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	05/22/2026

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, resident, and the Physician Assistant, the facility failed to transfer Resident #17 using a mechanical lift, placing the resident at risk for an avoidable injury. On 11/19/25, Nurse Aide #1 attempted to transfer Resident #17 from her bed using a slide board (a board used to transfer a resident from one sitting position to another such as chair, bed, etc.). At the time of the transfer, staff had not yet been educated or trained by the Therapy Department for the use of a slide board for transferring Resident #17 and Resident #17 fell to the floor. Results from x-rays noted a fractured left humerus (long bone in the upper arm), mildly displaced fracture of left tibia (shin bone) and right medial malleolus (inner side of ankle), and a partial dislocated shoulder. Resident #17 was sent to the Emergency Department for further evaluation. The hospital record revealed the Orthopedic Department (bone specialist) was consulted and recommended non operative management of fractures. The right ankle was splinted and left arm brace was placed, and 2) failed to prevent a moderately cognitively impaired resident who was identified as high risk for elopement and with prior exit seeking behaviors, from exiting the facility without a staff member present. This deficient practice affected 2 of 7 residents reviewed for accidents (Resident #27 and Resident #17). Findings included: 1. Resident #17 was admitted to the facility on [DATE]. Diagnoses included stroke with left sided weakness, contracture to left hand and left ankle. Review of the Minimum Data Set quarterly assessment dated [DATE] revealed Resident #17 was cognitively intact. She was dependent (Staff member does all of the effort. Resident does none of the effort to complete the activity; or the assistance of 2 or more staff members were required for the resident to complete the activity) with transfers. A one page copy of a care plan provided by the facility indicated Problem Start Date 01/09/25 Point of Care Resident Profile (a section in the residents' electronic record that was accessible to all nursing staff. The section included how to transfer a resident): Standards of Care Required for Resident with an Approach Start Date of 01/09/25 and discontinued on 11/21/25. The approach was: discontinued devices for ambulation / transfer: may use sliding board transfers per resident request. The discontinued reason was documented as no longer needed. A care plan dated 01/09/25 revealed a point of care resident profile: standards of care required for resident. Interventions included resident required maximum assist for all activities of daily living, bed mobility and hygiene and a mechanical lift. A physical therapy evaluation and plan completed by Physical Therapist (PT) #1 dated 11/04/25 was (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 - Actual harm Residents Affected - Few	reviewed. The evaluation indicated the reason for the referral was to evaluate Resident #17 to assess general functional mobility and wheelchair positioning due to reports of discomfort and attempts at out of bed time and a desire to be able to self-propel in a better fitting chair. The evaluation indicated the objective and short term goals for Resident #17 were as follows: Resident would demonstrate improved bilateral (both sides) hip flexion (bending) passive range of motion in order to facilitate improved comfort with seated position in a standard chair with a target date of 11/17/25. Resident would demonstrate improved sitting balance at the edge of the bed to require no more than a minimum assist while utilizing upper extremity support in order to improve core strength required for sustain out of bed sitting tolerance with a target date of 11/17/25. Resident would demonstrate tolerating sustained out of bed time greater than or equal to 4 hours in a wheelchair with necessary modifications for positioning/comfort in order to reduce bedbound behaviors and increase engagement in her long term care community with a target date of 12/01/25. The initial assessment on this evaluation by PT #1 revealed Resident #17's prior level of function was dependent when going from a sitting position to lying down position and lying down to sitting up on the side of the bed. Resident #17's transfer function was dependent with a mechanical lift. Resident #17's balance assessment indicated she required maximum assistance of 2 staff members to sit at the edge of the bed and was unable to sit unsupported. The assessment summary by PT #1 indicated Resident #17 presented with impaired postural control and profound core weakness associated with deconditioning and weakness from a prior stroke. There was no mention of Resident #17 being assessed to use a slide board to assist with transfers out of bed. A Physical Therapy Discharge Summary completed by PT #1 revealed Resident #17 was seen for 3 days during the 11/18/25 to 11/25/25 progress period. The discharge summary revealed Resident #17 demonstrated increased participation and motivation during this session, gradually progressing with her out of bed tolerance to 3 hours in recent sessions and progressing exceptionally well with regards to improving overall core strength. Progressive edge of the bed task was consistently introduced and tolerated well including postural holds and weight shifting with eventual successful incorporation of a slide board in order to minimize functional core usage. Transfer status remained as a mechanical lift with nursing staff secondary to the level of physical assistance needed and cueing strategies that were required with slide board usage during therapy sessions. Resident #17 sustained a fall from the edge of the bed on 11/19/25 with a nurse aide resulting in a left humerus fracture, anterior shoulder dislocation and right medial malleolus fracture. An interview was attempted with PT #1 on 05/21/26. PT #1 no longer worked at the facility and did not return the call. A phone interview was conducted with Nurse Aide (NA) #1 on 05/21/26 at 3:05 PM. NA #1 stated on 11/19/25 she was assigned to Resident #17 and she was attempting to get her out of bed. She stated therapy was supposed to be in the room with Resident #17 but they were not. She stated she moved Resident #17 to the edge of the bed and got her feet down on the floor and then placed the slide board under her buttocks. NA #1 stated the slide board was flat on the bed and was not across to the wheelchair when she asked Resident #17 to move forward a little and then she started to fall. NA #1 stated she broke Resident #17's fall and guided her to the floor. NA #1 stated at that time the Restorative Aide, Nurse #3 and a therapy staff member came into the room and they all transferred (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her with a mechanical lift back to the wheelchair. NA #1 stated the previous Rehabilitation (Rehab) Director told her it was okay to use the slide board to transfer Resident #17. NA #1 stated she did not receive any instruction or demonstration on how to use it, but she knew therapy was trying it out, so she thought it was okay to use. NA #1 stated using a slide board for Resident #17 was not on her resident care guide, and for as long as she worked at the facility (about a year), Resident #17 was always required to be transferred with a mechanical lift with two staff. NA #1 stated she should have waited for therapy to come into the room before she tried to transfer Resident #17 with the slide board. An interview was conducted with the Restorative Aide (RA) on 05/21/26 at 10:30 AM. The RA stated she was not in the room at the time Resident #17 fell on [DATE], but when she walked into the room and saw Resident #17 on the floor she went and told Nurse #3. She stated NA #1 was sitting on the floor with Resident #17 holding her up from behind. The RA stated she had only worked with therapy one time when therapy was trying the slide board with Resident #17. The RA stated Resident #17 was not at a goal yet to use it and no education was given to her to begin to use the slide board. The RA stated she had been working at the facility for 2 years and as long as she had been here, Resident #17 always used a mechanical lift with 2 staff members to get out of bed. A phone interview with Nurse #3 on 05/21/26 at 9:30 AM was conducted. Nurse #3 reported on 11/19/25 she was the nurse assigned on the hall Resident #17 resided on. She stated she was in a room with another resident, and the Restorative Aide came and notified her that Resident #17 was on the floor in her room. Nurse #3 stated when she entered the room, she noticed Resident #17 sitting on the floor and Nurse Aide (NA) #1 was sitting on the floor keeping Resident #17 propped up in a sitting position. Nurse #3 reported she completed a head-to-toe assessment on Resident #17 and she did not have any complaints of pain at the time and she was transferred to the wheelchair with four staff members using the mechanical lift. Nurse #3 stated Nurse Aide #1 was using a slide board and Resident #17 was a not a safe transfer with a slide board. Nurse #3 stated Resident #17 always required a mechanical lift with the assistance of two staff members whenever she was transferring out of bed. Nurse #3 stated that therapy was working with Resident #17 to use a slide board, but it had not been signed off by therapy for staff to use. Nurse #3 explained that once the Therapy Department determined a resident was at goal with a task, they would write a communication slip and instruct by demonstration to the nurses and nurse aides how the task should be done. Nurse #3 stated she never received any demonstration or education to use a slide board on Resident #17. She stated once the communication slip was done, the Director of Nursing would update the care plan and resident care guide (a reference for nursing staff to know how to transfer a resident) to reflect how the resident should be transferred. Nurse #3 stated on 11/19/25 after Resident #17 was transferred to her wheelchair she went to her hair dressing appointment, and it was not until later that day that Resident #17 said she was in pain in her left arm and she notified the provider and obtained an order for x-rays. Review of a summary of investigation form completed by Nurse #3 dated 11/19/25 revealed a Nurse Aide tried to use a sliding board to transfer resident to the wheelchair. The Nurse Aide had to let resident slide to the floor. Resident did not hit her head and was assisted to the wheelchair with four staff members using a mechanical lift. A physician's order written on 11/19/25 revealed an order entered by Nurse #3 to x-ray Resident #17's left arm. A progress note written on 11/19/25 at 10:22 PM by Nurse #5 revealed the x-ray company called the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at the proximal mid humeral shaft and anterior inferior subluxation (partial dislocation) of the humeral head (shoulder). The CT scan results for the right ankle revealed severe osteopenia, mildly displaced distal tibial fracture involving the medial malleolus (inner side of ankle). The hospital record revealed the Orthopedic Department (bone specialist) was consulted and recommended non operative management of fractures. The right ankle was splinted and left arm brace was placed. Resident was non weight bearing to left upper extremity and non-weight bearing to right lower extremity with left side residual weakness from a stroke to left upper and left lower extremities. Resident was discharged in stable condition back to the skilled nursing facility on 11/23/25. A progress note written by Nurse #3 on 11/23/25 at 12:46 PM revealed Resident returned to facility from hospital. Resident received pain medication prior to discharge and voiced no pain. Sling noted to left arm and right foot in soft cast/brace. A progress note written by Nurse #5 on 11/23/25 at 10:48 PM revealed Resident in bed with sling to the left arm and soft cast to the right lower extremity. Medicated with Norco one tablet at 3:15 PM and 9:15 PM for pain relief with good results. Resident stating pain was improved and manageable. An interview was conducted with Resident #17 on 05/18/26 at 11:20 AM. Resident #17 reported that she was being transferred out of bed by a Nurse Aide who was using a slide board and she fell off the slide board, but the nurse aide tried to stop her from falling and lowered her to the floor. Resident #17 stated she dislocated her shoulder and broke her arm and ankle. Resident #17 stated no one else was in the room except for her and the Nurse Aide when she fell. Resident #17 stated she had been always transferred with a mechanical lift with 2 nurse aides but the therapy staff was working with her just before she fell to try and transfer her out of bed with a slide board. An interview was conducted with the current Rehabilitation (Rehab) Director on 05/21/26 at 9:36 AM. The current Rehab Director stated at the time of Resident #17's fall in November she was working as an as needed Physical Therapist Assistant (PTA) and was not the Rehab Director. The current Rehab Director reviewed the goals on the evaluation for Resident #17 dated 11/04/25. She stated none of the goals addressed transferring with a slide board. She stated in the middle of the treatment plan which ran from 11/18/25 thru 11/25/25, Physical Therapist (PT) #1 attempted transfer training with a slide board on Resident #17. The current Rehab Director stated at this point, using a slide board was only being done by therapy and no training or education was given to the nursing staff for them to use a slide board on Resident #17 per the treatment plan. The current Rehab Director stated the nurse aide who attempted to transfer Resident #17 on 11/19/25 should not have tried to transfer her with a slide board since it was only attempted in one session by therapy on 11/18/25. The current Rehab Director stated there was a process for nurses and nurse aides to utilize a slide board on a resident. She stated the slide board use would have been implemented after Resident #17 was trained for a couple of weeks and was able to complete the slide board transfer with one person, then the Therapy Department would demonstrate to the nurses and nurse aides and then have the staff do a return demonstration in front of therapy staff to show that they were able to do the transfer safely with one person. The current Rehab Director stated a communication slip was to be used to communicate any transfer changes and that she would not verbally tell staff without completing a communicate slip. The current Rehab Director stated she kept the communication slips on file and was not able to find any communication slip indicating Resident #17 was to use a slide board for transfers. The current Rehab Director stated the communication slip would then be given to the Director of Nursing and the MDS Nurse so that the care plan and resident care guide would be updated to reflect the new transfer status. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with NA #6 on 05/21/26 at 10:37 AM. NA #6 stated she had worked at the facility for 6.5 years. She stated if she needed to know how to transfer a resident she would look at the resident care guide in the electronic record. She stated the resident care guide tells her everything she needs to know about a resident. NA #6 stated as long has she has been at the facility she has never known Resident #17 to use a slide board and her care guide says to use a mechanical lift with 2 staff members. An interview was conducted with MDS Nurse #1 on 05/21/26 at 11:10 AM. MDS Nurse #1 stated she was responsible for updating the care plans. She stated usually therapy would give her a communication slip to indicate any change in a resident's plan of care and she would use that communication slip to update the care plan. She stated she did not save the communication slips after she updated the care plan. She stated sometimes she would be told verbally in an Interdisciplinary Team (IDT) (includes Director of Nursing, MDS Nurses) meeting to make the change in the care plan. MDS Nurse #1 stated she was not able to see within the electronic record who entered the approach for using a slide board for transfers on 01/09/25 and she did not know how the Point of Care (resident care guide) was updated to reflect Resident #17 used a slide board. MDS Nurse #1 stated the interdisciplinary team just started updating the Point of Care during Interdisciplinary Team meetings when discussing new interventions but was not certain when it started but it was after Resident #17 fell. A phone interview was conducted with the previous Rehab Director on 05/21/26 at 3:26 PM. The previous Rehab Director stated she had started training the Restorative Aide the slide board transfer just before the fall but Resident #17 was not deemed appropriate for the slide board transfer at the time of the fall. The previous Rehab Director stated the only time nursing staff should have attempted to transfer Resident #17 with the slide board was if someone from the Therapy Department was in the room with them and they had received education on how to do it. The previous Rehab Director stated she was not in the room at the time of fall and added that someone came to her and told her Resident #17 fell. The previous Rehab Director stated she never told NA #1 that it was okay to use the slide board for Resident #17. The previous Rehab Director stated once the Therapy Department determined that Resident #17 was appropriate for the slide board, a demonstration would have been done with the nursing staff with a return demonstration to ensure the staff could transfer the resident safely. She stated a communication slip would then be filled out and given to the Interdisciplinary Team (IDT) to communicate that this was how the resident was going to transfer and the care plan would be updated. The previous Rehab Director stated the process was to use a communication slip and not share verbally. She added, she never verbally told any staff that Resident #17 was appropriate to use a slide board. She stated the communication slips had 3 carbon copies and she would keep a copy for the Therapy Department on file. An interview was conducted with the Physician Assistant (PA) on 05/22/26 at 10:00 AM. The PA stated that she did not know why the x-ray that was ordered on 11/19/25 did not actually get done until 11/21/25, but that at times the x-ray company had been known to take up to 48 hours to come out unless she put STAT (immediate) on the order which she did not. The PA stated she felt there was no delay in treatment and that on 11/20/25 she assessed Resident #17 and reported her arm did not look right, but she knew the x-ray was ordered. The PA stated she was made aware of Resident #17 having foot pain on 11/20/25 by Resident #17 and had x-rays for her right foot ordered too. She stated when the x-ray results resulted on 11/21/25 she reviewed the images and realized it was worse than she thought and saw that Resident #17 also had a dislocated her left shoulder, but when she assessed her on 11/20/25, Resident #17 had no concerns with her shoulder and she did not see any other concerns with her exam. The PA stated Orthopedics evaluated Resident #17 in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	provided supervision when outside on the porch, and on 4/22/26 the intervention for every 15- minute checks by staff for safety. Resident #27's care plan further indicated she was at moderated to high risk for falling related to cognitive function, weakness, and deconditioning. The interventions included encouraging her to use rollator walker with all transfers and ambulation. On 4/22/26 the intervention for every 15 minutes by staff for safety was added. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #27 was moderately cognitively impaired. She was independent with transfers and was ambulatory with a walker. Resident #27 was not coded yes for wandering or having a wander/elopement alarm. Review of the May 2026 Medication Administration record for Resident #27 revealed on 5/5/26 the 7:00 AM to 3:00 PM Nurse #11 documented that the safety alarm device was on the resident's right wrist. Medication Aide #1 (MA #1) documented the safety alarm device was not on her wrist on the 11:00 PM to 7:00 AM shift. Nurse #9 who was working the 3:00 PM to 11:00 PM shift didn't document whether the safety alarm device was on or not. An interview with Nurse #9 was conducted on 5/21/26 at 9:06 PM. Nurse #9 stated that Resident #27 had removed her safety alarm device on 5/5/26 and they had not been able to find it. She further stated that Resident #27 had refused to allow staff to place another safety alarm device on her. Nurse #9 indicated that she must have forgotten to document on the MAR on 5/5/26 that Resident #27 had removed her safety alarm device. She stated that she had made the DON aware that Resident #27 was not wearing a safety alarm device on 5/5/2026. Nurse #9 indicated that Resident #27 was on every 15-minute checks by staff. An observation and interview with Resident #27 were conducted on 5/19/26 at 1:19 PM. Observation of Resident # 27 in her room revealed she was not wearing an safety alarm device. Resident #27 stated she was not wearing a safety alarm device. She indicated she didn't want to wear a safety alarm device and didn't like it. On 5/19/26 at 4:56 PM the survey team exited the facility and observed Resident #27 sitting outside on the right side of the front porch of the facility without staff supervision. A survey team member immediately notified the Evening Receptionist that Resident #27 was outside while the remaining team members stayed with Resident #27. At 5:02 PM the Business Office Manager assisted Resident #27 back into the building. An interview with the Evening Receptionist was conducted on 5/19/26 PM at 5:00 PM. The Evening Receptionist stated she was aware Resident #27 was outside on the porch. She further stated that Resident #27's safety alarm device had not set the alarm off when she approached the door, so she thought it was okay for the resident to go outside. The Evening Receptionist did not report what time Resident #27 went outside. The Evening Receptionist indicated she was aware that Resident #27 was identified as a high risk for elopement and that her information was in the High Risk for Elopement book at the desk. She indicated she was educated regarding residents with high risk for elopement prior to today. The Evening Receptionist stated she was aware Resident #27 went outside but she was not able to see her from behind the receptionist desk. An interview with Business Office Manager was completed on 5/21/26 at 11:52 AM. The Business Office Manager stated her office was right behind the receptionist desk in the front lobby of the facility. She further stated that on 5/19/26 at approximately 5:00 PM she had overheard the Evening Receptionist telling another staff member that Resident #27 was outside unsupervised. The Business (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Office Manager indicated she was the staff member that went outside and assisted Resident #27 back into the facility. She stated she had received training regarding residents with high risk for elopement. An interview with Nurse #10 was completed on 5/22/26 at 7:44 AM. Nurse #10 stated she was the nurse assigned to Resident #27 on 5/19/26 at 5:00 PM. She further stated that she had observed Resident #27 ambulating with her walker down the hall towards the dining room a little before 5:00 PM. She indicated she had documented DR for dining room on the facility 15-minute Observation Monitoring Tool sheet. Nurse #10 stated Resident #27 was in the dining room eating at 5:15 PM and she had documented DR on the monitoring tool. She indicated she was unaware that Resident #27 was outside without staff supervision on 5/19/26 in between the 15-minute c

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to ensure the dumpster area and exterior exit leading to the dumpster area remained free of garbage and refuse for 2 of 2 dumpsters. This failure had the potential to attract pests and rodents. Findings included: An initial observation of the kitchen exterior exit leading to the dumpster area with the two dumpsters was made on 5/18/26 at 11:37 AM with the Dietary Manager (DM). Observed next to the dumpster area wall were scattered leaves, broken tree limbs, a discarded large white wooden door, a large pile of broken pieces of white door trim, seven intact wooden pallets, and a large quantity of scattered cigarette butts. A follow-up observation of the kitchen's exterior exit leading to the dumpster area was made on 5/20/26 at 8:10 AM with the Dietary Manager (DM). The area remained in the same condition observed on 05/18/26 and in addition, there were 11 total intact wooden pallets, a large plastic discarded children's play kitchen and two full 20-gallon plastic garbage cans at the kitchen exit door. The DM said she was aware the area should have been cleaned up by Maintenance months ago, she had asked them, but nothing had been done. A follow-up observation of the kitchen's exterior exit leading to the dumpster area was made on 5/20/26 at 9:15 AM with the Maintenance Assistant and Dietary Manager (DM). The area remained in the same condition as observed on 5/20/26. The Maintenance Assistant stated the dumpster and kitchen exit areas should have been cleaned up by maintenance months ago but just hadn't got around to cleaning up the areas yet. A follow-up observation was conducted of the kitchen exit area and dumpster area on 05/20/26 at 9:55 AM with the Administrator. She stated she expected maintenance and kitchen personnel to ensure the dumpster area to be free of debris and refuse, which currently was not, and a potential for pests and rodents. A follow-up observation and interview were conducted of the kitchen exit area and dumpster area on 05/20/26 at 12:41 PM with the Maintenance Director and District Dietary Manager. Observed up against and around the dumpster area wall included: Scattered leaves, broken tree limbs, discarded large white wooden door, large pile of broken pieces of white door trim, 11- intact wooden pallets, and large quantity of scattered cigarette butts, a discarded children's play kitchen, as well as two full 20-gallon plastic garbage cans near the kitchen exit. The Maintenance Director stated it was the responsibility of Dietary and Maintenance to ensure the area around the kitchen exit and dumpster area to be clean and free of debris and was not. The Maintenance Director stated he knew for a couple of months that the refuse and garbage by the dumpster, and kitchen area should have been removed but he had not gotten to it yet. A follow-up interview was conducted on 05/20/26 at 3:00 PM with the Administrator. She said she expected maintenance to ensure the exterior exit leading to the dumpster area and dumpster area were free of debris and cleaned up within the next couple of weeks and not remain a potential home for pests and rodents.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and Nurse Practitioner interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of psychotropic medications for 9 of 9 residents reviewed for unnecessary medications (Resident #8, #31, #46, #84, #27, #12, #3, #6, and #9). Findings included: a. Resident #8 was admitted on [DATE] with a diagnosis of depression. Review of Resident #8's electronic health record revealed physician orders dated 3/23/26 for duloxetine (an antidepressant) 60 milligrams (mg) twice per day, lorazepam (an antianxiety medication) 0.5 mg four times per day and Seroquel (an antipsychotic medication) 25 mg twice per day. Review of Resident #8's electronic health record revealed no consent form dated 3/23/26 for the psychotropic medications duloxetine, lorazepam and Seroquel. There was no evidence that the resident or resident representative were informed in advance of the risks and benefits of the psychotropic medications. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that Resident #8 had a severe cognitive impairment, demonstrated no behaviors, and received the following psychotropic medications: antipsychotics, antianxiety and antidepressant medications. Review of Resident #8's electronic Medication Administration Record (MAR) for March 2026 revealed that the resident received the psychotropic medications duloxetine, lorazepam and Seroquel daily as ordered. b. Resident #31 was admitted on [DATE] with diagnosis that included dementia and depression. Review of Resident #31's electronic health record revealed physician orders dated 11/3/25 for mirtazapine (an antidepressant) 7.5 mg at bedtime for insomnia and sertraline (an antidepressant) 50 mg once daily for depression. Review of Resident #31's electronic health record revealed no documentation of consent for the administration of mirtazapine and sertraline dated 11/3/25. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of psychotropic medication. Review of Resident #31's electronic MARs from November 2025 through May 2026 revealed the resident received the psychotropic medications mirtazapine and sertraline daily as ordered. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #31 had a severe cognitive impairment, demonstrated no behaviors, and received the following psychotropic medication: antidepressant. c. Resident #46 was admitted on [DATE] with diagnosis which included Parkinson's disease and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dementia with behaviors including restlessness, agitation, resisting care and verbal behaviors. Review of Resident #46's electronic health record revealed an order dated 2/12/26 for Seroquel (an antipsychotic medication) 25 mg twice daily. Review of Resident #46's electronic health record revealed there was no consent form for Seroquel dated 2/12/26. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. Review of Resident #46's electronic MARs for February, March, April and May 2026 revealed that the resident received the psychotropic medication Seroquel 25 mg twice daily as ordered. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #46 had a severe cognitive impairment, demonstrated verbal behaviors and rejection of care, and received an antipsychotic medication. d. Resident #84 was admitted on [DATE] with diagnosis of hypertension and depression. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #84 had a severe cognitive impairment, demonstrated no behaviors, and did not receive any psychotropic medications. Review of Resident #84's electronic health record revealed that the face sheet demographic information listed the resident as his own responsible party. Review of Resident #84's electronic health record revealed a physician order dated 5/6/26 for mirtazapine (an antidepressant) 7.5 mg at bedtime for insomnia. Review of Resident #84's electronic health record revealed no resident or responsible party consent signed and dated 5/6/26 for mirtazapine 7.5 mg at bedtime for insomnia. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. Review of Resident #84's electronic MAR for May 2026 revealed that the resident received the psychotropic medication mirtazapine 7.5 mg at bedtime daily starting on 5/6/26. e). Resident #27 was admitted to the facility on [DATE] with a diagnosis of dementia and anxiety. Review of the Resident #27's physicians' orders revealed an order dated 2/4/2026 for quetiapine 25 milligrams (mg) tablet; administer 25 mg at bedtime for restlessness and agitation. Review of Resident #27's physicians' orders revealed an order dated 3/3/2026 for the antipsychotic medication quetiapine 25 (mg) tablet; administer one tablet twice a day for dementia. Review of Resident #27's electronic Medication Administration Records from 3/3/2026 through 5/21/2026 revealed that the resident was administered quetiapine 25 mg twice a day starting 3/4/2026. A review of Resident #27's electronic medical record (EMR) indicated no documentation that the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident or resident representative was informed in advance of the risks or benefits of initiating the psychotropic antipsychotic medication quetiapine prescribed for dementia on 3/3/2026. In addition, there was no documentation of consent to treat with the psychotropic medication quetiapine in the record. Review of Resident #27's annual Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #27 was moderately cognitively impaired and received an antipsychotic medication. f). Resident #12 was admitted to the facility on [DATE] with mild recurrent major depressive disorder and muscle spasms. Resident #12's physician orders revealed the following orders dated 12/22/2025 for the antianxiety medication diazepam 2 mg tablet; administer 2 tablets for 4 mg once day for muscle spasms and duloxetine 60 mg capsule; administer one capsule orally every day for mild recurrent major depressive disorder. Review of Resident #12's (EMR) indicated no documentation that the resident or resident representative was informed in advance of the risks or benefits of initiating the psychotropic medication duloxetine prescribed for depression and the antianxiety medication diazepam prescribed for muscle spasms. In addition, there was no documentation of consent to treat with the psychotropic medications duloxetine and quetiapine and diazepam in the record. Review of Resident #12's electronic Medication Administration Record from 12/22/2025 through 5/21/2026 revealed that the resident received the antidepressant duloxetine and the antianxiety diazepam as ordered. Review of Resident #12's quarterly MDS assessment dated [DATE] revealed he was cognitively intact and received an antianxiety medication and an antidepressant medication. g). Resident #3 was admitted to the facility on [DATE]. Diagnoses included, in part, schizophrenia and major depressive disorder. Review of Resident #3's electronic health record revealed a physician order dated 01/06/26 for Fluoxetine (an antidepressant) 40 milligrams (mg) daily and an additional order written on 04/13/26 for Fluoxetine 10mg daily. The order indicated Resident #3 was to take a total of 50mg daily effective 04/13/26. Review of Resident #3's electronic health record revealed there was no consent form dated 01/06/26 for the psychotropic medication Fluoxetine 40mg daily and no consent form dated 04/13/26 for the Fluoxetine 10mg daily for a total of 50 mg. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. Review of Resident #3's electronic health record revealed a physician order dated 01/06/26 for Buspirone (an antidepressant) 15mg twice daily. Review of Resident #3's electronic health record revealed there was no consent form dated 01/06/26 for the psychotropic medication Buspirone 15mg. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's electronic health record revealed a physician order dated 04/06/26 for Trazodone (an antidepressant) 150mg daily at night. Review of Resident #3's electronic health record revealed there was no consent form dated 04/06/26 for the psychotropic medication Trazodone 150mg. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #3 was cognitively intact, demonstrated no behaviors, and received the following psychotropic medications: antipsychotics, antianxiety and antidepressant medications. h). Resident #6 was admitted to the facility on [DATE]. Diagnoses included, in part, schizoaffective disorder, bipolar, anxiety, and depression. Review of Resident 6's electronic health record revealed a physician order dated 01/03/26 for Risperdal Consta (an antipsychotic medication) Extended Release 25mg/2milliliters (ml) give 25 mg intramuscular once every two weeks on Monday. Review of Resident #6's electronic health record revealed there was no consent form dated 01/03/26 for the psychotropic medication Risperdal Consta 25mg. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. The MDS quarterly review dated 03/01/26 revealed Resident #6 was moderately cognitively impaired, demonstrated no behaviors and received the following psychotropic medications: antipsychotics and antidepressant medications. i). Resident #9 was admitted to the facility on [DATE]. Diagnoses included, in part, anxiety, depression and dementia with behavioral disturbance. Review of Resident #9's electronic health record revealed a physician order dated 02/04/26 for Seroquel (an antipsychotic) 25mg twice per day and an order for Seroquel 50mg give with 25mg dose to equal 75mg daily at night. Review of Resident #9's electronic health record revealed there was no consent form dated 02/04/26 for the psychotropic medication Seroquel 25mg or 50mg. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. Review of Resident #9's electronic health record revealed a physician order dated 02/04/26 for Trazodone (an antidepressant) 50mg one tablet daily at night. Review of Resident #9's electronic health record revealed there was no consent form dated 02/04/26 for the psychotropic medication Trazodone 50mg. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. Review of Resident #9's electronic health record revealed a physician order dated 02/05/26 for Escitalopram Oxalate (an antidepressant) 5mg once daily. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's electronic health record revealed there was no consent form dated 02/05/26 for the psychotropic medication Escitalopram Oxalate 5mg. There was no evidence that the resident or resident representative was informed in advance of the risks and benefits of the psychotropic medication. The MDS quarterly review dated 03/24/26 revealed Resident #9 was moderately cognitively impaired, demonstrated no behaviors was receiving the following psychotropic medication: antidepressant medication. An interview with Nurse #1 on 05/20/26 at 2:40 PM revealed he believed the Admissions Nurse; the Director of Nursing or the Unit Manager were responsible for obtaining a consent for residents on psychotropic medication. He stated he had never obtained the consents for Resident #9's psychotropic medications. An interview was conducted with the Director of Nursing (DON) on 05/20/26 at 4:15 PM. The Director of Nursing stated that the nurses assigned to the resident were expected to obtain the consent for the psychotropic medications on admission and whenever the physician orders were changed with increases or any addition of a new medication. The DON stated that she was overall responsible to ensure that the consents was obtained prior to the medication being initiated. The DON confirmed that there were times that the consents were not obtained prior to the medication being administered. The DON indicated that she had been working on trying to improve the process of obtaining the consents and informing the resident and resident representative of the risks verses benefits of the psychotropic medications. The DON stated she has been trying to reeducate the staff about this but not all staff have been educated yet.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident and the Physician Assistant interviews, the facility failed to provide a resident with dignity and respect when she was not provided incontinence care when requested and was left in a soiled brief and felt gross as a result of having to wait. This was for 1 of 2 residents observed for dignity (Resident #3). Findings included: Resident #3 was admitted to the facility on [DATE]. The Minimum Data Set quarterly assessment dated [DATE] revealed resident was cognitively intact, with adequate vision and demonstrated no behaviors such as refusal of care. Resident #3 was fully dependent on all activities of daily living (ADL) care. Resident was always incontinent of bowel and had an indwelling urinary catheter. An interview with Resident #3, who had a tracheostomy (a procedure to include placing a breathing tube into the trachea or windpipe) and she wears a Passy Muir Valve (PMV) which is a one-way speaking and swallowing valve for tracheostomy residents to aide in verbally communicating, on 05/19/26 at 11:10 AM. Resident #3 revealed that on 05/13/26 she reported to Nurse Aide (NA) #3 at 12:30 PM she was incontinent of bowel in her brief. She stated she was already out of bed in her wheelchair and it would have required two staff members to put her back into bed to change her. She stated she was told by NA #3 that she could not get to her right now because she had to go to the dining room. Resident #3 reported she was not eating lunch so she was not eating while being soiled, but she wanted to go outside on the porch and did not want to go out smelling of poop. Resident #3 stated she had to wait until after lunch to be changed. Resident #3 stated she reminded NA #3 after lunch at 1:10 PM that she needed to be changed again and NA #3 stated she needed to find another staff member to assist with getting her changed. Resident #3 stated it was not until 2:50 PM that she was finally changed. Resident #3 stated she did not go outside on the porch and felt gross sitting in a brief filled with feces for almost 2.5 hours. A phone interview was conducted with NA #3 on 05/21/26 at 2:00 PM. NA #3 stated on 05/13/26 she was assigned to Resident #3. She stated Resident #3 required 2 staff members when providing incontinence care. NA #3 stated on 05/13/26, Resident #3 told her she was incontinent of bowel and needed to be changed. NA #3 did not recall the exact time, but she told Resident #3 she had to feed the residents in the dining room and she would take care of her when she got back. NA #3 stated it usually took 30 to 35 minutes in the dining room. NA #3 stated when she returned from the dining room, she was waiting for NA #2 to be available and assist her with changing Resident #3 which took about another 15 minutes. NA #3 stated Resident #3 had to wait about 45 minutes and was changed before 1:30 PM not 2:50 PM. NA #3 stated she knew Resident #3 was waiting to go out on the porch. An interview was conducted with NA #2 on 05/22/26 at 12:30 PM. NA #2 stated on 05/13/26 Resident #3 told her she was incontinent of bowel and needed to be changed about 1:00 PM. NA #2 stated she told Resident #3 she would let NA #3 know so that she could assist her. NA #2 stated she told NA #3 and NA #3 told NA #2 to give her a second. NA #2 stated she was not sure how long it actually took until NA #3 was ready to assist with changing Resident #3. NA #2 stated NA #3 was in the dining room, but she was back on the hall by 12:30 because lunch time was 12:00 PM in the dining room and usually took about 30 minutes. NA #2 stated when she and NA #3 changed her the bowel had not leaked through the brief and her skin was intact. An interview with Nurse #1 on 05/22/26 at 2:10 PM was conducted. Nurse #1 stated he was not made aware by Resident #3 or the nurse aides that Resident #3 was incontinent and needed to be changed. He stated had he been told he would have assisted NA #2 with changing Resident #3. An interview with the Director of Nursing (DON) on 05/22/26 at 3:00 PM revealed she would have expected NA #3 to assist with changing Resident #3 before she left for the dining room and not to let Resident #3 sit in her soiled brief. The DON added that this unit had 14 residents and had one of the nurse aides notified the Nurse, he could have assisted with changing Resident #3. The DON stated she had given education several times due to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple grievances to the staff on this unit that anytime another nurse aide was not available to assist with Resident #3, the nurse aides should be seeking help from the floor Nurse, a Unit Manager, other aides from other units, or herself to help assist. An interview with the Physician Assistant on 05/22/26 at 3:30 PM revealed there was no reason Resident #3 had to sit in her soiled brief for an extended period of time. The Physician Assistant stated she was not sure how long exactly Resident #3 sat in her brief but that it was close to an hour. The Physician Assistant stated no resident should have to sit in soiled brief for this long when staff were made aware she needed to be changed.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Physician Assistant (PA) interviews, the facility failed to notify the provider and responsible party (RP) of transfer from dialysis to the emergency department (ED) due to a shunt bleeding event at dialysis for 1 of 2 sampled resident reviewed for dialysis (Resident #2). Findings included:Facility's Dialysis Policy dated 7/9/23 read in part: Facility staff will monitor for any signs and symptoms of potential dialysis related complications, including bleeding. The facility staff will notify the resident's physician immediately of any of the above findings.Resident #2 was admitted on [DATE]. His medical diagnoses included end state renal disease (ESRD) and stroke.Reviewof Resident #2's Medical Administration Record (MAR) dated 5/2026 revealed to give Eliquis (a prescription anticoagulant/blood thinner used to prevent risk of stroke) 2.5 mg (milligram) twice daily due to stroke, and to monitor dialysis fistula site for sign or symptom of increased drainage. Further review of the medical record for Resident #2 revealed no documentation of the resident being sent to the ED from dialysis on 03/30/26. There was no documentation that the physician or the Resident's Responsible Party (RP) were notified of resident's 3/30/26 bleeding event at the dialysis center and transfer to the ED. A nursing note dated 3/30/26 at 10:22 PM from Nurse #8 revealed Resident #2 returned from hospital via ambulance on stretcher. His vital signs were within normal limits, with no bleeding noted through pressure dressing to fistula site. An interview was conducted on 5/19/26 at 8:25 AM with Nurse #6. She stated on 3/30/26 she neither the DON were not notified of Resident #2 being sent to the ED by the dialysis center, due to fistula bleeding. She stated the dialysis center should have notified the facility and resident's RP of the ED visit on 3/30/26 and did not.An interview was conducted on 5/20/26 at 8:25 AM with Nurse #6. She stated she was Resident #2's nurse on 3/30/26, which was resident's dialysis day. She said she assessed the resident that morning before dialysis and made sure he had a snack with him. She said she never received a call anytime throughout the day from dialysis saying they had transported the resident to the ED due to a fistula bleed. She stated it wasn't until the end of her shift, around 6:00 PM, that dialysis called, saying they had sent the resident to the ED. Nurse #6 said she thought the dialysis center would have contacted resident's Physician (MD) and RP when they first transferred him to the ED, so she did not have to. She stated now looking back she should have contacted resident's MD and RP when she was first notified around 6:00 PM from the ED, that Resident #2 was transferred to the ED from dialysis and to not have relied on the dialysis center to have notified them. She said it was her fault for not calling resident's MD and RP of resident's transfer to ED. A follow-up interview was conducted on 5/20/26 at 10:45 AM with Nurse #6. She stated on 3/30/26 she worked the 7:00 AM to 7:00 PM shift and was Resident #2's nurse. She stated around 6:00 PM she was notified by the hospital that Resident #2 was sent to the ED from dialysis due to fistula shunt bleeding while at dialysis. She stated she did not notify resident's RP or MD, because she thought dialysis would have done it since they were the ones who transferred the resident to the ED. She stated the dialysis center never contacted the facility that they had sent the resident to the ED. She said at the time, she thought the resident was still at dialysis until the hospital contacted her around 6:00 PM notifying her that they had transferred Resident #2 to the ED. The nurse stated she should have then immediately notified the MD and RP once she received the 6:00 PM phone call from the ED that Resident #2 was at the ED, and to not have expected the dialysis center to have notified MD and RP, since the resident was her patient and her responsibility, and not the dialysis centers. A follow-up interview was conducted on 5/20/26 at 10:50 AM with the DON. She stated the dialysis center contacted her on 03/31/26 to say that on 3/30/26 when Resident #2 was transferred from dialysis to ED, dialysis staff did not contact resident's RP or MD of the ED visit. DON stated that it was her expectation, that on 03/30/26, around 6:00 PM, when Nurse #6 first heard that Resident #2 was sent to the hospital from (continued on next page)

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	345537	A. Building B. Wing	05/22/2026

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis, that she should have immediately notified resident's RP and MD, since Resident #2 was still her patient, even though he was sent to the hospital from dialysis.An interview was conducted on 5/20/26 at 11:15 AM with the Physician Assistant (PA). She stated she was not notified on the evening of 3/30/26, that Resident #2 had been transferred to the ED from dialysis. She stated it was her expectation that Resident #2's physician should have been notified by his nurse the evening of 3/20/26 once the nurse was informed by the ED of the resident's transfer, so she could have then assessed the resident's situation and treated the resident if needed once he returned from the ED.An interview was conducted on 5/19/26 at 1:45 PM with the Administrator. She stated when Resident #2 was at dialysis on 3/30/26 his shunt site started to bleed so dialysis sent him to the ED for observation and treatment and failed to notify the facility or RP of the ED visit. The Administrator said the facility's nursing staff found out about the ED visit around 6:00 PM on 3/30/26 when the ED called the facility, informing them that Resident #2 was transferred from dialysis to ED, due to a fistula bleeding event, while at dialysis. The Administrator said the dialysis center should have notified the facility and RP of the ED visit and did not. She also said to the nurse, once she became aware Resident #2 transfer to the ED, she should have called the attending physician and resident's RP and did not.A follow-up interview was conducted on 5/19/26 at 3:47 PM with the Administrator. She said it was her expectation that when Nurse #6 was notified by the hospital around 6:00 PM on 03/30/26 that Resident #2 was at the ED, she should have immediately notified resident's MD and RP, since it was the facility's responsibility to notify resident's family and MD, and not dialysis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to provide incontinence care to 1 of 2 dependent residents reviewed for activity of daily living (ADL) care (Resident #9). Findings included: Resident #9 was admitted to the facility on [DATE]. Diagnoses included stroke and dermatitis (a broad term that describes various types of skin inflammation and skin rashes). Review of Resident #9's care plan revealed a plan of care updated on 01/23/2025 for urinary incontinence with a goal that Resident will be remain free from complications of incontinence such as skin breakdown and urinary tract infections (UTI). Approaches for this goal included to clean peri-area with each incontinent episode and observe for signs and symptoms of UTI such as pain, burning, blood tinged urine, no urine output, and change of behavior/mental status. The Minimum Data Set quarterly review dated 03/24/26 revealed Resident #9 was moderately cognitively impaired and did not have any behaviors such as refusal of care. Resident #9 required substantial to maximum assistance with personal hygiene and toileting and was coded as being frequently incontinent of bladder and bowel. An interview with Resident #9 on 05/18/26 at 10:30 AM revealed he asked his Nurse Aide to change him earlier this morning before breakfast and the Nurse Aide said he would be back and has not come back yet. The Resident's call light was not activated during the interview. Resident #9 stated his brief was very wet and he needed to be changed. Resident #9 stated the last time he was changed was during the night shift on 05/18/26. An interview was conducted with Nurse Aide (NA) #4 on 05/18/26 at 11:00 AM. NA #4 reported he had completed his rounds this morning on Resident #9 when he came in at 7:00 AM. NA #4 stated he was incontinent of urine at that time and he changed Resident #9. On 05/18/26 at 11:00 AM NA #4 was accompanied to Resident #9's room and NA #4 was asked to check on Resident #9 at this time. NA #4 pulled Resident #9's bed sheets down and stated when he checked Resident #9 this morning during rounds, he checked his chuck pad (a pad placed under the resident) and it was not wet so he thought Resident #9 did not need to be changed. NA #4 checked Resident #9's brief at this time and it was noted to be saturated with urine, and the chuck pad was dry. NA #4 then stated he did change Resident #9 this morning during his first round and Resident #9 stated, he absolutely did not! NA #4 then clarified that he did not actually change Resident #9 during his rounds this morning at 7:00 AM or when Resident #9 told him he needed to be changed before breakfast and that he just checked the chuck pad. NA #4 stated he should have checked Resident #9's brief and not the pad underneath the resident. Incontinence care was provided at the completion of the interview. An interview was conducted with the Treatment Nurse on 05/18/26 at 12:20 PM. The Treatment Nurse stated that Resident #9 had no skin breakdown to his peri area. An interview was conducted with the Director of Nursing (DON) on 05/22/26 at 3:00 PM. The DON reported she expected her nursing aide staff to be checking and changing residents every 2 hours during their rounds or whenever a resident requested to be changed. The DON stated NA #4 should have been checking the resident's brief and not the pad underneath him.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Physician Assistant (PA), and Pharmacy Services Director interviews, the facility failed to provide the discharge summary needed for the pharmacist to conduct a comprehensive medication review. As a result, the pharmacist did not identify a medication error, leading to the administration of 27 doses of the anticoagulant Eliquis (a prescription blood thinner used to prevent and treat blood clots and reduce stroke risk) for 1 of 5 residents reviewed for unnecessary medications (Resident #8). Findings included: Resident #8 was admitted on [DATE] with diagnosis which included atrial fibrillation (an irregular heart rhythm) and history of falls. Review of Resident #8's electronic health record revealed that the resident was discharged to the hospital on 3/18/26 due to weakness, recurrent falls and a fall with a head strike resulting in increased confusion. Resident #8 was readmitted to the facility on [DATE]. Review of Resident #8's electronic health record revealed a hospital Discharge summary dated [DATE] which indicated to discontinue the anticoagulant medication Eliquis due to repetitive falls and the risk of bleeding. A review of the hospital discharge summary listed medications which had not changed included Eliquis 5 mg two times daily. A handwritten notation indicated the medication Eliquis was crossed out with a notation to discontinue the medication initialed by the facility Physician Assistant (PA). A review of Resident #8's electronic physician orders included an order dated 3/23/26 at 11:36 AM entered by Nurse #12 for Eliquis 5 milligrams (mg) twice per day. The start date of the medication was 3/23/36. A review of Resident #8's electronic Medication Administration Record (MAR) for March 2026 indicated that Eliquis 5 mg was administered twice daily at 8:00 AM and 6:00 PM from March 23 through March 31, 2026, with the first dose administered on 3/23/26 at 6:00 PM (a total of 17 doses were documented as administered). A review of a New admission Pharmacy Review dated 3/23/26 completed by the Pharmacy Services Director indicated no medication therapy issues were identified upon initial review. An interview was conducted by phone with the Pharmacy Services Director on 5/20/26 at 3:15 PM. He stated that he completed the initial pharmacy review of Resident #8's medications when the resident returned from the hospital on 3/23/26. During this review, he did not identify any medication therapy issues. He explained that he relied on the physician orders entered into the computer and assumed they had been transcribed accurately. Although he had access to the electronic health record, he reported that he did not review the hospital discharge summary as part of his initial pharmacy assessment as this information was frequently not available at the time of the initial review.Review of Resident #8's electronic MAR for April 2026 indicated that Eliquis 5 mg was administered twice daily on 4/1/26, 4/2/26, 4/3/26, 4/4/26, and 4/5/26 (a total of 10 doses were documented as administered). An interview with the Physician Assistant (PA) on 5/20/26 at 1:30 PM stated that when Resident #8 returned from the hospital on 3/23/26, she documented on the paper copy of the medication orders from the hospital and in her clinical notes that Eliquis was to be discontinued. She emphasized that Resident #8 was at heightened risk of bleeding and other complications if she were to fall while receiving an anticoagulant. The PA reported that she later discovered Resident #8 had erroneously received Eliquis from 3/23/26 through 4/6/26, and the pharmacist had not identified the error on the initial medication regimen review.An interview with the Director of Nursing (DON) on 5/20/26 at 4:30 PM revealed that the hospital medication orders were not faxed to the pharmacy, resulting in the Pharmacist not having the orders when the admission medication regimen was completed. Although the Pharmacist would typically be able to access the orders once they were scanned into the resident's electronic health record, this scanning did not occur for several days. The DON acknowledged that the pharmacist's inability to obtain the orders in a timely manner affected their ability to complete an accurate medication review and represented a breakdown in the facility's process.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Physician Assistant (PA), Physician and Pharmacy Manager interviews, the facility failed to discontinue an anticoagulant medication following readmission to the facility resulting in 27 doses of the anticoagulant Eliquis (a prescription blood thinner used to prevent and treat blood clots and reduce stroke risk) administered in error to a resident that was a high fall risk. This occurred for 1 of 5 residents reviewed for unnecessary medications (Resident #8). Findings included: Resident #8 was admitted on [DATE] with diagnosis which included atrial fibrillation (an irregular heart rhythm) and history of falls. Review of Resident #8's electronic health record revealed that the resident was discharged to the hospital on 3/18/26 due to weakness, recurrent falls and a fall with a head strike resulting in increased confusion. Resident #8 was readmitted to the facility on [DATE]. Review of Resident #8's electronic health record revealed a hospital Discharge summary dated [DATE] which indicated that the resident was on a chronic anticoagulant medication for atrial fibrillation prior to hospitalization, however it was deemed unsafe for anticoagulant therapy to be continued due to repetitive falls. The hospital discharge summary indicated that a discussion was held in the hospital with Resident #8's Power of Attorney and the Physician. It was decided to discontinue the anticoagulant medication due to repetitive falls and the risk of bleeding. A review of the hospital Discharge summary dated [DATE] listed medications which had not changed included Eliquis 5 mg two times daily. However, a handwritten notation on the paper copy of the medication orders from the hospital indicated the medication Eliquis was crossed out with a notation to discontinue the medication initialed by the Physician Assistant (PA). A review of Resident #8's electronic physician orders included an order dated 3/23/26 at 11:36 AM entered by Nurse #12 for Eliquis 5 milligrams (mg) twice per day. The start date of the medication was 3/23/26. An interview was conducted via phone with Nurse #12 on 5/20/26 at 3:55 PM. Nurse #12 was identified as the nurse who inputted into the computer the medication order for Resident #8 for Eliquis 5 mg twice per day on 3/23/26. Nurse #12 stated that she had worked at the facility for a few months on an as needed basis and had only entered orders into the computer a few times. Nurse #12 reported that she was trained that the process was when a resident was admitted or readmitted the nurse received the admission packet with the medication list included and the orders were entered from that list. The Nurse stated that the provider reviewed the orders and made changes as needed. Nurse #12 reported the provider was supposed to check the orders before the nurse entered the medications into the computer. The Nurse stated that she did not recall what information she used to enter the orders for Resident #8 when she was readmitted on [DATE] and did not recall if she saw the written copy of the orders that the PA verified in which the medication Eliquis was discontinued. Nurse # 12 stated she was unaware that she had entered Resident #8's medication orders incorrectly resulting in a significant medication error. A review of the PA progress note dated 3/24/26 indicated that Resident #8 had experienced recurrent falls, and the risks of continued anticoagulation therapy were determined to outweigh the benefits. As a result, Eliquis was discontinued after the hospital physician discussed this with the resident's Power of Attorney during the recent hospitalization.An interview with the Physician Assistant (PA) on 5/20/26 at 1:30 PM revealed that Resident #8 was identified as high risk for falls upon admission on [DATE]. The PA stated that the anticoagulant Eliquis was contraindicated for Resident #8 due to her elevated fall risk and history of falls. The PA further explained that when Resident #8 returned from the hospital on 3/23/26, she documented in the paper copy of the medication orders from the hospital and in her clinical notes that Eliquis was to be discontinued and the resident was not to receive the anticoagulant. The PA stated that she reviewed the hospital documentation and was reassured to see that the hospital physician addressed the anticoagulant therapy with the resident's Power of Attorney, and Eliquis was discontinued at that time. She emphasized that Resident #8 was at heightened risk of bleeding and other complications if (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she were to fall while receiving an anticoagulant. A review of the resident's quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #8 had severe cognitive impairment and received an anticoagulant medication.A review of Resident #8's electronic Medication Administration Record (MAR) for March 2026 indicated that Eliquis 5 mg was administered twice daily at 8:00 AM and 6:00 PM from 3/23/26 through 3/31/26, with the first dose administered on 3/23/26 at 6:00 PM (a total of 17 doses were documented as administered).Review of Resident #8's electronic MAR for April 2026 indicated that Eliquis 5 mg was administered twice daily on 4/1/26, 4/2/26, 4/3/26, 4/4/26, and 4/5/26 (a total of 10 doses were documented as administered). A nursing progress note dated 4/6/26 at 8:46 AM written by Nurse #1 indicated that Resident #8 was noted sitting on the floor mat beside the bed. The resident stated she tried to get out of bed when she fell and hit her head on the side table. The note indicated Resident #8 voiced no complaints of pain or discomfort at the time of the incident and neurological checks were within normal limits. The provider was notified of the incident. A Physician Assistant (PA) progress note dated 4/6/26 at 1:30 PM indicated Resident #8 had a fall this morning in which she hit her head. The resident was seen after the fall. Resident #8 reported a headache but denied dizziness. Nursing reported Resident #8 had been receiving Eliquis since 3/23/26. The PA progress note indicated that this was a medication error which was discussed with the Director of Nursing (DON). A CT (computed tomography) scan of the head was ordered STAT (as soon as possible) instead of sending the resident out to the emergency department. If neurological checks changed or she developed signs and symptoms of head bleed or headache worsens the resident will be sent to the emergency department. Resident #8 was seen on afternoon rounds and continued to have a headache. A physician order dated 4/6/26 indicated to discontinue Eliquis 5 mg twice per day. A nursing progress note dated 4/6/26 at 6:00 PM written by Nurse #13 indicated that a new order was received to send Resident #8 to the emergency department for evaluation and treatment due to a fall with a head strike and the facility was unable to obtain a Stat CT scan. A nursing progress note written by the Director of Nursing dated 4/7/26 at 12:45 PM listed as a late entry recorded on 4/8/26 at 12:48 PM indicated Resident #8 had a fall on 4/6/26 and received Eliquis in error. The note indicated that Eliquis was now discontinued. A PA progress note dated 4/7/26 at 1:47 PM indicated that a Stat CT could not be scheduled for 4/6/26 so Resident #8 was sent to the emergency department for evaluation. A CT scan obtained at the hospital indicated no evidence of acute intracranial abnormality. Resident #8 returned to the facility with no new orders. An interview with the Physician Assistant (PA) on 5/20/26 at 1:30 PM revealed she later discovered Resident #8 had erroneously received Eliquis from 3/23/26 through 4/6/26, describing this as a significant medication error. An interview with the Director of Nursing (DON) on 5/20/26 at 4:30 PM revealed that when a resident was admitted or readmitted to the facility the physician orders were to be verified by the Physician Assistant (PA) or the physician, after which the first nurse was responsible for entering the orders into the computer system. She reported that the hospital medication orders were not faxed to the pharmacy and, as a result, the pharmacy did not receive a copy of the orders. Although the pharmacy would normally be able to access the orders once they were scanned into the resident's electronic health record, this scanning did not occur until several days later. She clarified that the intended process required the nurse on the next shift to verify the orders entered by the first nurse, and to sign off confirming that the verification had been completed. According to the DON, the error occurred because Nurse #12 did not see the orders that had been verified and signed by the PA and the second check by the next shift nurse was not completed. She acknowledged that there was a breakdown in the order-entry and order-verification process. The DON further indicated that she did not investigate the medication error, did not implement a plan of correction, and was unable to explain why these steps were not taken. She stated that following the incident, she provided re-education to the nursing staff on the correct process for entering and verifying orders and she expected orders to be transcribed accurately. The DON indicated the facility did not have a process for reviewing new orders in morning meeting or a manager assigned to do this and therefore the error was not identified (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	until the resident fell and the staff informed the PA that Resident #8 received the anticoagulant Eliquis. An interview conducted with the Physician on 5/21/26 at 4:30 PM via phone revealed that he expected the medication orders to be entered into the computer accurately. He stated that the resident receiving 27 doses of Eliquis in error constituted a significant medication error and placed the resident at an increased risk for bleeding especially with her increased fall risk.

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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 implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to Resident #9 who had a Stage IV pressure ulcer on his heel. This occurred with 1 of 3 staff members observed for infection control practices (Treatment Nurse). Findings included: The Infection Control Policy dated 02/28/25 revealed Enhanced Barrier Precautions referred to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employed targeted gown and glove use during high contact resident care activities. During an observation on 05/22/26 at 10:52 AM Resident #9 was observed lying in bed. There was no Enhanced Barrier Precaution sign observed on the door of Resident #9's room and there was no Personal Protective Equipment (PPE) on the door or outside of the room. The Treatment Nurse was observed applying gloves. She then removed the offloading boot (a soft boot to protect heels while in bed) to the left heel, removed the resident's sock, and then removed the existing dressing from the left heel. The Treatment Nurse washed her hands, applied new gloves, cleansed the wound with normal saline, applied the treatment ordered for the wound and covered the wound with a foam dressing. The Treatment Nurse did not apply a gown when she was doing this pressure ulcer wound care. An interview was conducted with the Treatment Nurse on 05/22/26 at 11:02 AM. The Treatment Nurse stated she should have had a gown on while she doing the treatment on Resident #9. She stated there should have been an Enhanced Barrier Precaution sign on Resident #9's door as well as PPE set up at the resident's doorway. The Treatment Nurse stated up until a week or so, Resident #9 had a deep tissue injury to the left heel and the wound was not opened so he was not on Enhanced Barrier Precautions. The Treatment Nurse stated once that left heel opened and became a Stage IV opened wound, she should have put the Enhanced Barrier Precaution sign on his door with PPE and she should have been wearing a gown while changing this dressing. An interview was conducted with the Director of Nursing (DON) on 05/22/26 at 3:00 PM revealed the facility did not have an Infection Preventionist (IP) at this time and the Director of Nursing (DON) was acting as the IP. The DON stated all staff had received infection control training and should be following the infection control guidelines and wearing the appropriate PPE when providing direct care to residents who had any skin opening requiring a dressing. The DON added that Resident #9 should have had a sign on his door for Enhanced Barrier Precautions since he had an opened Stage IV pressure ulcer wound.