STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. Building B. Wing	02/26/2026

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

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff and resident interviews, the facility failed to assess Resident #62 for the ability to self-administer medications for 1 of 1 resident reviewed for self-administering medications.The findings included:Resident #62 was admitted to the facility on [DATE].Resident #62's quarterly Minimum Data Set assessment dated [DATE] revealed she was cognitively intact.Review of Resident #62's physician orders revealed there were no orders for a calcium carbonate (Tums) medication.Review of Resident #62's medical record revealed there was no self-administer assessment. On 02/16/2026 at 10:19 AM an observation was made of Resident #62's room where there was a bottle of calcium carbonate (Tums) tablets on her bed which was approximately 1/4 full. Resident #62 was not in the room. On 02/16/2026 at 3:18 PM an observation of the bottle of calcium carbonate (Tums) tablets was sitting on the Resident's over bed table which was approximately 1/4 full. Resident #62 was not in the room. On 02/17/2026 at 10:30 AM an observation and interview were conducted with Resident #62. The Resident stated her family brought the bottle of Tums to her because she needed them when she had heartburn. She stated she did not take them often, but she wanted to be able to take them when she needed them. Resident #62 could not say when the last time was that she took the tablets. On 02/18/2026 at 11:13 AM an interview and observation were made in Resident #62's room with Nurse #4. The Nurse stated she did not know that Resident #62 kept the Tums tablets in her room. The Nurse explained that Resident #62 did not have an order to self-administer medications and that she believed Resident #62 would not be safe to self-administer because some days she could be lethargic because of her medications. Nurse #4 removed the bottle of medication from the Resident's room.An interview was conducted with the Director of Nursing (DON) on 02/19/26 at 10:40 AM. The DON explained that Resident #62 did not have an order to self-administer and that they would get an order for an antacid for her heartburn.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, family, and staff interviews, the facility failed to complete a Do Not Resuscitate (DNR) form (a DNR form is a legal document signed by the physician) for a resident with a DNR physician order (Resident #11) at admission. The facility also failed to ensure resident advanced directive information was consistent throughout the medical record (Resident #31 and Resident #62). This deficient practice occurred for 3 of 6 residents reviewed for advanced directives.Findings included: 1. Resident #11 was admitted to the facility on [DATE]. A review of Resident #11's physician orders revealed an order for advanced directive of do not resuscitate (DNR) dated [DATE]. An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #11 was severely cognitively impaired. A review of Resident #11's electronic medical record (EMR) revealed the advanced directive banner at the top of Resident #11's EMR page documented that his advance directive was DNR. Review of the advanced directives notebook kept at the nurse's station revealed there were no advanced directives on file for Resident #11. On [DATE] at 3:28 PM an interview was conducted with Nurse #3 who was assigned to Resident #11 that day ([DATE]). Nurse #3 explained that if she had to immediately determine a resident's advanced directives, she would look at the resident's medical record on the computer and she would look in the advanced directives notebook kept at the nurse's station. Nurse #3 looked in the advanced directives notebook for Resident #11's DNR form and acknowledged the form was not in the book. Nurse #3 stated that she was unsure who completed the code forms when a resident was admitted . Nurse #3 indicated that the Assistant Director of Nursing (ADON) and Director of Nursing (DON) would be responsible for ensuring the code forms were in the notebook stored at the nurse's station. An interview was conducted with the DON on [DATE] at 3:43 PM. The DON explained that if a resident was a DNR then there should be a DNR form in the advanced directive notebook at the nurse's station in case of an emergency. The DON verbalized that Resident #11 was a DNR and verified on the EMR. The DON stated that the Social Worker was responsible for completing the advanced directive forms upon admission. The Social Worker was also responsible for audits of the advanced directive notebook to ensure the correct forms were in place. The DON explained that the previous Social Worker worked [DATE] through last week but was no longer employed at the facility. The new Social Worker began work today and would have no knowledge of Resident #11's advanced directive information. The DON verbalized she was unaware if the former Social Worker discussed advanced directives with Resident #11's family when he was admitted . The DON indicated Resident #11 was admitted from the hospital with an order for DNR, but she was unsure if the former Social Worker had a completed DNR form. An interview with the Administrator was conducted on [DATE] at 12:11 PM. The Administrator stated that the DNR forms should be available for facility and emergency staff in case a resident had an emergency. The Administrator verbalized that she would expect the staff to follow the physician's orders and all advanced directive information should match and completed accurately. The Administrator (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the ADON and DON would be responsible for ensuring accurate code forms were placed in the advanced directive folder if there was no Social Worker available. 2. Resident #62 was admitted to the facility on [DATE]. Review of Resident #62's electronic health record revealed a physician's order dated [DATE] for Do Not Resituate (DNR). Review of Resident #62's care plan revised [DATE] revealed a Full Code status. The interventions included honoring the Resident's wishes and reviewing the (code status) with the Resident and/or family during quarterly care conferences. Review of Resident #62's quarterly Minimum Data Set assessment dated [DATE] revealed she was cognitively intact. Review of Resident #62's physician progress note dated [DATE] revealed the advanced directive status was Full Code Blue. Review of the code status notebook kept at the nursing desk revealed there was no advanced directive information in the notebook for Resident #62. On [DATE] at 12:11 PM during an interview with the Administrator, she explained that it was her expectation that the staff follow the advanced directives and the advanced directive information should be the same throughout the medical record. An interview was conducted with the Director of Nursing (DON) on [DATE] at 12:36 PM. The DON explained that the advanced directive paperwork was initiated at admission and periodically audited by the Social Worker (SW) which included making sure the advanced directives were in place and matched in the medical records and in the code status notebook at the desk, but the SW resigned last week. The DON stated it was possible that the discrepancies happened during one of the Resident's admissions to the hospital. Regardless, the DON indicated the advanced directives should match throughout the medical record. During an interview with Nurse #3 on [DATE] at 9:10 AM the Nurse explained that if she had to determine what a resident's code status was, she would either look on the residents' profile page in their medical record (the profile page displays the residents' picture with their advanced directive listed underneath) or look in the code status notebook at the nursing desk. She indicated that if nothing was in the code status notebook then she would refer to the profile page in the medical record. An interview was conducted with the Unit Manager (UM) on [DATE] at 11:46 AM. The UM explained that if she had to determine a residents' code status in a hurry it would depend on if her computer was booted up and if so, she would look at the profile page where the advanced directive was listed under their picture. She continued to explain that if she was closer to the nursing desk she would look in the code status notebook. The UM stated the two areas should match. 3. Review of the hospital Discharge summary dated [DATE] revealed Resident #31's code status was No Cardiopulmonary Resuscitation (CPR) (DNR). Resident #31 was admitted to the facility on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #31's physician orders revealed an order dated [DATE] which indicated a Do Not Resuscitate (DNR) status in the event he had no pulse and was not breathing. Review of the code book (a binder that contained paper copies of residents' advanced directives and code status) revealed Resident #31's paper medical record indicated the Medical Orders for Scope of Treatment (MOST) form dated [DATE] stated a preference for Attempt Cardiopulmonary Resuscitate (CPR) in the event Resident #31 had no pulse and was not breathing. The form was signed by Resident #31's Responsible Party (RP) on [DATE]. The MOST form did not have a physician's signature. Review of the Advanced Directive Discussion Document located in the code book and completed by the Director of Sales and Marketing/admission Coordinator dated [DATE] revealed to provide Cardiopulmonary Resuscitation in the event Resident #31 had no pulse and was not breathing. The form was signed by Resident #31's RP on [DATE]. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #31 had moderately impaired cognition. Further review of Resident #31's electronic medical record (EMR) revealed a physician's progress note dated [DATE] that read in part: Code Status: Do Not Attempt Resuscitation (DNR/no CPR). An interview was conducted on [DATE] at 3:38 PM with Nurse #3 who stated that she does not check the code book unless there was an emergency. She explained that if there was an emergency, she would check the code book and the resident's EMR for the resident's code status. Nurse #3 revealed that she did not know who completed the advance directive information and code status when residents were admitted to the facility. Nurse #3 further explained that the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were responsible for checking the code book. An interview was conducted with Resident #31 on [DATE] at 9:10 AM. Resident #31 stated that he had an advanced directive in place and that he and his RP had made the decision that he would not want any type of CPR. Multiple unsuccessful attempts to contact Resident #31's RP were made. An interview was conducted with the Director of Sales and Marketing/admission Coordinator on [DATE] 2:34 PM who stated that she had been completing the advanced directive discussions and paperwork with newly admitted residents and/or their RP since the facility did not have a current Social Worker (SW). She explained that she met with Resident #31's RP on [DATE] and Resident #31's RP completed the Advanced Directive Discussion Form and the MOST form. She further explained that Resident #31's RP indicated that she wanted Resident #31 to receive CPR on both documents. The Director of Sales and Marketing/admission Coordinator stated that she placed Resident #31's completed Advanced Directive Discussion Form and the MOST form in the code notebook (a binder that contained paper copies of residents' advanced directives and code status) at the nursing station. An interview was conducted on [DATE] 3:43 PM with the Director of Nursing (DON) who stated Resident #31's had not been deemed incompetent, and his RP had signed all of his admission paperwork including his Advanced Directive Discussion Form and his MOST form. The DON verified Resident #31's physician order in the EMR for a DNR did not match the Advanced Directive Discussion Form and the MOST form which indicated to provide CPR. The DON also verified that Resident #31's MOST form had not been signed by the physician. The Director of Nursing (DON) revealed the admission Coordinator completed (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the advanced directive forms because the facility did not have a current SW. The DON explained that the admission Coordinator placed the forms in the code notebook at the nursing station when she should have placed the forms in the physician's folder for review and signature. An interview was conducted on [DATE] 4:11 PM with the Administrator who stated she expected the staff to follow the advanced directive orders and that all advanced directive information should match and be correct in all locations including in the EMR and the code notebook at the nursing station. The Administrator further stated that if the advanced directive information did not match, she expected the staff to clarify the information with the resident and the RP to ensure the resident's wishes were honored.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of resident narcotic medications for 1 of 4 resident reviewed for misappropriation of resident property (Resident #62).Findings included:Resident #62 was admitted to the facility on [DATE].Review of Resident #62's physician orders revealed an order for 5 milligram (mg) oxycodone HCl oral tablet (an opioid pain medication) with one tablet to be administered by mouth every 12 hours for pain. This order was dated 06/06/25. Additionally, Resident #62 had another order for 5mg oxycodone HCl oral tablet with one tablet to be administered by mouth every 6 hours as needed for breakthrough pain. This order was dated 06/06/25 and discontinued on 09/04/25.Review of the facility's record of a pharmacy delivery notification revealed Resident #62 had a pharmacy order that included 2 cards of 30 tablets each of 5mg oxycodone immediate release tablets that were delivered by the pharmacy on 09/04/25. Additional review of the pharmacy delivery notification revealed it was signed as received by Nurse #3 at 10:38 PM.An interview with Nurse #3 on 02/18/2026 at 2:46 PM revealed she worked 2nd shift most of the time. Nurse #3 stated when the pharmacy made a delivery of opioid or narcotic medications, the medications came in a sealed purple bag, and they were handed off to one of the nurses that was working at the time of the delivery. She continued, stating that the nurse who received the delivery would be responsible for verifying the medication and the amount delivered and would then sign off as having received the mediation. Nurse #3 verified that she was the nurse who signed for the pharmacy delivery of Resident #62's Oxycodone HCL medication on 09/04/25. Per Nurse #3, she distinctly remembered there were two, thirty pill count cards for Resident #62 that were delivered on 09/04/25 and that she verified the count and medication before signing off on the pharmacy's delivery sheet. Nurse #3 stated after she signed for the medication delivery, she delivered Resident #62's medication to the nurse (Nurse #4) who was assigned to Resident #62 that evening as she would need to complete two separate Controlled Drug Count Sheets one for each card of medication delivered. Nurse #3 stated she had no idea what happened to Resident #62's Oxycodone but stated it never made it to the medication cart as only one Controlled Drug Count Sheet was completed.Review of Resident #62's controlled drug count sheet dated from 08/31/25 through 09/06/25 revealed there were 41 cards of medications at shift change at 3:00 PM on 09/04/25 on the medication cart belonging to the hall where Resident #62 resided. Per the controlled drug count sheet, Nurse #4 was the oncoming nurse and verified that there were 41 cards of medications at that shift change. Additional review of the controlled drug count sheet revealed Nurse #4 signed off at 11:00 PM that there continued to be 41 cards of medication on the medication cart. There did not appear to be any addition or subtraction of medication cards while Nurse #4 was working. The 2 cards of Oxycodone that were delivered to the facility for Resident #62 on 09/04/25 were not added to the controlled drug count sheet by Nurse #4.Multiple attempts to reach Nurse #4 via telephone on 02/18/26 and 02/19/26 were unsuccessful. Nurse #4 was no longer an employee at the facility.An interview with the Director of Nursing (DON) on 02/19/26 at 5:11 PM revealed she was aware of Resident #62's 30 missing oxycodone tablets and indicated that she had assisted in the investigation. She reported she was initially informed of a discrepancy when a first shift nurse requested a refill for Resident #62's Oxycodone medication due to Resident #62 only having a few pills left on one card that was delivered on 09/04/25 and the pharmacy informed them they could not fill the prescription due to their records indicating that Resident #62 had 60 opioid (oxycodone) medications delivered 09/04/25 and it was too soon for the medication to be refilled as there should be at least 30 pills of the opioid medication still available. The Director of Nursing stated they searched the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cart for the additional card of medication but were unsuccessful in locating it. The DON stated at that time, she reported the concern to the Former Administrator and the Regional Nurse Consultant. She was directed to count all the cards on all the facility's medication carts which was completed and reportedly found no discrepancies. The Director of Nursing also reported she reviewed 30 days of pharmacy deliveries with no discrepancies found. The Director of Nursing reported she interviewed Nurse #3 who had signed for the delivery and was reportedly told that Nurse #3 did not count or verify the medications and just signed the delivery paperwork and could not verify if 30 or 60 oxycodone tablets were delivered from the pharmacy. The Director of Nursing reported she spoke with multiple other staff members who were present at the time of the delivery but was unable to locate a staff member who could verify 2 cards (60 pills) of Oxycodone were delivered for Resident #62 on 09/04/25. The Director of Nursing reported she had no idea whether the pharmacy failed to bring both cards (60 tablets) of Oxycodone medications for Resident #62 or if one of the two Oxycodone medication cards went missing between delivery by the pharmacy and delivery to the medication cart.An interview with the Former Administrator, who was the Administrator at the time of the incident on 09/04/25, was completed via telephone on 02/19/26 at 6:31 PM. The Former Administrator stated it was hard to remember this incident as he believed it occurred shortly after he started. He stated he believed the Director of Nursing reported to him that there was some missing medication and when they began investigating, it seemed to had been going on for a couple weeks before it was discovered. The Former Administrator reported he recalled that the situation was discovered when a nurse went to try and reorder an Oxycodone medication for Resident #62 and the pharmacy reported it was too early to refill. He stated he remembered this investigation centered around Nurse #4 as she was the nurse assigned to the medication cart the Oxycodone medication went to after delivery. However, he stated they were ultimately unable to determine what actually happened to the missing card of medication and that they ordered another card of opioid medication at the facility's expense. He reported he had no further knowledge of the investigation due to him not being at the facility any longer.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, resident and staff interviews, and Psychiatric Nurse Practitioner (NP) the facility failed to refer one resident with a new mental health diagnosis for Preadmission Screening and Resident Review (PASRR) level II for 1 of 1 resident for PASRR (Resident #31).The findings included:A PASRR level I was completed on 10/29/2025 prior to Resident #31's admission to the facility with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition.Review of the hospital Discharge summary dated [DATE] revealed Resident #31 experienced hallucinations and was talking to the ceiling. Resident #31 received haloperidol (antipsychotic used to treat schizophrenia) 1 milligram (mg) twice a day for agitation and quetiapine (atypical antipsychotic used to treat schizophrenia) 50 mg twice a day and 100 mg at bedtime with no indication for use documented. Resident #31 was evaluated by the hospital psychiatrist, and the quetiapine was discontinued and loxapine (antipsychotic mainly used to treat schizophrenia) 10 mg twice a day was initiated. Resident #31's discharge orders included follow up with the facility psychiatrist and continue haloperidol 1 mg twice a day for agitation, loxapine 10 mg twice a day, and buspirone (medication used to treat anxiety) 15 mg three times a day. The hospital discharge did not reveal that Resident #31 had a diagnosis of schizophrenia. Review of Resident #31's electronic medical record (EMR) revealed Resident #31 was admitted to the facility on [DATE]. Resident #31 had no mental health diagnoses when he was admitted to the facility.A psychiatry visit note dated 01/09/2026 revealed Resident #31 served in the military and then later served with the Central Intelligence Agency (CIA). Resident #31's military history was confirmed by his family member. During the visit Resident #31 stated that I lost it at the hospital, and I started seeing things that were not there, became delusional and blacked out. Resident #31's family member reported that he had hallucinations and paranoia while in the hospital which resulted in a nurse in the hospital being physically injured by Resident #31. Resident #31 denied any signs or symptoms of anger or anxiety during the visit. No emotional or behavioral outburst have occurred since Resident #31 arrived at the facility.Review of the electronic medical record (EMR) revealed Resident #31 was diagnosed with paranoid schizophrenia on 01/13/2026. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had moderately impaired cognition and the MDS coding indicated he had a level I PASRR. The MDS revealed Resident #31 had schizophrenia and he had received antipsychotics, anti-anxiety medications, and anticonvulsants during the 7 day look back period.An interview was conducted with Resident #31 on 2/17/2026 at 9:04 AM. Resident #31 stated that he had served in the military for 13 years and was stationed in Bosnia and Afghanistan. He further explained that he had suffered with mental illness since his return from active military duty and had night terrors related to his war experiences. Resident #31 further explained that he has received psychiatry counseling for many years. Resident #31 could not recall when he was first diagnosed with paranoid schizophrenia. A telephone interview was conducted on 02/18/2026 10:51 AM with the Psychiatric NP who cared for Resident #31. The Psychiatric NP stated that during his initial visit with Resident #31 on 01/09/2026, Resident #31 stated that he was a veteran and suffered from paranoid schizophrenia and had a long standing history of mental illness related to his military experiences. The Psychiatric NP stated that Resident #31's history was verified with his family member and further stated that Resident #31 was managing very well on his current medication regimen. The Psychiatric NP stated that Resident #31 should have been evaluated for a level II PASRR due to his mental health history.An (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview was conducted with the MDS Coordinator on 02/17/2026 at 12:57 PM. The MDS Coordinator stated that she identified Resident #31's diagnosis of paranoid schizophrenia on a psychiatric note dated 01/09/2026. The MDS Coordinator stated that Resident #31 did not have a diagnosis of paranoid schizophrenia on his hospital Discharge summary dated [DATE]. The MDS Coordinator explained that she did not have access to request Level II PASRR evaluations, but she passed the information along to the previous Social Worker (SW) who was no longer employed with the facility. The MDS Coordinator could not recall when she passed the information to the previous SW. The MDS Coordinator further revealed that the previous SW did not have access to request Level II PASRR evaluations and the only person in the facility who had access was the Assistant Business Office Manager. The MDS Coordinator stated that she thought the SW passed the information along to the Assistant Business Office Manager. Multiple unsuccessful attempts to contact the previous SW were made.An interview was conducted with the Assistant Business Office Manager on 02/17/2026 at 1:27 PM. The Assistant Business Office Manager stated that she had not received any information or request to submit a request for a Level II PASRR evaluation for Resident #31. The Assistant Business Office Manager stated that she usually received that information during the morning clinical meetings.During an interview on 02/18/26 at 1:08 PM with the Administrator, she communicated her understanding that PASRR level II evaluations should be completed in a timely manner upon the admission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. The Administrator stated that Resident #31 should have had a PASRR level II evaluation submitted when the diagnosis of paranoid schizophrenia was added to his diagnoses. The Administrator further stated that she did not know why the referral for a level II PASRR was not submitted for Resident #31.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan for 1 of 6 residents whose comprehensive care plans were reviewed (Resident #63).The findings included:Resident #63 was admitted to the facility on [DATE] with diagnoses which included dementia, Parkinson's disease, and diabetes mellitus (DM).Review of Resident #63's admission Minimum Data Set (MDS) assessment dated [DATE] revealed moderately impaired cognition. Resident #63 required supervision with eating and bed mobility, moderate assistance with oral hygiene, toileting, and transfers, and required maximum assistance with bathing and dressing. The MDS also revealed Resident #63 was incontinent of bowel and bladder. Resident #63's MDS was coded for Parkinson's Disease, dementia, hypertension, diabetes, and arthritis. The MDS also indicated Resident #63 had no pain and no weight loss but received a therapeutic diet. She was at risk for pressure ulcer development and had no wounds. She had received anti-psychotic, anti-anxiety, and hypoglycemic medications during the 7 day look back period. The MDS also revealed Resident #63 was planning to discharge back to the community.Review of Resident #63's comprehensive care plan dated 12/10/2025 revealed one care plan entry was developed by the Registered Dietician (RD) related to the potential for nutritional problems. There were no other care areas addressed in Resident #63's comprehensive care plan.Review of the Care Area Assessments (CAA) (a tool used to identify relevant causes, risk factors and complications in order to develop a person-centered plan of care) completed by the MDS Coordinator on 12/12/2025 revealed Resident #63 triggered for the following CAAs: 1. Cognitive loss/Dementia2. Functional Abilities for Self-Care and Mobility3. Urinary Incontinence4. Psychosocial Well-being5. Activities6. Falls7. Nutritional Status8. Pressure Ulcer Injury9. Psychotropic Drug UseA review of Resident #63's care plan was completed on 02/18/2026 at 7:40 AM with the MDS Coordinator who verified the only care plan entry for Resident #63 was for nutrition which was completed by the RD. She further stated that she remembered completing Resident #63's comprehensive care plan and does not know what happened to her care plan. The MDS Coordinator also stated that she was aware that a comprehensive care plan should be developed within 21 days of the resident's admission to the facility. The MDS Coordinator further explained that the facility had two recent computer upgrades, and she thought something happened to Resident #63's care plan when the computer updates occurred. An interview was conducted on 2/18/2026 at 9:02 AM with the Administrator who stated that she expected all residents to have an accurate and complete comprehensive care plan and the care plan should reflect the resident's clinical condition, medications, and care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. Building B. Wing	02/26/2026

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a care plan in the area of urinary catheter for 1 of 3 residents reviewed for care plans (Resident #99). The findings included:Resident #99 was admitted to the facility on [DATE] with diagnoses that included urinary retention. The Resident was discharged on 07/22/25.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #99 had an indwelling urinary catheter.Review of Resident #99's medical record revealed orders dated 06/23/25 for urinary catheter, change catheter as needed, change catheter bag as needed, catheter care every shift and as needed, place stat lock to secure catheter and to check placement every shift.Review of Resident #99's Treatment Administrator Record for June and July 2025 revealed the Resident had a urinary catheter and received daily care for the urinary catheter.Review of Resident #99's comprehensive care plan dated 07/03/25 revealed there was no mention of a urinary catheter on the care plan.During an interview with the MDS Coordinator on 02/26/26 at 5:15 PM the MDS Coordinator reviewed Resident #99's care plan and acknowledged the urinary catheter was not on the care plan. She continued to explain that during the time of Resident #99's admission to the facility the facility was undergoing a change in companies which included an electronic medical record upgrade, and it was possible that when she was completing the care plan the system did not accept her input of the care plan.An interview was conducted on 02/26/26 at 5:40 PM with the Administrator who stated that she expected all residents to have an accurate and complete comprehensive care plan and the care plan should reflect the resident's clinical condition, medications, and care needs.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, family member, and staff interviews, the facility failed to ensure a resident's toenails were trimmed and podiatry services were arranged for 1 of 1 resident reviewed for foot care (Resident #63).The findings included:Resident #63 was admitted to the facility on [DATE] with diagnoses which included dementia, Parkinson's disease, and diabetes mellitus (DM).Review of the admission nursing assessment dated [DATE] did not reveal any issues with Resident #63's toenails.Review of Resident #63's admission Minimum Data Set (MDS) assessment dated [DATE] revealed moderately impaired cognition. Resident #63 required moderate assistant with bed mobility, toileting and transfers and required maximum assistant with bathing and dressing. The MDS also revealed Resident #63 had Parkinson's Disease, dementia, DM, and arthritis. The MDS indicated Resident #63 had no rejections of care and was at risk for pressure ulcer development. Review of Resident #63's care plan dated 12/10/2025 revealed one care plan was developed by the registered dietician (RD) related to the potential for nutritional problems. There were no other care areas addressed in Resident #63's care plan. Review of Resident #63's weekly nursing assessments from 12/03/2025 through 02/17/2026 revealed no notation that her toenails were long and thick and needed trimmed.Review of the facility's podiatry clinic schedule for 12/29/2025, revealed Resident #63 was not seen by the podiatrist. There were no consultation reports or notations in Resident #63's Electronic Medical Record (EMR) that she was scheduled to see the podiatrist or that she had been seen by a podiatrist since admission to the facility.An observation and interview were conducted on 02/16/2026 1:19 PM. Resident #63's toes revealed thick, long, jagged toenails on both feet. Resident #63's left great toenail had a brownish coloring at the base of the nailbed which had started to extend upward to the middle of the toenail. Resident #63 stated that her toenails looked nasty and she would like to have them trimmed. She explained that she had not been able to bend down and take care of her toenails and feet for a long time. She further explained that her daughter trimmed her toenails before she came to the facility. An observation and interview were conducted on 02/17/2026 11:24 AM with the wound nurse and the Assistant Director of Nursing (ADON). The wound nurse stated that she usually noticed resident's toenails when she provided wound care to their feet, but she did not notice Resident #63's toenails and she did not request for her to be added to the podiatry list. The ADON stated that Resident #63 would need to be seen by the podiatrist because she was diabetic and it would be best for the podiatrist to take care of her toenails. The ADON also stated that the facility's Social Worker usually added residents to the podiatry list, but the facility did not currently have a Social Worker. The ADON stated that she was responsible for adding residents to the podiatry schedule but added she had not referred Resident #63 to the podiatrist since her admission.An additional interview with Resident #63 and her family member was conducted on02/17/2026 2:28 PM. The family member stated Resident #63 had not been able to care for her feet and toenails in a long time. The family member explained that she used to keep Resident #63's toenails trimmed and groomed because Resident #63 was a diabetic and she knew how important it was too watch her feet for diabetic complications. Resident #63 stated that her toes did not hurt but she would like to have her toenails trimmed because they looked so bad.An interview was conducted with Nurse Aide (NA) #2 on 02/19/2026 8:19 AM who stated that she often gave Resident #63 her showers. NA #2 stated she had noticed Resident #63's toenails were very long and needed to be trimmed. NA #2 stated but to be honest, I don't remember if I told anyone about Resident #63's toenails. NA #2 further explained that she usually reported any concerns or issues to the resident's assigned nurse. An interview was conducted on 02/19/2026 4:36 PM with the DON & Administrator. The Administrator stated that she understood the concerns with Resident #63's toenails and (continued on next page)

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	345329	A. Building B. Wing	02/26/2026

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained that the nursing staff should observe resident's toenails when they completed their skin assessments and showers. She stated that she expected all residents to be referred to Podiatry services if needed, especially residents with diabetes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Consultant Pharmacist interviews, the facility failed to have a system in place to ensure an accurate account of 1 of 1 resident's controlled medications (Resident #98), failed to have effective systems in place to ensure 2 of 2 residents (Resident #53 and Resident #74) had their physician prescribed narcotic pain medication available for administration, and the facility also failed to have a system to maintain an accurate receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation of controlled drugs for 5 of 5 months. The deficient practice occurred for 3 of 4 residents reviewed for misappropriation of medications.The findings included: Resident #98 was admitted to the facility on [DATE]. Resident #98 discharged on 01/15/26. A physician order dated 08/29/25 read; Oxycodone HCl oral tablet 30 milligrams (mg) – Give one tablet by mouth every 4 hours as needed for chronic pain. Review of the Initial Allegation Report submitted to the state agency on 12/23/25 indicated there was possible misappropriation of Resident #98's medication after noticing a discrepancy in Resident #98's oxycodone medication. Review of the Investigation Report dated 12/30/25 revealed Resident #98 was discharged from the facility to the hospital and while he was out of the facility, two doses of Resident #98's 30 milligram(mg) Oxycodone (a opioid pain medication) was signed out as being given to Resident #98. The facility's investigation found that one of the oxycodone tablets was signed out by Nurse #4 but were unable to determine who signed out the 2nd oxycodone tablet. Nurse #4 was reportedly uncooperative with the investigation and was terminated and the facility reported Nurse #4 to the Board of Nursing. Per the facility's report, due to Nurse #4's lack of cooperation and being unable to determine the 2nd signature, they could not unsubstantiate or substantiate the allegation. Review of Resident #98's progress notes in his electronic health record revealed a note dated 12/17/25 that read: [Patient] is unresponsive and hypotensive and hypoxic. [Emergency Medical Services] called. Patient's [family] notified. The note was time-stamped 5:40 PM and was written by Nurse #4. Additional review of Resident #98's progress notes revealed a note dated 12/17/25 at 8:33 PM that was a medication administration note for a single 30 mg oxycodone tablet. This note was written by Nurse #4. Review of Resident #98's Medication Administration Record from December 2025 revealed the last dose of Oxycodone 30 mg tablet was signed as being provided to Resident #98 at 2:49 PM on 12/17/25 by Nurse #4. Review of Resident #98's Controlled Medication Utilization Record for Resident #98's 30 mg Oxycodone tablets dated 12/17/25 revealed 2 doses of Oxycodone 30 mg tablets were signed out after Resident #98 was sent out to the hospital. One dose was signed out by Nurse #4 on 12/17/25 at 6:00 PM and another dose was signed out on the same date with an unreadable time with an unreadable signature. Multiple attempts to reach Nurse #4 via telephone call on 02/18/26 and 02/19/26 were unsuccessful. (continued on next page)

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	345329	A. Building B. Wing	02/26/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing on 02/19/26 at 4:55 PM revealed she was familiar with the incident and reported she had investigated this potential diversion of Resident #98's medication. The Director of Nursing reported Resident #98 was sent out to the hospital on [DATE] and after he was discharged , she requested after Resident #98 left (time unknown) that his medications be pulled from the medication cart so they could be sent back to the pharmacy. She stated she could not recall who brought her Resident #98's medication but reported while she was reviewing the medications and the controlled medication utilization records, she noted there appeared to be 2 doses of Resident #98's 30 mg Oxycodone that were dispensed after Resident #98 discharged from the facility. She stated at that time she notified the Former Administrator. She reported she and the former Administrator attempted to reach Nurse #4 multiple times, but Nurse #4 continued to have reasons she could not talk or come to the facility. The Director of Nursing stated she did receive a text from Nurse #4 which was a statement of what led to Resident #98 being discharged to the hospital, but nothing was said about why she appeared to have signed out at least one dose of Resident #98's 30 mg Oxycodone after he discharged to the hospital. When the Director of Nursing reached out for an explanation, Nurse #4 never responded. The Director of Nursing reported Nurse #4 was ultimately terminated due to what appeared to be her dispensing medications for a resident who was not in the building at the time they were dispensed and for failure to respond to the investigation inquiries. The Director of Nursing stated she was confident that Nurse #4 had, at least, signed out one of the doses of Resident #98's 30 mg Oxycodone. An interview with the Former Administrator on 02/19/26 at 6:27 PM revealed he remembered there was an issue with Nurse #4 and they believed she had diverted some opioid medications from a resident at the facility. He reported he did recall Nurse #4 not being very cooperative with the investigation and was ultimately terminated. He reported that he believed that the incident and Nurse #4 were reported to the Board of Nursing and apologized but stated he could not recall much else regarding the investigation. 2. Resident #53 was initially admitted to the facility on [DATE] with a readmission date of 01/15/26. A physician order for Resident #53 dated 11/21/25 read: oxycodone (an opioid pain medication) 15 milligrams (mg), one (1) tablet by mouth every 6 hours, scheduled for pain. A review of Resident #53's medication administration record (MAR) from December 2025 revealed oxycodone 15 mg, one (1) tablet by mouth, was administered as ordered from 12/05/25 through 12/10/25. The times of administration were: 6:00 PM, 12:00 AM, 6:00 AM, and 12:00 PM Resident #102 was admitted to the facility on [DATE] with diagnoses which included chronic pain and opioid dependence. A review of Resident #102's physician's orders revealed an order dated 11/04/25 for oxycodone 15 mg one (1) tablet by mouth twice daily scheduled. A review of the completed controlled substance accountability record for Resident #102 dated 11/30/25 for oxycodone 15 mg immediate?release tablets, revealed that Resident #53 was administered oxycodone 15 mg per the physician order using Resident #102's supply of oxycodone 15 mg from 12/05/25 at 6:00 PM through 12/10/25 at 12:00 PM by multiple nurses. Nurses documented that medication was borrowed for Resident #53. During the time frame 12/05/25 to 12/10/25 the following nurses documented that they borrowed oxycodone 15 milligrams from Resident #102 for Resident #53: Nurse #9, Nurse #7, (continued on next page)

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	345329	A. Building B. Wing	02/26/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #5, Nurse #11, and the Unit Manager. A total of 20 tablets were borrowed from Resident #102's medication supply for Resident #53. A telephone interview with Nurse #7 who was no longer employed at the facility was conducted on 2/20/26 at 2:18 PM. Nurse #7 had documented borrowing oxycodone from Resident #102 for Resident #53 on 12/06/25 at 12:00 AM and 5:00 AM. Nurse #7 stated she could not recall those incidents when oxycodone had to be borrowed. She verbalized that it was common for controlled medications not to be available and to have to be borrowed from another resident. Nurse #7 indicated that nurses were supposed to notify the Director of Nursing (DON) when they borrowed medication, but she did not know how the controlled substances borrowed were replaced or reimbursed. Nurse #7 stated she had not notified the DON before she borrowed the oxycodone from Resident #102 for Resident #53. An interview with the Unit Manager was conducted on 2/24/26 at 9:39 AM. The Unit Manager stated that she remembered signing out several doses of oxycodone from Resident #102's card for Resident #53 because Resident #53's oxycodone prescription had run out. The Unit Manager documented that she borrowed oxycodone 15 mg from Resident #102 for Resident #53 on 12/08/25 at 12:00 PM, 12/09/2025 at 12:00 PM, and 12/10/25 at 12:00 PM. The Unit Manager recalled that Resident #53 required a hard script (a printed order with the provider's signature) for his oxycodone to be refilled in December 2025. The prescription was sent in, but there had been a billing issue which she was aware of because Resident #53's insurance required a prior authorization, and the medication was not delivered from the pharmacy before his supply ran out. Because Resident #53's own oxycodone supply had been exhausted, they borrowed from Resident #102 until Resident #53's prescription could be refilled. The Unit Manager verbalized that there had been a backup supply of oxycodone 5 mg tablets in the facility, but since Resident #53 received 15 mg, they borrowed from Resident #102, who had the same dosage, and she did not attempt to get it out of the backup supply. The Unit Manager stated that it was common for nurses to borrow controlled substances if they ran out from the pharmacy, although borrowing should only have been done upon approval of the DON. The Unit Manager stated that she did not speak with the DON prior to borrowing, nor did she notify the DON that Resident #53's oxycodone had not been received from the pharmacy. The Unit Manager stated that the process for ordering controlled substances was to reorder when the supply was getting low. The refill could be reordered directly from the pharmacy through the medication administration record (MAR). If there were no refills left, the pharmacy required a hard script. The Unit Manager indicated that although the medication might be ordered by one nurse, if that nurse did not work on the same hall every day, the order might not be followed up on. Some refills required prior authorization, and the DON completed those. The Unit Manager stated she did not review the controlled substance accountability records, but those sheets went to the DON. The Unit Manager verbalized she did not know how medication that was borrowed from one resident for another would be replaced, but she believed the DON handled that. An interview was conducted with the DON on 2/24/26 at 4:32 PM. The DON verbalized that there was no policy for borrowing controlled substances from one resident for another. The DON explained that she had not been aware that controlled substances were borrowed so frequently. The DON stated that nurses were not to borrow medications. The DON indicated that nurses had borrowed medications including controlled substances in the past but were supposed to notify her for approval. The DON stated that she had only received two to three phone calls over the last few months to approve borrowing medication. The DON reported that controlled substances should have been delivered from the pharmacy prior to any residents running out. However, even though controlled substances might be ordered, the pharmacy would not fill them for various reasons, including billing issues. If residents ran out of medication, the nurse should have called the provider for an order. Resident #53's insurance required the facility to (continued on next page)

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	345329	A. Building B. Wing	02/26/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complete a prior authorization for every refill of his medications, and that often-caused delays in orders, which had been an ongoing issue. The DON confirmed she completed the prior authorizations. Residents whose medications required prior authorization appeared as an alert on the pharmacy website page, which the DON checked daily. Prior authorization required several steps in the process, and this was usually what caused delays in controlled substance medication refills. Sometimes the provider did not complete their forms, or the pharmacy rejected the request without providing a reason. If the prior authorization was approved, sometimes the pharmacy automatically sent the controlled substance, but sometimes it did not, and the staff had to call the pharmacy to request delivery. The DON reported that she reviewed the controlled substance accountability records when they were returned to her after the medication was completed. She stated she did not review Resident #102's controlled substance accountability record dated 11/30/25 when it was returned but declined to state why she had not reviewed it. The DON indicated that if the nurses told her they borrowed medication, she would call the pharmacy to get the medication replaced. The DON could not produce records showing that Resident #53's oxycodone 15 mg had been reordered, delivered, or that Resident #102 had been reimbursed for the borrowed oxycodone. An interview with the Regional Nurse Consultant was conducted on 02/24/26 at 11:24 AM. He stated the facility followed all pharmacy policies related to controlled substances. The Regional Nurse Consultant stated that he was unaware that nurses were borrowing controlled substances for other residents and they were not supposed to borrow controlled substances. An interview with the Administrator was conducted on 2/24/26 at 6:12 PM. The Administrator stated that any concerns with the administration and documentation of controlled substances, including borrowing, should have been addressed by nursing leadership immediately. The Administrator verbalized that she would have expected the nurses to reorder controlled substances prescribed for all residents in a timely manner so they would not run out. If medication was not available from the pharmacy, the nurse would have been expected to call a provider for directions. If it was a billing issue, that should have been addressed quickly so the residents could receive their medication. A telephone interview with the Consultant Pharmacist was conducted on 02/25/26 at 2:44 PM. The Consultant Pharmacist reported that she performed the medication audits monthly. The audits consisted of checking all the medication carts, reviewing the controlled substance accountability records and reconciling it to the MAR and controlled substances inside the medication cart. She randomly selected a few residents to review records to ensure correct documentation was completed. The Consultant Pharmacist stated that the facility had a history of controlled substance documentation discrepancies and had been an ongoing issue at the facility. However, she had not noticed nurses borrowing from other residents on the controlled substance accountability records. The Consultant Pharmacist indicated she was not familiar with how the facility handled the process for borrowed controlled substances. When asked if borrowing controlled substances from one resident to the other violated pharmacy policy, the Consultant Pharmacist declined to answer but stated it violated best practice. 3. Resident #74 was admitted to the facility on [DATE]. A physician's order for Resident #74 dated 10/28/25 read: oxycodone (an opioid pain medication) 10 milligrams (mg), one (1) tablet by mouth every 4 hours as needed for pain. Do not give 1 hour prior to or after scheduled oxycodone. A review of Resident #74's medication administration record from December 2025 revealed oxycodone 10 mg by mouth every 4 hours as needed for pain was administered to Resident #74 on the following (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dates and times: on 12/22/25 at 10:29 AM, on 12/28/25 at 4:34 PM, on 12/29/25 at 9:30 AM and 5:40 PM, and on 12/30/25 at 9:16 AM and 5:54 PM. Resident #102 was admitted to the facility on [DATE]. A review of Resident #102's physician's orders revealed an order dated 09/23/25 for oxycodone 5 mg one (1) tablet by mouth every 24 hours as needed for pain. A review of the completed controlled substance accountability record dated December 2025 for Resident #102 for oxycodone 5 mg tablets revealed that Resident #74's prescribed oxycodone dose of 10 mg was administered using 2 tablets of Resident #102's 5 mg oxycodone tablets by multiple nurses. Nurses documented the medication was borrowed for Resident #74 on the controlled substance accountability record for Resident #102. The following staff documented on the controlled substance accountability record for Resident #102 that they borrowed oxycodone 5 mg tablets for Resident #74, the Unit Manager, Nurse #9, and Nurse #8 during December 2025. A total of 12 tablets were borrowed from Resident #102's medication for Resident #74. An interview with the Unit Manager was conducted on 02/24/26 at 9:39 AM. The Unit Manager stated she remembered she signed out several doses of oxycodone from Resident #102 for Resident #74 because Resident #74 was out of her oxycodone prescription. The Unit Manager documented on Resident #102's control substance accountability record for December 2025 that she borrowed oxycodone 5 mg from Resident #102 for Resident #74 on 12/22/25 at 10:29 AM 2 tablets, 12/29/25 at 9:30 AM 2 tablets, and 12/30/25 at 9:16 AM 2 tablets. The Unit Manager could not recall why Resident #74 was out of her medication but because Resident #74's own oxycodone supply had been exhausted, they borrowed from Resident #102 until Resident #74's could be refilled. The Unit Manager verbalized that there was a backup supply of oxycodone 5 mg tablets, and she could not explain why she did not obtain it from the backup supply and instead borrowed it from Resident #102. The Unit Manager stated it was common for nurses to borrow controlled substances if they ran out. She stated that even though she borrowed the medication, she did not speak with the Director of Nursing (DON) for approval. The Unit Manager stated the process to order controlled substances were if the supply ran low, it could be reordered directly from the pharmacy. If there were no refills left, the pharmacy would require a hard script. The Unit Manager indicated that although the medication might be ordered by one nurse, if they did not work on the same hall every day, it may not be followed up on. Some refills required prior authorization, and the DON completed that. The Unit Manager stated she did not review the controlled substance accountability records, but those sheets all went to the DON when completed. The Unit Manager verbalized she did not know how medication borrowed from one resident for another would be replaced, but she thought the DON handled that. An interview with the Regional Nurse Consultant was conducted on 02/24/26 at 11:24 AM. He stated the facility followed all pharmacy policies related to controlled substances. The Regional Nurse Consultant stated that he was unaware that nurses were borrowing controlled substances for other residents and they were not supposed to borrow controlled substances. An interview was conducted with the DON on 02/24/26 at 4:32 PM. The DON verbalized there was no policy to borrow controlled substances from one resident for another. The DON explained she was not aware controlled substances were borrowed so frequently. The DON stated the nurses were not to borrow medications. The DON indicated nurses had borrowed controlled medications in the past but were supposed to notify her for approval. The DON stated she had only received 2–3 phone calls over the last few months to approve borrowed medication. The DON reported controlled substances should have (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. Building B. Wing	02/26/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been delivered from the pharmacy prior to any residents running out. However, even though controlled substances might be ordered, the pharmacy did not fill them for various reasons, including billing issues. If they ran out of medication, the nurse should have called the provider for direction. The DON stated residents with certain insurance plans/company required the facility to complete a prior authorization for every refill of their medications, and that often caused a delay in orders; that had been an ongoing issue. The DON stated she was not sure if Resident #74 required prior authorization. The DON confirmed she completed the prior authorizations. The residents whose medications required prior authorization showed up as an alert on the pharmacy website page, which the DON checked daily. Prior authorization required several steps in the process, and this was usually what caused delays in controlled substance medication refills. Sometimes the provider did not complete their forms, or the pharmacy rejected it but did not provide a reason. If the prior authorization was approved, sometimes the pharmacy automatically sent the controlled substance, but sometimes it did not, and the staff would have to call the pharmacy to get them to deliver it. The DON reported she reviewed the controlled substance accountability records when they were returned to her after the medication was completed. She stated she had not reviewed Resident #102's December 2025 controlled substance accountability record when it was returned but declined to say why she had not reviewed it. The DON indicated that if the nurses told her they borrowed, she would call the pharmacy to get the medication replaced. The DON could not produce records of Resident #74's oxycodone 10 mg being reordered, delivered, or that Resident #102 had been reimbursed for the borrowed oxycodone. An interview with the Administrator was conducted on 02/24/26 at 6:12 PM. The Administrator stated any concerns with the administration and documentation of controlled substances, including borrowing, should have been addressed by nursing leadership immediately. The Administrator verbalized she would have expected the nurses to reorder controlled substances prescribed for all residents in a timely manner so they would not run out. If medication was not available from the pharmacy, the nurse would have been expected to call a provider for direction. If it was a billing issue, that would have been addressed quickly so the residents would receive their medication. A telephone interview with the Consultant Pharmacist was conducted on 02/25/26 at 2:44 PM. The Consultant Pharmacist reported that she performed the medication audits monthly. The audits consisted of checking all the medication carts, reviewing the controlled substance accountability records and reconciling it to the MAR and controlled substances inside the medication cart. She randomly selected a few residents to review records to ensure correct documentation was completed. The Consultant Pharmacist stated that the facility had a history of controlled substance documentation discrepancies and had been an ongoing issue at the facility. However, she had not noticed nurses borrowing from other residents on the controlled substance accountability records. The Consultant Pharmacist indicated she was not familiar with how the facility handled the process for borrowed controlled substances. When asked if borrowing controlled substances from one resident to the other violated pharmacy policy, the Consultant Pharmacist declined to answer but stated it violated best practice. 4. a. The Monthly Storage Audit form dated 09/24/25 and completed by the Consultant Pharmacist revealed the facility had not met 2 pharmacy requirements under Controlled Substances. The document read in part, shift change count properly documented. Not met with the following comments noted, shift change blank on all carts. Another entry read, medication count reconciles with controlled substance accountability record (a comparison performed by reviewing the controlled substance accountability records and then verifying the administering nurse documented that medication was administered on the Medication Administration Record (MAR)). Not met with the following comments: E hall shift change medication count reconciliation sheet dated 09/18/25 had a (continued on next page)

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	345329	A. Building B. Wing	02/26/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discrepancy: 62 cards were documented by oncoming nurse. 8 cards were removed. 53 cards were documented at the end of the shift, but the card count should have been 54. Resident #98 had a physician's order for oxycodone (an opioid pain medication). 29 doses were signed on the controlled substance accountability record and only 27 doses were documented on Resident #98's MAR as administered. Resident #35 had a physician's order for tramadol (an opioid pain medication). 13 doses were signed on the controlled substance accountability record, and only 12 doses were documented on Resident #35's MAR as administered. b. The Monthly Storage Audit form dated 10/21/25 and completed by the Consultant Pharmacist revealed the facility had not met 2 pharmacy requirements under Controlled Substances. The document read in part, shift change count properly documented. Not met with the following comments for missing nurse signatures noted on all medication carts. Another entry read, medication count reconciles with controlled substance accountability record. Not met with the following comments: Several missing nurse signatures on the controlled substance accountability record (no residents were named). Several controlled substance accountability record numbers did not add up correctly and were hard to follow (no resident names provided). On B hall medication cart, a nurse had documented 11 medication cards were present, but there were 16 medication cards. As needed (PRN) substances were administered before the next dose should have been administered (no specific incidents mentioned). c. The Monthly Storage Audit form dated 11/19/25 and completed by the Consultant Pharmacist revealed the facility had not met 2 pharmacy requirements under Controlled Substances. The document read in part, shift change count properly documented. Not met with the following comments noted, missing nurse signatures on halls B, C, and D. Another entry read, medication count reconciles with controlled substance accountability record. Not met with the following comments: Resident #100 had a physician's order for oxycodone. Between 11/12/25 and 11/18/25 there were 19 doses signed on the controlled substance accountability record, but only 17 doses were documented on the MAR. The 11/17/25 as needed dose of oxycodone was administered too early for Resident #100. Resident #37 had a physician's order for hydrocodone/acetaminophen (an opioid pain medication) every 6 hours as needed. The 11/16/25 PRN dose was administered at 12:25 PM and again at 4:40 PM. d. The Monthly Storage Audit form dated 12/23/25 and completed by the Consultant Pharmacist revealed the facility had not met 2 pharmacy requirements under Controlled Substances. The document read in part, shift change count properly documented. Not met with the following comments for missing nurse signatures noted on all medication carts. Another entry read medication count reconciles with controlled substance accountability record. Not met with the following comments: Resident #61 had a physician's order for lorazepam (a psychoactive medication which treats anxiety) as needed. 2 doses were signed on the controlled substance accountability record and were not documented on Resident #61's MAR as administered. Resident #97 had a physician's order for lorazepam as needed. One dose was signed on the controlled substance accountability record but was not documented on Resident #97's MAR as administered. Resident #13 had a physician's order for lorazepam as needed. 12 doses were signed on the controlled substance accountability record but only 5 doses were documented on Resident #13's MAR as administered. Resident #32 had a physician's order for lorazepam as needed. A dose dated 11/25/25 and 11/26/25 were wasted without a witness signature. e. The Monthly Storage Audit form dated 01/20/26 and completed by the Consultant Pharmacist revealed the facility had not met 2 pharmacy requirements under Controlled Substances. The document read: shift change count properly documented for missing nurse signatures noted on hall A, C, D, and E. Another entry read medication count reconciles with controlled substance accountability record. Not met with the following comments: Resident #82 had a physician's order for oxycodone. 6 doses that were (continued on next page)

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	345329	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	345329	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, manufacturer's instructions, and staff and Consultant Pharmacist interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 26 opportunities, resulting in a medication error rate of 15.38% for 2 of 3 residents observed during the medication administration (Resident #4 and Resident #85).The findings included:1. Resident #4 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD).Review of Resident #4's physician orders revealed orders for 1) fluticasone propionate nasal spray one spray in both nostrils one time a day for allergic rhinitis dated 05/02/23, 2) budesonide/glycopyrrolate/formoterol fumarate (steroid) inhaler 160-9-4.8 MCG/ACT (micrograms per activation) inhalation aerosol inhale 2 puffs two times a day for COPD. Rinse mouth with water after use. Do not swallow, dated 11/21/24, and 3) albuterol sulfate inhalation aerosol solution 108 (90 base) MCG/ACT inhale 2 puffs orally four times a day for COPD dated 03/30/23.Review of Resident #4's Minimum Data Set assessment dated [DATE] revealed her cognition was moderately impaired.On 02/17/26 at 9:19 AM an observation of a medication pass was made of Nurse #2 who was medicating Resident #4. Nurse #2 handed Resident #4 the nasal spray and the two inhalers and allowed the Resident to medicate herself without providing instructions of how to administer the medications. Resident #4 administered herself two sprays of nasal spray inhaler in each nostril, three puffs of the albuterol sulfate inhalation and after the Resident administered the 2 puffs of budesonide/glycopyrrolate/formoterol fumarate inhaler, the Nurse did not instruct the Resident to rinse her mouth with water.An interview was conducted with Nurse #2 on 017/26 at 12:51 PM. The Nurse was asked to review the medication pass for Resident #4 earlier that morning and the Nurse stated that he knew that the Resident gave herself too many puffs of the albuterol inhaler and the nasal inhaler. The Nurse stated he knew that he should have encouraged Resident #4 to rinse her mouth with water after she used the steroid inhaler but that normally she would be having her breakfast and drinking fluids when he gave her the inhalers and that morning, she had already had her breakfast, and he did not think about it. Nurse #2 stated the steroid inhaler could cause oral thrush and he should have encouraged the Resident to rinse her mouth with water.An interview was conducted with the Consultant Pharmacist on 02/17/26 at 2:10 PM who explained that the nurses should encourage the residents to rinse their mouths with water after each use of a steroid inhaler because of the possibility that they could develop oral thrush.During an interview with the Director of Nursing (DON) on 02/19/26 at 10:19 AM the DON explained that if Nurse #2 was going to let Resident #4 administer her inhalers, then he should have instructed her on how to give the inhalers. The DON stated Nurse #2 should have instructed the Resident to rinse her mouth with water after she administered the steroid inhaler. 2. The manufacturer's instructions for prefilled insulin pen indicated that priming the insulin pen each time was an important step to ensure there were no air bubbles in the insulin and the full dose of insulin was given. Priming the insulin pen: 1. Dial up 2 units: turn the dose selector dial to 2 units, 2. Prime the pen: Press the injection button to let out any air bubbles and ensure the insulin is flowing correctly, 3. Check for a drop of insulin: you should see a drop of insulin on the tip of the needle, 4. Repeat if necessary.Resident #85 was admitted on [DATE] with diagnoses that included diabetes mellitus.Review of Resident #85's physician orders dated 02/17/26 revealed Lispro insulin give 8 units subcutaneously if the blood sugar was between 301 and 350 before each meal.On 02/17/26 at 12:05 PM an observation was made of Nurse #3 medicating Resident #85 via an insulin pen. The Nurse removed the Lispro insulin pen from the medication cart and set the counter to 8 units. Nurse #3 administered the 8 units of insulin without priming the insulin pen as advised (continued on next page)

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	345329	A. Building B. Wing	02/26/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the manufacturer's instructions.An interview was conducted with Nurse #3 on 02/17/2026 at 12:05 PM. The Nurse was asked to explain the procedure when giving insulin using an insulin pen and Nurse #3 stated she gave the insulin by the five rights of giving any medication. When the Nurse was asked if she was aware of priming the insulin pen before giving the insulin the Nurse stated yes, I do remember that and realized that she did not prime the pen. She stated she should have primed the pen to 2 units to remove the air from the needle before she set the dial to 8 units. She indicated that she forgot to prime the pen.An interview was conducted with the Consultant Pharmacist on 02/17/2026 at 2:10 PM who explained that it was important to prime the needle when giving insulin via an insulin pen because it was important to remove the excess air from the needle to ensure the full dose of insulin was administered.During an interview with the Director of Nursing (DON) on 02/19/26 at 10:19 AM the DON stated Nurse #3 should have primed the insulin pen before administering the insulin to Resident #85.

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	345329	A. Building B. Wing	02/26/2026

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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 manufacturer guidelines, observations and staff interviews, the facility failed to label DuoNeb solution (inhalation breathing solution) with an open date for 1 of 3 medication carts (C and D medication cart) reviewed for medication storage.The findings included:Review of the manufacturer's guidelines for DuoNeb solution indicated: After opening the foil pouch individual vials of DuoNeb should be used within 14 days. On 02/17/26 at 2:30 PM an observation was made of the C and D medication cart accompanied by Nurse #1. The observation yielded an open and undated box of Duoneb solutions in the drawer of the medication cart and available for use. The delivery date on the box was 12/23/25.An interview was conducted with Nurse #1 on 02/17/25 at 2:30 PM who explained that the box of DuoNeb should be dated when opened because if the vials were not used within 7 days, then they should have been discarded. During an interview with the Director of Nursing (DON) on 02/19/26 at 10:30 AM the DON explained that the medication carts should be checked every day by the Nurse on the cart and making sure the DuoNeb solutions were dated was a part of the daily checks. The DON stated her expectation was that the Nurse who opened the box of DuoNeb solution should be the one who dated the box.

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	345329	A. Building B. Wing	02/26/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews, the facility failed to follow their Infection Control policy and Hand Hygiene policy when Nurse Aide #1 did not perform hand hygiene before applying clean gloves and Nurse Aide #1 nor the Unit Manager applied gowns while providing suprapubic catheter care on Resident #26. This deficient practice occurred for 2 of 7 staff members observed for infection control practices (Nurse Aide #1 and Nurse #4).The findings included:Review of the facility's policy and procedure entitled Hand Hygiene revised June 2025 read in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.Review of the facility's Enhanced Barrier Precautions policy last revised June 2025 read in part as follows: Enhanced barrier precaution (EBP) are utilized to reduce the transmission of multidrug resistant organisms (MDROs) to residents. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include dressing, providing hygiene, and changing briefs. EBPs are indicated for residents with indwelling medical devices regardless of MDRO colonization. Indwelling medical devices include urinary catheters. EBPs remain in place for the duration of the resident's stay or until resolution or discontinuation of the indwelling medical device (catheter) that places them at risk.An observation of suprapubic catheter care was conducted on Resident #26 on 02/18/26 at 2:00 PM by Nurse Aide (NA) #1 and Nurse #4. Upon entering the Resident's room both staff removed gloves from the personal protective equipment (PPE) tower that was mounted on the Resident's door and applied the gloves but did not apply a gown. An enhanced barrier precaution sign that indicated the specific PPE required which was a gown and gloves was posted on the door. NA #1 removed the dirty dressing from the Resident's suprapubic site then removed her dirty gloves and applied clean gloves without sanitizing her hands. The NA cleaned the suprapubic site and catheter tubing then removed her dirty gloves and without utilizing hand sanitizer she applied clean gloves. Nurse #4 then applied a dressing to the suprapubic site and removed her gloves and washed her hands.An interview was conducted with Nurse Aide #1 on 02/18/2026 at 2:20 PM. The NA was asked what precautions Resident #26 was currently on and the NA explained that it was enhanced barrier precautions and that she should have worn a gown while providing care to Resident #26. The NA continued to explain that she realized that she did not wash her hands between gloves changes which she should have. She stated she was nervous and forgot. On 02/18/2026 at 2:40 PM during an interview with Nurse #4 the Nurse explained that she did not know what type of precautions Resident #26 was on until she pulled his information up on the computer during the interview. The Nurse continued to explain that the Resident was on enhanced barrier precautions, and she should have worn a gown. She stated she did not pay attention to the enhanced barrier precaution sign posted on the Resident's door and that she did not do anything to Resident #26 that would warrant wearing a gown.An interview was conducted with the Director of Nursing (DON) on 10/19/26 at 10:06 AM. The DON explained that NA and the Nurse should have worn a gown for enhanced barrier precautions and that NA #1 should have washed or sanitized her hands between glove changes. She indicated both staff needed to be reeducated on enhanced barrier precautions.