STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources-Wilmington, Inc	2305 Silver Stream Lane Wilmington, NC 28401

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 staff, Responsible Party (RP), Nurse Practitioner (NP), and Medical Director, the facility failed to provide the necessary supervision to prevent Resident #1, a resident with severe cognitive impairment and a known history of an unsupervised exit, from leaving the facility at night without staff's knowledge when the outside temperature was 30 degrees Fahrenheit (F). On 2/9/2026 at approximately 11:55 PM, two individuals unknown to the facility who had been walking through the facility's parking lot, returned Resident #1 in her wheelchair to the facility and alerted Nurse #3 that they had found the resident outside by herself, sitting in a ditch. Staff were unaware the resident was missing and outside unsupervised. The facility's alarm device system (an electronic system utilized to manage wandering behaviors for residents by triggering an alarm and locking doors when a resident wearing an electronic monitoring device approached an exit) was not functioning at all exit doors. Resident #1, who wore an electronic monitoring device, was supposed to be on observational monitoring every 15 minutes, but these checks were not implemented. Resident #1 was last seen approximately 1 hour and 10 minutes prior to the time she was brought back to the facility. Resident #1 was not injured; however, there was a high likelihood of serious harm, injury, or death, with risks that included hypothermia (a lifeˆthreatening medical emergency that occurs when core body temperature drops below 95 F) and injuries from falling and/or being struck by a vehicle. This deficient practice affected 1 of 3 residents reviewed for accidents.Immediate Jeopardy began on 2/9/2026 when Resident #1 exited the facility unsupervised at night in below freezing temperatures. The immediate jeopardy was removed on 2/27/2026 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit and dementia with agitation. Resident #1 resided on the 200 hall.Resident #1's care plan, initiated on 10/23/2024 and last reviewed/revised on 12/8/2025, revealed a plan of care addressing cognitive loss/dementia or impaired thought processes related to dementia and a Brief Interview for Mental Status (BIMS) score of less than 13 (a score of less than 13 indicates cognitive impairment). Resident #1 displayed the following cognitive problems: inattention, disorganized thinking, and an altered level of consciousness. The interventions included asking yes/no questions to determine the resident's needs and cueing, reorienting, and supervising as needed. The care plan also indicated the resident experienced wandering. The interventions included ensuring the resident had properly fitting and appropriate footwear, equipping her with a device that alarmed when she approached exit doors, checking the device for proper functioning daily, and checking its placement every shift. Resident #1's care plan further indicated she was at high risk for falling related to cognitive function, weakness, and deconditioning. The interventions included for her to have a low bed with fall mats to both sides of bed, nonskid footwear, and staff to provide frequent checks for safety The quarterly Minimum Data (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set (MDS) assessment dated [DATE] indicated Resident #1 was severely cognitively impaired. She was dependent on staff for transfers to a wheelchair and was able to independently wheel 150 feet once seated. Resident #1 was coded for wandering behaviors that occurred 4-6 days a week and for wearing a wandering/elopement alarm device. An active physician's order (initiated on 10/2/2024) directed staff to check Resident #1 for proper alarm device placement, test the battery every shift, and check the alarm device expiration date and replace it prior to expiration.An interview was completed with the Director of Nursing (DON) on 2/25/2026 at 11:29 AM. She indicated that Resident #1 had exited the facility without supervision in the past (previously cited by the State Agency). She stated that the first time Resident #1 exited the facility, she had gotten approximately 20 feet from the front entrance of the facility and fell at the end of the sidewalk. The DON revealed that the facility's alarm device system had not been working properly since the beginning of January 2026. She indicated the audio alert signal was not functioning properly for the 200 hall exit door and they were unable to hear the alert when residents wearing a safety alarm device approached the door. She explained that the annunciator (the device that provided visible and audio alerts to staff when a resident wearing alarm device approached the door or exited the door) for the door was not functioning and the alarm for the 200 hall exit door was not able to be heard in the facility. She stated that all other doors in the facility were functioning. She further stated the system was unable to be repaired until 3/23/2026. She indicated in the interim, she had initiated every 15-minute checks by staff for safety for the residents who were identified as high risk for elopement, including Resident #1. The DON stated the nursing staff were supposed to be documenting the every 15-minute checks on the residents. An interview with the Administrator was completed on 2/25/2026 at 1:45 PM. The Administrator stated she was aware that the facility's alarm device system was not working properly for the 200 hall exit door. She indicated that she had contacted the door safety alarm company on 1/8/2026 regarding the system not functioning properly. The Administrator indicated that the alarm device company had sent a representative to determine the problem and identified that the annunciator needed to be repaired. She indicated that the project manager had informed her the repairs would be done on 3/23/2026. The Administrator indicated that in the interim, the nursing staff had implemented every 15-minute checks for the residents identified as at high risk of elopement. She reported that Resident #1 was at high risk for elopement. An interview was completed with the Maintenance Director on 2/26/2026 1:45 PM. The Maintenance Director stated he was the person responsible for changing the codes on the security alarm doors that exited to the outside of the facility. This included the 200-hall exit door. He further stated that the code was only given to staff members and that it was changed frequently. The Maintenance Director stated that he was aware the door alarm system had not been working properly for the 200 hall exit door due to annunciator not sounding. The Maintenance Director indicated that the system was going to be replaced by the manufacturer on 3/23/2026 because someone had tampered with the audio part of the system to try to decrease the loudness of the alarm. He stated that the 200 hall exit door was the only door affected, and that the front door and all other door alarm systems were operating. The Maintenance Director indicated that all of the doors would open after being pushed on for 15 seconds for fire safety, but the 200 hall exit door was the only door that was not alarming when a resident with an alarm security device approached the door or exited the door. Review of the February 2026 Medication Administration Record for Resident #1 revealed on 2/9/2026 on the 3:00 PM to 11:00 PM shift Nurse #1 documented the electronic alarm device was on Resident #1's left ankle and the battery was working. A telephone interview was completed with Nurse #2 on 2/26/2026 at 10:56 AM. Nurse #2 stated that she was the charge nurse on the 300 hall on the 3:00 PM to 11:00 PM shift on 2/9/2026. She further stated that at around 10:45 PM that night she observed Resident #1 self-propelling in her wheelchair on the 300 hall. Nurse #2 stated she called Nurse #1 and told her Resident #1 was on her hall. She indicated Nurse #1 came and retrieved Resident #1 from the 300 hall and took her back to the 200 hall. Nurse #2 stated that was the last time she observed Resident #1 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated they found her sitting in a ditch and assumed she was a resident at the facility. She stated she was unable to get any more information from them before they had taken off walking when she brought Resident #1 into the facility. Nurse #3 indicated she was not exactly sure which ditch they were talking about or if Resident #1 had fallen out of her wheelchair. Nurse #3 explained that she did not know the people that returned her to the facility, but that homeless people frequently cut across the back parking lot from the park that was located behind the facility. Nurse #3 stated she had gotten Resident #1 in the building and quickly applied several blankets on her because she (the resident) was complaining of being cold. Nurse #3 indicated it was very cold that night and Resident #1 was just wearing a light jacket, pants, shirt, and socks and shoes. She stated that she had quickly took Resident #1 to her room on the 200 hall, so she and the DON could take her vital signs and assess her for injuries. Nurse #3 indicated Resident #1's temperature was 98.0 F, her vital signs were stable, and she had no bruising, scratches, or dirt on her clothing. She explained that the resident did not appear to have fallen out of her wheelchair based on her appearance. She stated Resident #1 was not shivering and her lips were pink. Nurse #3 stated prior to Resident #1 being returned to the facility after the unsupervised exit, she had not seen Resident #1 that night and she was not aware Resident #1 was outside. Review of the medical record revealed Nurse #3 did not document her assessment of Resident #1 on 2/9/26. A telephone interview was conducted on 2/26/2026 at 4:25 AM with NA #2. NA #2 confirmed she was the NA assigned to care for Resident #1 on 2/9/2026 beginning at 11:00 PM through 2/10/2026 at 7:00 AM. She indicated that at the beginning of her shift the first thing she did was stock her cart with supplies for incontinence rounds. She stated she was answering call lights and was not conducting every 15-minute checks on Resident #1. She further stated that she thought Resident #1 was in bed during this time and that the nurse was conducting every 15-minute checks. NA #2 explained she was unaware Resident #1 was not in the facility until she was returned to the unit by Nurse #3.An interview was completed with Nurse Aide (NA) #1 on 2/25/2026 at 2:05 PM. NA #1 stated she was assigned to work the 200 hall on 2/9/2026 at 11:00 PM through 2/10/2026 at 7:00 AM. She stated that she was not the NA assigned to care for Resident #1 as she was working the back section of the 200 hall (Resident #1 resided on the front section of the 200 hall). NA #1 indicated she didn't know Resident #1 was missing and she had not seen her until Nurse #2 returned her to the unit in her wheelchair. She indicated that it was about 12:00 AM when Resident #1 was returned to the unit. NA #1 stated that the assigned nurse was responsible for conducting every 15-minute checks on the residents on her assignment that wore alarm devices. She indicated that it was everyone's responsibility to keep an eye on the residents wearing the alarm devices. An interview with the Administrator was completed on 2/25/2026 at 3:25 PM. The Administrator stated that there had been some security camera videos of the incident that occurred on 2/9/2026 involving Resident #1 exiting the facility without staff knowledge or supervision. She further stated that the view of the 200 hall exit door from the security camera was obscured by a tree and the dumpster area. The Administrator indicated that they had determined Resident #1 must have exited from the 200 hall door by process of elimination because the other exit doors were visible on the security camera and the resident had not exited through any of those doors. The Administrator explained that the only video footage that had shown Resident #1 was of her being pushed across the back parking lot by two people to the 100 hall door on 2/9/2026 at 11:55 PM. The Administrator indicated the facility was unable to determine the exact time of exit but none of the staff recalled seeing her after 10:45 PM. During an interview with the Administrator on 2/25/2026 at 1:45 PM she stated that she no longer had the security camera video from 2/9/2026 of Resident #1 being outside. She explained that the security system tapes were recorded over every 7 days. An observation of the 200 hall exit door and the back parking lot was conducted in the presence of the Administrator on 2/25/2026 at 3:45 PM. The 200 hall exit door was a fire door that led to the back parking lot of the facility. The Administrator entered the code to exit the door and explained that if someone pushed on it for 15 seconds it would open due to fire safety regulations. Upon exiting the 200 hall door there was a tree with branches that (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	obscured the full view of the exit door. There was a sidewalk to the right of the 200 hall exit door that led to the 300 hall door and to the left led into the staff parking lot. Directly in front of the 200 hall door was a dirt path that went into the trees behind the facility. The dirt path was covered with pine needles and led down to a 2-lane road approximately a hundred yards from the 200 hall exit door of the facility. During the observation, two random men wearing coats and backpacks emerged from the woods and cut across the back of the parking lot. There were 2 large security light poles and security lights were observed on the building. The staff parking lot to the left of the 200 hall door led to a large approximately 8-foot-deep ditch and a water retention pond with a fence around it. The facility was the last building on the street and there was a cul-de-sac that led to the guest parking lot in front of the building and the staff parking lot was in the back of the building.An interview with the DON in the presence of the Administrator was completed on 2/25/2026 at 3:15 PM. The DON stated that she had received a call from the facility on 2/9/2026 around 12:00 AM regarding Resident #1's elopement and she had arrived at the facility within minutes. She stated the facility had immediately conducted a full census bed count and all residents were accounted for. The DON stated that she assessed Resident #1 for any injuries and there were no bruises or scratches upon assessment. She stated that Resident #1's vital signs were within normal limits and her temperature was 98.0 F. The DON indicated the nursing staff were supposed to conduct every 15-minute checks on Resident #1, but the incident occurred because it happened around the change of shift and there was some ambiguity about who was responsible for performing the 15 minutes checks at the time of the incident. She explained that because Nurse #1 was still in the building completing her documentation after 11:00 PM, Nurse #1 had not technically handed over the front hall assignment to conduct every 15-minute checks on Resident #1. The DON stated that she believed Resident #1 was outside the facility for less than an hour, but they could not determine the exact time of exit. She stated that none of the nursing staff recalled seeing Resident #1 after 10:45 PM on 2/9/2026. The DON indicated that according to the staff assignment sheets, MA #1 and NA #2 were the staff members that were responsible for every 15-minute checks on Resident #1 on 2/9/2026 beginning at 11:00 PM through 2/10/2026 at 7:00 AM. She explained that there was a list of residents that were identified as high risk for wandering assigned to each medication cart that the nurse or MA were responsible for performing every 15-minute checks on. During an interview with the DON on 2/25/2026 at 11:29 AM she indicated that the investigation into the 2/9/2026 incident revealed Resident #1 had exited through the 200 hall fire door at the back of the building and was returned to the facility at the 100 hall back door at approximately 11:55 PM by two individuals who were walking through the parking lot. She stated that homeless people frequently cut through their parking lot from the trees behind the facility to the street. An interview was completed with Resident #1's Responsible Party (RP) on 2/25/2026 at 1:35 PM. The RP stated that she was notified by a nurse on 2/9/2026 at around midnight that Resident #1 had been found outside the facility. She stated she was very concerned because it had been extremely cold that night. The RP reported that the Administrator had shown her a few video clips from security camera footage depicting Resident #1 being pushed in her wheelchair across the parking lot toward the facility door by two individuals who had found her outside while walking by. She stated that Resident #1 had been dressed in a shirt, pants, a light jacket, and shoes, but her hands and face had no protection from the cold.An interview was completed with the Nurse Practitioner (NP) on 2/26/2026 at 11:00 AM. The NP stated that the facility had called the on-call provider that night at 12:25 AM and informed them that Resident #1 was found outside without supervision for an undetermined amount of time. She stated that according to the message Resident #1's vital signs were stable. The NP indicated there was a high risk for an elderly person to develop hypothermia from being outside even a short period of time with a temperature outside below 32 degrees F. The NP indicated Resident #1 had dementia and was not safe to be outside alone. She explained Resident #1 was at high risk for elopement, had exited the facility without staff supervision before, and had sustained a laceration (cut) to her head during the previous incident. The NP stated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she had assessed Resident #1 for any injuries and checked her skin on 2/10/2026 and there were no bruises or scratches on her. The NP stated that if Resident #1 had fallen out of her wheelchair, she would have expected her to have some kind of injury. A telephone interview with the Medical Director was completed on 2/26/2026 at 1:38 PM. The Medical Director stated that the greatest risk for Resident #1 being outside for any length of time in below 32-degree temperature without protection from the cold would be hypothermia. The Administrator was notified of Immediate Jeopardy on 2/25/2026 at 4:35 PM. The facility provided the following immediate jeopardy removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #1 was admitted to the facility on [DATE] with diagnoses of dementia, severity, with agitation. Resident #1's baseline cognitive status was confused. Resident #1 was able to self-propel via wheelchair throughout the unit, at times requiring redirection to her room. Resident #1 had a history of exit seeking behavior and was considered a high risk for elopement. Resident #1 was on 15-minute checks, which were supposed to be completed by nursing staff. These checks were assigned to the nursing staff that were assigned to the resident. However, any staff on the unit that have checked on the resident could also provide a 15-minute check as needed. On the evening of 2/09/2026 at approximately 11:55 pm, Resident #1 was escorted from the parking lot into the facility by non-facility staff. Facility staff conducted a full census bed count immediately. All residents were accounted for. Upon return to the facility, Resident #1 was assisted to her room by Nurse #3. The Director of Nursing (DON) performed a comprehensive assessment of Resident #1. Resident #1 did not have any observed injuries or other adverse findings. Her body temperature was 98 degrees Fahrenheit. Her skin was intact. Her lips were pink and she was not observed to be shivering. She was dressed in pants, shirt, jacket and shoes and socks. Resident #1 was alert and oriented to person. Resident #1 does not remember being outside and is unable to explain where she was going/what she was doing. According to Nurse #1 and Nurse #2, the resident had last been observed on 2/09/2026 at 10:45 pm. She was being returned to her unit from another area at that time. Resident #1 was continued on 15-minute monitoring checks. There were no subsequent attempts to exit the facility without supervision. Resident #1 has been placed on one-to-one monitoring beginning on 2/25/2026. One to one monitoring will continue until an electronic monitoring device can be applied. This will occur when the annunciator to the door alarm is repaired or she is able to transfer to a facility with a secure, locked unit. The annunciator is what produces the alarm sounds at the nursing stations. The quote for the repair was received on 1/14/2026 and was signed the same day by the Administrator. On 1/23/2026 the Administrator was informed by the project manager that the soonest this task could be completed would be 3/23/2026. The resident's representative and physician were notified of the incident by facility nursing staff on 2/10/2026 at 12:05am. An investigation into the incident was completed on 2/10/2026 by the Administrator and it was found that the resident had exited the 200-hall door. It was determined that Resident #1 exited the 200-hall door by reviewing security footage of each exit door. Through process of elimination, we were able to determine that Resident #1 did not exit through any other door. Resident #1 is identified in the cameras that have view of the area of the 200-hall door. During staff interviews, it was determined that 15-minute checks were not completed during shift change and for the scheduled check that followed. The staff assigned to care for the resident was responsible for the 15-minute checks, however, it had not been made clear which staff (outgoing or incoming) would complete these checks and at what time the 15-minute checks ended for one staff member and started for another. Formal assignments were not made during this event, which led to confusion about who was actually performing the task. An Elopement assessment was completed on Resident #1 on 2/25/2026 by the DON. It was determined that Resident #1 was at continued risk for elopement. Resident #1's picture and name remain in the elopement book. The elopement book contains enlarged photographs and names of residents at risk for elopement. This book is maintained at the nursing station and front desk at the facility. A Resident experiences wandering care plan was revised by the DON on 2/25/2026 to include one to one (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitoring. This care plan also included the following: remove resident from other residents' rooms and unsafe situations; when the resident begins to wander, provide comfort measures for basic needs (e.g. pain, hunger, toileting, to hot / cold , etc.); and provide care, activities, and a daily schedule that resembles the resident's prior lifestyle. An audit was completed by the Administrator on 2/10/2026. The Administrator reviewed all residents who are currently at risk for elopement to ensure that appropriate interventions are in place to prevent elopement and ensure resident safety. This was done by reviewing the Elopement Risk Assessment. This assessment assists in determining who may be at high risk for elopement. It was determined that 11 residents are at high risk of elopement. None of these additional residents have exited the facility and continue on 15-minute checks. The 15-minute checks will be on-going for all high-risk residents until the wanderguard annunciators are replaced on 3/23/2026. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.A wanderer custom banner flag was added to the face sheet of all residents identified as being high risk for elopement. This was completed by the DON on 2/25/2026.A list of all residents with this banner flag will be maintained by the DON/designee and will be placed in front of the elopement books at each nursing station and the receptionist desk.An elopement drill will be conducted by the Maintenance Director on 2/26/2026. The purpose of this drill is to heighten awareness for all staff. This drill will entail the Administrator/designee safely move a resident to an undisclosed location, announcing CODE FIND (which is the facility's emergency code for a missing resident) and observing the actions of staff to determine appropriate actions per the Elopement policy. Discussions occur after the drill to highlight successes and failures of the actions. A 15-minute Resident Monitoring Tool was revised by the Corporate Compliance Manager on 02/26/2026 to include instructions for the initiation and completion of the tasks required for 15-minute checks. The revisions include the formal assignment of staff to perform 15-minutes checks, how to complete the form, who to give the form to when completed, and time changes to shifts so that the off-going shift will complete the check on the hour to ensure the oncoming shift has time to get report and assignments. The process for assignments has been revised to include the following:The assignment sheets for 15-minute monitoring checks will be completed by the DON/designee. The NA assigned to care for the resident will be assigned the responsibility of completing the 15-minute checksThe nurse in charge on the unit will delegate who will cover the checks as needed. All facility staff will be in-serviced beginning 2/25/2026 by the Staff Development Coordinator (SDC), DON and/or RN Supervisor on the above and the following: Elopement Policy: Procedures to determine residents at high risk for elopement and actions to take when a high-risk resident exits the facility unsupervised. Location of the elopement book with information on who has been identified as an elopement risk. 15-minute monitoring checks - purpose, procedure, documentation. Staff that are being in-serviced will perform a teach-back method to the individual providing the education. The teach-back method is where the staff being educated will repeat, in their own words, what they need to know or do regarding what the task is and the importance of it. The importance of supervising residents and ensuring that residents are safe while in the facility. Ensuring that during shift change, breaks and mealtimes, another employee is assigned to complete the checks. Any facility staff out on leave or on PRN (as needed) status will be educated prior to returning to duty by the Director of Nursing, Staff Development Coordinator, and/or the Nursing Supervisor. The Director of Nursing, Staff Development Coordinator and the Nurse Supervisor were advised of this responsibility on 02/25/2026 by the Administrator. The SDC will be responsible for tracking staff that have not received the education. Any newly hired staff are educated on the policy and procedures during orientation by the Staff Development Coordinator/designee. The Administrator and the Director of Nursing will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy. Immediate Jeopardy Removal Date: 02-27-2026 The immediate jeopardy removal plan was validated on 3/2/2026. Resident #1 was observed to have a 1:1 sitter with her at all times. The audit conducted on 2/10/26 was verified. The education sign in sheets were reviewed for the in-services conducted with [TRUNCAT