discuss the resident's needs, goals and discharge plans. She stated the MDS Coordinator was typically the one responsible for developing the discharge care plan and she was not sure why or how Resident #83's got overlooked. During an interview on 07/09/26 at 3:30 PM, the MDS Coordinator revealed she had been in her position for approximately three months and she had a list of focused care areas that should always be incorporated into a resident's comprehensive care plan which included a discharge plan. The MDS Coordinator explained she had planned on conducting an audit of resident comprehensive care plans to make sure the appropriate plans were in place but hadn't had time. The MDS Coordinator confirmed Resident #83 did not have a discharge care plan and explained there was some confusion as to whether the MDS Coordinator or SW was responsible for developing the discharge care plan.During an interview on 07/09/26 at 5:03 PM, the Administrator stated a discharge care plan should be developed as part of the resident's comprehensive care plan. The Administrator revealed the SW was responsible for starting the discharge planning process upon a resident's admission and documenting updates to the discharge plan as the resident's needs or goals changed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for residents who were admitted to the facility with serious mental health disorders for 2 of 6 residents reviewed for PASRR (Resident #2 and Resident #75).Findings included:a. A North Carolina (NC) Level I PASRR screening form dated 02/23/26 for Resident #2 noted a screening type of PASRR only review. There were no mental health diagnoses documented on the NC Level I PASRR screen.A PASRR Determination Notification letter dated 02/25/26 revealed Resident #2 had a Level I PASRR with no expiration date.Resident #2 was admitted to the facility on [DATE] with diagnoses that included Post-Traumatic Stress Disorder (PTSD), depression and anxiety disorder.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #2's active psychiatric/mood disorder diagnoses included anxiety disorder, depression (other than bipolar) and PTSD. He received antianxiety and antidepressant medications during the MDS assessment look-back period.A psychiatric progress note dated 05/20/26 revealed Resident #2 was seen for an initial evaluation related to depression, anxiety and PTSD. The psychiatric provider noted Resident #2 currently received sertraline (antidepressant) 100 milligrams (mg) daily with good effect and lorazepam (antianxiety) 0.5 mg three times a day was restarted. The psychiatric provider noted Resident #2 appeared emotionally stable and she would hold off on making any medication changes.The facility was unable to provide documentation that a request for a Level II PASRR evaluation had been submitted for Resident #2. During an interview on 07/07/26 at 12:05 PM, the Social Worker (SW) confirmed she was responsible for submitting requests for PASRR re-evaluations as needed. The SW confirmed Resident #2 had diagnoses of PTSD, depression and anxiety when he admitted to the facility on [DATE]. The SW stated a request for a Level II PASRR evaluation should have been submitted and it was an oversight.b. A North Carolina (NC) Level 1 PASRR screening form dated 06/12/25 for Resident #75 noted a screening type of PASRR only review. There were no mental health diagnoses documented on the NC Level I PASRR screen.A PASRR Determination Notification letter dated 06/12/25 revealed Resident #75 had a Level I PASRR with no expiration date.Resident #75 was admitted to the facility on [DATE] with diagnoses that included Post-Traumatic Stress Disorder (PTSD), major depressive disorder and anxiety disorder.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #75's active psychiatric/mood disorder diagnoses included anxiety disorder, depression (other than bipolar) and PTSD. He received antidepressant medications during the MDS assessment look-back period.A psychiatric progress note dated 12/10/25 revealed Resident #75 was seen for an initial evaluation related to active psychiatric diagnoses of major depressive disorder, generalized anxiety disorder, PTSD, and dementia with behaviors. The psychiatric provider noted Resident #75 currently received duloxetine (antidepressant) 30 milligrams (mg) every morning with new orders provided to increase the dosage to 30 mg twice a day.A psychiatric progress note dated 05/27/26 revealed that per staff report, Resident #75's mood and behavior had been manageable but he appeared more anxious and fixated on his pain. The psychiatric provider noted Resident #75 reported anxiety and occasional depression. New orders were provided to start lorazepam 0.5 mg three times a day for anxiety.The facility was unable to provide documentation that a request for a Level II PASRR evaluation had been submitted for Resident #75. During an interview on 07/07/26 at 12:05 PM, the Social Worker (SW) confirmed she was responsible for submitting requests for PASRR re-evaluations as needed. The SW confirmed Resident #75 had diagnoses of PTSD, major depressive disorder and anxiety when he admitted to the facility on [DATE]. She stated a request for a Level II PASRR evaluation should have (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been submitted and it was an oversight.A continuation of the interview with the SW on 07/07/26 at 12:05 PM revealed she checked the North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) upon a resident's admission to the facility to see if the resident had a PASRR but she did not check to see if mental health diagnoses were included in the initial screening. The SW explained that she tried review the resident's admission documentation and if she noticed that the resident had mental health diagnoses with a Level 1 PASSR, she submitted a request for a Level II PASRR evaluation. During an interview on 07/07/26 at 12:15 PM, the Administrator stated she would expect for the SW to submit a request for a Level II PASRR evaluation when a resident was admitted with a Level I PASRR and had mental health diagnoses, per the regulatory guidelines.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to prevent the administration of expired medications for 1 of 5 residents reviewed for Medication Administration (Resident #71).The findings included:Resident #71 was admitted to the facility on [DATE].Review of a physician's order dated 4/30/26 revealed Resident #71 was prescribed Vitamin B12 oral tablet. Give 500 micrograms (MCG) by mouth one time a day for supplement. During a medication storage observation conducted on 7/8/26 at 8:45 AM with the Director of Nursing Services and Medication Aide (MA) #1 on the A Hall Medication Cart, a bottle of Vitamin Bˆ12 500 MCG with an expiration date of 1/2026 was discovered with 92 pills remaining. MA #1 stated that the expired Vitamin B-12 had been administered to one resident that morning. MA #1 reported Resident #71 had received one pill of Vitamin Bˆ12 500 MCG that morning. She stated she became aware the medication was expired when it was discovered during the medication storage observation. The medication was removed from the A Hall Medication Cart by the Director of Nursing Services. MA #1 further indicated she should have checked the expiration date before administering the medication, stating she just didn't think to look before giving the expired dose that morning. A review conducted on 7/8/26 at 8:55 AM of the medication administration record (MAR) for the day of 7/8/26 revealed Resident #71 was administered Vitamin B12 oral tablet 500 MCG by MA #1 during the morning administration.On 7/8/26 at 8:50 AM an interview with the Director of Nursing Services revealed his expectation was for the Nurse or MA to check the expiration date before administering any medication. He stated he expected residents to be administered medications that were not expired. On 7/8/26 at 11:16 AM an interview with the Nurse Practitioner revealed she did not consider expired Vitamin B-12 being administered to a resident a major medication error. She stated she would not send a resident out to the hospital for having had expired Vitamin B-12 administered to them. She further indicated that she expected non-expired medications to be administered to residents.On 7/8/26 at 1:10 PM an interview with the Administrator revealed that her expectation was for residents to be administered medications that were not expired.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews with the Nurse Practitioner (NP), a Family Member and staff, the facility failed to recognize a cognitively impaired resident had left the facility unsupervised. Staff were not aware the resident had exited the facility until a Family Member who was visiting reported a resident was wandering in the parking lot. The deficient practice occurred for 1 of 5 residents reviewed for accidents (Resident #87).Findings included:Resident #87 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia, and anxiety disorder. Resident #87 was discharged from the facility on 03/01/26.A nurse's progress note dated 06/30/25 revealed Resident #87 was observed at the facility's front door, punching numbers into the keypad. The note revealed Resident #87 wanted to sit outside on the porch, and the nurse had explained a staff member needed to be with her when outside and that Resident #87 understood. An elopement evaluation dated 09/03/25 revealed Resident #87 was able to leave the building on her own, had impaired decision-making skills, had not made repetitive statements about going home, did not have a history of wandering or elopement, had not experienced a recent room change, did not wander aimlessly about the facility, and had not had a recent change in medications. Based on the evaluation Resident #87 was not at risk for elopement.The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #87's cognition was moderately impaired and there had been no delusional, physical, verbal, or wandering behaviors during the lookback period. Resident #87 walked and transferred independently, had no falls, and her active diagnoses included Alzheimer's disease, dementia, and anxiety disorder. The care plan dated 12/05/25 identified Resident #87 was at risk for falls related to confusion and being unaware of safety needs and had a deficit in the ability to complete self-care tasks due to impaired cognition and dementia. Interventions included to educate the resident, family, and caregivers about safety reminders and what to do if a fall occurred and the need for a safe environment with even floors free from spills and/or clutter, adequate glare-free light, a working and reachable call light, the bed in low position at night, and personal items within reach. The Nurse Aide (NA) activities of daily living task documentation dated 12/28/25 at 2:22 PM revealed Resident #87 was eating.During a telephone interview on 07/08/26 at 9:20 AM, the Family Member explained she was in a room visiting another resident when she saw Resident #87 wandering around the parking lot. She described Resident #87 had a jacket and pocketbook on her arm and was walking around from car to car looking in the windows, and it appeared as if she was looking for someone. She did not recall what time it was when she saw Resident #87 outside and did not see her walk out of the building but stated Resident #87 could not have been outside very long because she had a clear view from the window to the parking lot. The Family Member stated she saw Resident #87 in the middle area of parking lot and watched her for a couple minutes then reported it to Nurse #3 who went right away to check on Resident #87. She revealed when visiting the facility, she had to use a code to open the door when going in and out of the building and when Resident #87 got out on 12/28/25 there were a lot of visitors, and the parking lot was full. Review of Nurse #2's progress note dated 12/26/25 at 2:40 PM revealed a Family Member had alerted Nurse #3 that Resident #87 was outside in the parking lot looking in car windows and Nurse #3 returned Resident #87 back inside the building. The note included Resident #87 had stated she followed, her out.During a telephone interview on 07/09/26 at 12:55 PM, Nurse #3 stated she did not recall if she or assigned Nurse #2 brought Resident #87 back inside the building on 12/28/25. She confirmed that a Family Member who was visiting another resident on the hall she was assigned had reported to her Resident #87 was outside in the parking lot looking into car windows. She had the Family Member write a statement and stated from what she recalled, Resident #87 was found outside in the front area of parking lot and did not get far away from the building.A review of the Family Member's statement who reported Resident #87 was outside was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 12/28/25 at 3:30 PM and read, I saw a resident walking in the parking lot. She was walking around the cars looking in the windows. I called Nurse #3's attention to this. A review of a written statement with no name or date read, why you went outside, was going out with [NAME]. Who was [NAME], she goes in with goods to see what a person does. I like to go outside a lot. A lady was going to join me. I told her it's okay I go out a lot. Where were you outside, I don't usually make to the motels. I asked were you in the parking lot. Interviews were conducted with Nurse #2 on 07/07/26 at 10:49 AM and 07/07/26 at 5:29 PM. Nurse #2 confirmed she was assigned on the hall where Resident #87 resided on 12/28/25. Nurse #2 stated Resident #87 had followed a visitor(s) outside, and she was told Resident #87 was at the front of the parking lot standing by a car and looking inside. She revealed that a Family Member visiting another resident saw Resident #87 and reported it to Nurse #3 and Nurse #3 brought Resident #87 back inside the facility. Nurse #2 revealed the last time she saw Resident #87 she was sitting in dining room eating and that was approximately 12:00 PM or 12:30 PM and stated lunch was typically finished around 1:00 PM or 2:00 PM. Nurse #2 stated she was not actively looking for Resident #87 and did not know she had got outside of the facility unsupervised. She described Resident #87 would stand at the front entrance doors, but she had not seen her attempt to exit the facility unsupervised.Telephone interviews were conducted with NA #1 on 07/08/26 at 1:17 PM and 07/09/26 at 10:27 AM. NA #1 confirmed on 12/28/25 she was the assigned to the hall where Resident #87's room was located. NA #1 stated she was providing care to another resident and when finished and back on the hall was told Resident #87 was let outside by someone and was in the parking lot looking inside cars. NA #1 stated Resident #87 was already back inside the facility, and she was not actively looking, or aware Resident #87 was missing until it was reported to her. NA #1 confirmed she had documented the activities of daily task for Resident #87 on 12/28/25 at 2:22 PM and she saw Resident #87 in dining room eating a snack and this was the last time she had seen the resident. NA #1 revealed she had not heard Resident #87 say she wanted to leave the facility or saw her trying to open a door. She described Resident #87 liked to sit in the dining room and was social and was either in dining room, walking on the hall, or in her room. An observation from the main entrance doors to the parking lot was conducted on 07/09/26 at 1:14 PM with the Administrator. According to the website Google Earth from the front entrance doors to the parking spaces located in front of the window where the Family Member saw Resident #87 was approximately 85 feet and from the front entrance doors to the middle of the parking lot was approximately 115 feet.Review of the website Wunderground revealed the outside temperature in the [NAME] City/[NAME] area on 12/28/25 from 1:55 PM through 3:55 PM was 64 degrees and there was no precipitation. An SBAR (situation/background/assessment/recommendation) dated 12/28/25 at 5:33 PM revealed Resident #87 was evaluated for altered mental status and increased confusion. Her blood pressure was 142/71, pulse 90, respirations 17, oxygen saturation level 96% on room air, and temperature 98.2.A skin check dated 12/28/25 at 5:28 PM revealed Resident #87 had no skin issues and was noted to have warm and dry skin with normal color and turgor. The previous NP progress note dated 12/30/25 revealed Resident #87 had eloped from the building but safely returned with no injury and noted she was in no acute distress.During a telephone interview on 07/09/26 at 9:35 AM, the previous NP revealed Resident #87 would pace up and down the hall and ask several times what was going on and needed constant redirection and reassurance. She stated Resident #87 had dementia and needed someone to be with her if she was outside of the facility. The NP stated she had not heard Resident #87 say she wanted to go home or leave the facility. The NP revealed if left outside alone unsupervised there was a possibility Resident #87 could wander away from the facility towards the road or woods.During an interview on 07/09/26 at 10:09 AM, the previous Director of Nursing (DON) stated she was not at the facility and did not recall specifics related to Resident #87's elopement on 12/28/25. She described Resident #87 liked to sit in the front lobby area and watch people come and go and talked about doing things and going places with her family. She had not heard Resident #87 say she wanted or needed to leave or go home.During interviews on 07/08/26 at 12:46 PM, 07/09/26 at 1:14 PM and 4:43 PM the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated she was called on 12/28/25 when Resident #87 got out of the facility and spoke with Nurse #3. Nurse #3 reported a Family Member saw Resident #87 outside in the parking lot looking in the windows of cars. The Administrator revealed Resident #87's was standing by a car that was parked in the spaces closest to the facility and in front of the window where the Family Member saw Resident #87. She explained Nurse #3 went to the front entrance door and called Resident #87 by name, and she walked back into the facility without incident. The Administrator revealed she attempted to interview Resident #87 and confirmed it was the written statement with no name or date. She revealed the information Resident #87 had provided did not make sense, so she stopped the interview. She explained that all the door locks and alarms including the entrance doors were checked and there were no issues identified and it was determined Resident #87 exited from the front entrance door. She explained that the Receptionist monitored the front entrance doors, but since April 2025 the facility no longer had a fulltime Receptionist and there was no Receptionist on 12/28/25. She stated based on her investigation she determined Resident #87 exited from the front entrance doors but did not know if she pushed the button behind the Receptionist desk to unlock the door or was let out by a visitor.

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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. Based on observations and staff interviews, the facility failed to remove expired medications and secure an unattended medication cart for 2 of 4 medication carts reviewed for medication storage (A hall cart and C hall cart).Findings included: a. On 7/8/26 at 8:17 AM, during an observation of the C Hall Medication Cart with the Director of Nursing Services, the medication cart was found unlocked, unattended, and located inside the C and D Hall Nursing Station. The nursing station had two points of entry: one entrance with a door that was unlocked, and a second entrance that had no door at all, leaving the area completely open. Both entrances were accessible to residents and visitors. On 7/8/26 at 8:18 AM an interview with the Director of Nursing Services revealed that the cart belonged to Nurse #1. He stated that his expectation was that the Nurse or the Medication Aide (MA) locked the Medication Cart when it was unattended by a Nurse or an MA.On 7/8/26 at 8:21 AM an interview with Nurse #1 revealed that she had checked the C Hall Medication Cart in morning during handoff with the night shift Nurse. She stated that she had locked the C Hall Medication Cart upon finishing hand off with the night shift Nurse. She further indicated that she was unsure why the C Hall Medication Cart was unlocked. She stated that she was the only one that had a key to the C Hall Medication Cart. She further indicated that she always locked her Medication Cart when she walked away from it.b. An observation of the A Hall Medication Cart on 7/8/26 at 8:45 AM with the Director of Nursing Services and Medication Aide #1 (MA) revealed a bottle of Vitamin B-12 500 micrograms (mcg) with an expiration date of 1/2026 with 92 pills available for use. On 7/8/26 at 8:46 AM an interview with MA #1 revealed that she did not normally work on A Hall. She stated that she had administered the Vitamin B-12 500 mcg to a resident. She further indicated that she should have checked the expiration date before she administered the medication. She stated that she just didn't think to look at the medication expiration date before she administered the expired medication this morning. On 7/8/26 at 8:50 AM an interview with the Director of Nursing Services revealed that his expectation was that the Nurse or MA checked the expiration date before administering any medication. He further revealed all Nurses or MAs were to check the Medication cart at the beginning of each shift for expired medications and remove any expired medications and return them to the pharmacy. He stated he expected that residents were administered medication that were not expired. c. An observation of the A Hall Medication Cart on 7/8/26 at 8:52 AM with the Director of Nursing Services and Medication Aide #1 (MA) revealed a bottle of Vitamin B-12 1000 mcg with an expiration date of 6/2026 with 11 pills was available for use. On 7/8/26 at 8 52 AM an interview with Medication Aide #1 (MA) revealed that she checked expiration dates on all medications and restocked her medication cart once a week. She stated that all expired medications are removed from the cart and returned to pharmacy. She stated that this medication had not been used today. On 7/8/26 at 8:53 AM an interview with the Director of Nursing Services revealed that his expectation was that the Nurse who took over the Medication carts checked all expiration dates on all medications before the start of each shift. He further indicated that all expired medications were to be removed from the medication cart and returned to pharmacyOn 7/8/26 at 1:10 PM an interview with the Administrator revealed that her expectation was that expired medications should be removed from the medication carts and replaced with non-expired medications. She stated she expected that residents were administered medication that were not expired. The Administrator further revealed that her expectation was that all medication carts were to be locked by the Nurse or MA when the medication carts were unattended

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, test tray and Speech Language Pathologist (SLP), Registered Dietitian (RD) and staff interviews, the facility failed to serve pureed food items with an applesauce or pudding-like consistency. This failure had the potential to affect 2 of 2 residents who had orders for an advanced dysphagia (difficulty swallowing) diet with pureed-texture foods (smooth, moist pudding-like foods that require no chewing).The findings included:During an observation of the lunch meal service in the main dining room on 07/06/26 at 1:26 PM, the SLP reported residents who had orders for a pureed diet could not eat the food due to the food items being too thick for the residents to swallow. She explained the pureed food items sent out from the kitchen were a paste-like consistency but should be more of an applesauce-like consistency and when she noticed residents received pureed food that was too thick, she took the food back to the kitchen to have dietary staff add more liquid. The SLP revealed she felt the inconsistency in the preparation of pureed food was due to high turnover in dietary and dietary staff not being well-trained.A test tray of a lunch meal was conducted with the District Dietary Manager on 07/08/26 at 1:34 PM which consisted of pureed chicken with gravy, pureed collard greens, mashed potatoes, pureed bread, and a pureed brownie for dessert. The chicken, collard greens, mashed potatoes and bread were all pureed to a smooth, pudding-like consistency; however, the brownie puree was thick and sticky, similar to a peanut butter consistency, and was unable to be shaken off the spoon. During an interview on 07/08/26 at 1:36 PM, the District Dietary Manager agreed the pureed brownie was too thick and stated the longer it sat, the thicker it got. She stated the pureed brownie needed more milk added in order for it to be the correct pudding-like consistency.During a follow-up interview on 07/09/26 at 8:11 AM, the SLP revealed that for the past year, 90% of the time the pureed food sent out from the kitchen was the consistency of paste or peanut butter which was hard for residents with dysphagia to swallow. The SLP explained when she noticed the pureed texture was not at the correct consistency she provided education to dietary staff. She stated she would and get the dietary staff trained so that they were pureeing food at the right consistency but then the dietary staff would leave and she had to start all over. The SLP stated she had voiced her concerns to the Administrator who tried to get the issue addressed but the inconsistency in the preparation of the pureed food continued to be an issue.During a phone interview on 07/09/26 at 10:22 AM, the RD revealed she was aware of the concerns regarding the consistency of the pureed food items served to residents. She explained pureed texture should not be thick or stick to the spoon and should be more of a pudding-like consistency that easily slides off the spoon. The RD reported that the SLP had educated dietary staff regarding pureed texture food items but dietary staff continued to struggle with preparing pureed food at the correct consistency.During a follow-up interview on 07/09/26 at 10:57 AM, the District Dietary Manager revealed there had been a lapse between Dietary Managers at the facility for about three weeks, with support staff filling in to help the facility dietary staff, and a new Dietary Manager had just been hired. She confirmed the inconsistency of the pureed-texture foods served to residents had been an issue. She explained the SLP had brought concerns to her attention on several occasions regarding the consistency of the pureed food items and conducted in-services with dietary staff. The District Dietary Manager explained pureed texture should be a pudding-like consistency, not diced or chopped, and slide off the utensil. She stated there was no recipe for pureeing the food items which made it hard to be consistent. The Dietary Manager explained that as far as ensuring the correct consistency of pureed food, staff would need more in-servicing on how to properly prepare pureed foods by using liquid to reach the desired consistency and having a Dietary Manager on the line for monitoring meal service.During an interview on 07/09/26 at 5:03 PM, the Administrator revealed she was aware of concerns with the inconsistency of pureed food items and after multiple conversations with the District Dietary Manager, the inconsistency of pureed items remained an ongoing issue. The (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator explained pureed food items should be thin enough to slide through the prongs of a fork and during her observations, the meat and vegetables were usually okay, but food items such as bread and desserts were usually too thick. The Administrator stated it was her expectation for residents to receive the correct diet consistency as per their diet order.

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated dietary concerns voiced by residents during Resident Council meetings for 6 of 12 months reviewed (January 2026, February 2026, March 2026, April 2026, May 2026, and July 2026).Findings included:The Resident Council minutes for the period August 2025 through July 2026 were reviewed and revealed the following:Resident Council minutes dated 01/09/26 noted in part, old business was noted as read and approved and any issues not resolved were moved to new business. Under new business, residents voiced food was the main concern, menus have been reviewed with food managers, and the diet doesn't reflect residents' likes or dislikes. Snacks were not being passed. Resident Council minutes dated 02/06/26 noted in part, old business was noted as resident council had not received a reply from administration in regard to January concerns. Under new business, residents voiced food was the main concern, meats were processed meats and not real meat. Resident Council minutes dated 03/06/26 noted in part, old business was noted as responses from administration were discussed and food continued to be an ongoing issue. Under new business, residents voiced snacks were not offered. Residents waited in the dining room for meals to be served. Resident Council minutes dated 04/03/26 noted in part, old business was noted as no follow up from administration from March concerns. Under new business, residents voiced food was still a concern. Residents' preferences were not being honored. Staff were not asking residents' preference for meals. Meals were late. Breakfast at 9:00 AM and lunch at 1:45PM. Resident Council minutes dated 05/01/26 noted in part, old business noted as responses from administration were discussed and food continued to be a concern. Under new business, residents voiced food still the main concern. Mealtimes were off schedule. Only one staff member delivered meal trays. Resident Council minutes dated 07/03/26 noted in part, old business was noted as reviewed. Under new business, residents voiced food dislikes were still an issue. When a resident was out with family, they did not get a dinner tray.The facility's grievance logs for the period August 2025 through July 2026 were reviewed. Grievances filed on behalf of the Resident Council related to the concerns voiced during the monthly meetings were all noted as resolved.A Resident Council group interview was conducted on 07/07/26 at 1:50 PM with Resident #30, Resident #36, Resident #40, Resident #71, and Resident #78 in attendance. All residents reported ongoing dietary concerns, specifically that food preferences were not being followed. The residents agreed that menu choices provided to staff were not what was being served to the residents. Residents reported there was inconsistency between what they had ordered for lunch or dinner and what they received.During an interview on 07/09/26 at 6:18 PM, the Dietary Manager revealed she attended Food Committee meetings, which took place immediately after Resident Council and included the same residents as Resident Council. She stated the Food Committee discussed similar food issues each month, and she was aware of the food concerns voiced by residents. The Dietary Manager confirmed she had worked with the Corporate Registered Dietitian to develop a more culturally appropriate menu that still met the nutritional needs of the residents. She expressed it is an ongoing process that will take some time to make changes.During an interview on 07/09/26 at 09:58 AM, the Activity Director revealed she did not attend the Resident Council meeting at the request of the residents. She stated the Resident Council President documented the meeting minutes and provided her the minutes after the meeting. The Activity Director reviewed the Resident Council minutes with the Administrator and Social Worker (SW). The Activity Director stated that grievances from the meeting minutes were transferred to a grievance form by the SW and dispersed to the appropriate department for resolution. Resolved grievances were returned to the Resident Council President to be presented to the Resident Council. The Activity Director stated the food issues were reoccurring concerns for Resident Council. She also confirmed the facility had a Food Council that met after Resident Council.During an interview on 07/09/26 at 10:19 AM, the SW revealed she met with the Resident Council President and (continued on next page)

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Administrator the day after the Resident Council meeting to review the new grievances and communicate progress on past grievances. She stated she transferred all new grievances from the Resident Council minutes to a grievance form and provided the appropriate department with the form. Once the grievances were resolved, she gave a copy of the resolved grievance form to the Resident Council president and placed another copy in the grievance log.During an interview on 07/09/26 at 10:31 AM, the Administrator stated she met, or the SW met, with the Resident Council President to review Resident Council grievances. She was aware there had been repeated dietary concerns voiced during Resident Council meetings. The Administrator explained she continued to meet with the Dietary Manager to improve and resolve the residents' dietary concerns.