STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34A002	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Berry Neuro-Medical Treatment Center	400 Old Smithfield Road Goldsboro, NC 27533

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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 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 50234 Based on record reviews and staff and legal guardian interviews, the facility failed to manage a resident trust fund account by not crediting interest earned on resident trust accounts with a balance over $100 for 1 of 1 resident reviewed for personal funds (Resident #103). The findings included: Resident #103 was readmitted to the facility 3/17/24. Review of Resident #103's trust fund statement dated 12/12/24 revealed he had more than $100 in his trust fund account. The statement did not contain information about interest payments or fees paid to the bank for the account. In an interview on 12/13/24 at 10:06 AM, the Business Manager said the resident's trust funds were pooled into one account. None of the residents received interest on their accounts because, after subtracting the amount paid to the bank in fees, the interest would only amount to approximately a penny. She said interest used to be paid to the residents' accounts years ago (how many years was not recalled) but no longer was included. In an interview on 12/16/24 at 2:22 PM, the Administrator said the resident trust fund statements did not include information about interest because the fees charged by the bank were usually higher than the amount of interest that accrued on the account, so there was no money to disperse among the residents.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to document written advance directive information and/or an opportunity to formulate an advance directive was provided for 16 of 19 residents reviewed for advance directives. (Resident's #'s 19, 30, 40, 42, 48, 59, 63, 71, 72, 73, 83, 87, 88, 97, 99 and 125). Findings included: The Advance-Care Directives and Right for a Nature Death policy dated [DATE] read in part: (1) that patients/residents who have the capacity to receive the advance care directive information and to articulate whether they have made an advance care directive be given the information upon admission or when they gain/regain such capacity, (2) the facility should periodically review the capacity status of patients/residents, (3) designated appropriate staff at each facility shall have resource information of organizations that have agreed to assist facility patients/residents in making advance care directives, and (4) facilities shall regularly review advance care directives and verify that legal requirements are met and that the terms of any such directive continue to represent the patient's/resident's wishes. The policy further stated any living will and health care power of attorney, portable Do Not Resuscitate (DNR) or Medical Order for Scope of Treatment (MOST) form shall be reviewed with the patient/resident when there is a substantial change in condition, when there is a change in treatment preferences, and annually by the attending physician or other person designated by the treatment team to ensure the advance directive and/or physician orders continue to comply with the patient/resident 's wishes. This review shall be documented in the patient's/resident's medical record. Findings included: a. Resident #19 was readmitted to the facility on [DATE] with diagnoses including seizures (convulsions). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #19 was severely cognitively impaired. Physician orders dated [DATE] included an order for cardiopulmonary resuscitation (CPR). There was no documentation in Resident #19's medical record that education regarding the formulation of advance directives and/or an opportunity to formulate an advance directive was offered. b. Resident #30 was admitted to the facility on [DATE] with diagnoses including hypertension and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #30 was severely cognitively impaired. Physician orders dated [DATE] included an order for cardiopulmonary resuscitation (CPR). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation in Resident #30's a medical record that education regarding the formulation of advance directives and/or an opportunity to formulate an advance directive was offered. c. Resident #40 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, hypertension, and coronary (heart) arterial disease. The quarterly Minimum data Set (MDS) assessment dated [DATE] indicated Resident #40 was severely cognitively impaired. Resident #40's medical record indicated that Resident #40's code status was a full code (all resuscitative measures would be attempted). There was no documentation in Resident #40'a medical record that education regarding the formulation of advance directives and/or an opportunity to formulate an advance directive was offered. d. Resident #42 was admitted to the facility on [DATE] with diagnoses that include pneumonia and cerebral palsy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #42 was severely cognitively impaired. Physician orders dated [DATE] for Resident #42 included a code status of full code. There was no documentation in Resident #42's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. e. Resident #48 was readmitted to the facility on [DATE] with diagnoses that include diabetes mellitus, depression, and dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #48 was severely cognitively impaired. Resident #48's medical record indicated that Resident #48's code status was a full code. There was no documentation in Resident #48's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. f. Resident #59 was admitted to the facility on [DATE] with diagnoses that included profound intellectual disabilities. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #59 was severely cognitively impaired. Resident #59's medical record indicated that Resident #59's code status was a full code. There was no documentation in Resident #59's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Resident #63 was admitted to the facility on [DATE] with diagnoses that include heart failure. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #63 was severely cognitively impaired. Physician orders dated [DATE] included a code status for cardiopulmonary resuscitation (CPR). There was no documentation in Resident #63's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. h. Resident #71 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease and seizures (convulsions). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #71 was severely cognitively impaired. There was no documentation in Resident #71's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. i. Resident #72 was admitted to the facility on [DATE] with diagnoses that include anxiety disorder and epilepsy (convulsions). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 was severely cognitively impaired. Resident #72's medical record indicated that Resident #72's code status was do not resuscitate (DNR). There was no documentation in Resident #72's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. j. Resident #73 was readmitted to the facility on [DATE] with diagnoses that include seizure (convulsions) disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #73 was severely cognitively impaired. Resident #73's medical record indicated that Resident #73's code status was a full code. There was no documentation in Resident #73's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. k. Resident #83 was admitted to the facility on [DATE] with diagnoses that include depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #83 was severely cognitively impaired. Resident #83's medical record indicated that Resident #83's code status was a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation in Resident #83's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. l. Resident #87 was admitted to the facility on [DATE] with diagnoses that include hypertension and seizures (convulsions). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #87 was severely cognitively impaired. Resident #87's medical record indicated that Resident #87's code status was a full code. There was no documentation in Resident #87's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. m. Resident #88 was admitted to the facility on [DATE] with diagnoses that include seizures (convulsions). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #88 was severely cognitively impaired. Resident #88's medical record indicated that Resident #88's code status was a full code. There was no documentation in Resident #88's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. n. Resident #97 was readmitted to the facility on [DATE] with diagnoses that include seizures (convulsions) and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #97 was severely cognitively impaired. Physician orders dated [DATE] included a code status for full code. There was no documentation in Resident #97's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. o. Resident #99 was admitted to the facility on [DATE] with diagnoses that include depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicted Resident #99 was severely cognitively impaired. Resident #99's medical record indicated that Resident #99's code status was a full code. There was no documentation in the medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. p. Resident #125's was admitted to the facility on [DATE], with diagnoses that include stroke, chronic kidney disease, and diabetes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #125 was severely cognitively impaired. Resident #125's care plan dated [DATE] recorded Resident #125 wished to be a full code. Resident #125's medical record indicated that Resident #125's code status was a full code. There was no documentation in Resident #125's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. In an interview with Floor Shift Supervisor #2 on [DATE] at 2:20 pm, she explained the physician was the person who addressed advance directives with the residents' responsible party and documented the discussion in the physician progress notes. She stated advance directives were reviewed during care plan meetings with residents' responsible party. In an interview with the Director of Standards on [DATE] at 11:30 am, she said documentation that the physician discussed advance directives with residents' responsible party should be located in physician progress notes, and the residents' code status was reviewed during care plan meetings. In an interview with Medical Doctor #1 on [DATE] at 10:52 am, he explained on admission to the facility that all residents were recognized as a full code status until a relationship was established with the residents' responsible party or there was a change in the residents' condition to discuss code status and advance directives. He stated due to his unawareness of the need to document discussion of advance directives and code status in the medical record, there was no documentation addressing advance directives with the residents' responsible party in the medical records. In a phone interview with the Administrator on [DATE] at 11:36 am, she explained advance directives were to be addressed with the residents' responsible party on admission and readmission to the facility, when there was a significant change in the resident, and during the annual care plan meeting. She stated advance directives were discussed in the residents' annual care plan meeting with the residents' responsible party but the facility had not documented the discussion of advance directives in the residents' medical record. She further explained that not all residents' responsible party attend the annual care plan meeting, and the facility had not called the residents' responsible party that were not present at the annual care plan meeting to address advance directives.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. 50234 Based on record review, and staff and Medical Director interviews, the facility failed to notify the primary care physician when Resident #103 was not provided bolus tube feedings (a way to send formula through a tube directly into the stomach) per the physician order. On 9/28/24 Nurse #1 did not feed Resident #103 his bolus tube feeding because she believed he was full. Nurse #1 was aware of the physician's orders, she deliberately disregarded them, and she independently made the decision to deviate from the physician's orders without notifying the physician. Nurse #1 confirmed this was not a new practice for her and she had done this previously for an undetermined number of times and instances without notifying the physician. Deviating from the physician orders by not providing tube feeding formula without notifying the physician deprived Resident #103 of his assessed nutritional needs. When staff purposefully disregard physician's orders and make treatment decisions on their own, it places all residents at risk of serious harm and/or death. This deficient practice was identified for 1 of 1 resident (Resident #103) reviewed for notification of changes. Immediate jeopardy began on 9/28/24 when Nurse #1 did not provide Resident #103's bolus tube feeding without notifying the physician. Immediate jeopardy was removed on 12/14/24 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 to ensure education is completed and monitoring systems put in place are effective. The findings included: Resident #103 was readmitted to the facility 3/17/24 with diagnoses which included esophageal dysmotility (esophagus does not move in a coordinated way), recurrent aspiration pneumonia, dysphagia (difficulty swallowing), a gastric tube (feeding tube), and a history of weight loss. Resident #103's physician order dated 4/11/24 revealed he was to receive a 2-Calorie formula bolus (poured directly into the gastric tube through a syringe or through gravity) one carton 4 times a day at midnight, 6:00 AM, noon, and 6:00 PM and Check residuals before accessing the gastric tube and hold the bolus for one hour if residuals were greater than 30 cc (cubic centimeters). Resident #103's Treatment Administration Record (TAR) for 8/01/24 through 9/30/24 revealed Nurse #1 initialed the TAR for having administered Resident #103's 12 midnight and 6:00 AM bolus tube feeding twenty-seven times in that time period. There were no notes on the TAR to indicate the resident had to have his feeding held for any reason by Nurse #1. Resident #103's nursing progress notes from 8/1/24 to 9/30/24 did not document any notes that Nurse #1 had to hold Resident #103's tube feeding for residuals, nausea, vomiting, or gagging. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/12/24 at 8:55 AM, Nurse Aid (NA) #1 said she reported to Unit Manager #2 that Nurse #1 didn't provide Resident #103 his formula (bolus tube feeding) during the night shift from 9/28/24 at 11:00 PM through 9/29/24 at 7:00 AM. NA #1 said she sent an email to Unit Manager #2 on 9/29/24 after her shift (time sent not available), reporting her concerns that Resident #103 was not fed by Nurse #1. NA #1 said this was not the first time Nurse #1 had not fed Resident #103. NA #1 said she had witnessed Nurse #1 not providing Resident #103 his feedings multiple times since she started working on his unit approximately one year ago. NA #1 stated there had been so many times she couldn't count them or remember exact dates when this occurred. The interview further revealed NA #1 had reported her concerns to other staff, including NA #10, and charge nurses on previous occasions (names of nurses and dates reported not recalled), but said nothing ever seemed to be done. An incident report written by Unit Manager #2 dated 9/30/24 alleged that Nurse #1 did not give Resident #103 his midnight or 6:00 AM formula feeding and was not seen on the unit all night long. The allegation continued to say that Nurse #1 did not provide the 6:00 AM feeding as ordered as well and the resident was not fed until 8:00 AM. The incident report noted the nurse had not given the resident his feedings several times in the past as well. In an interview on 12/13/24 2:51 PM, Unit Manager #2 stated she had received an email on 9/30/24 from NA #1, who was working with Resident #103 during night shift (11:00 PM to 7:00 AM) the weekend of 9/28/24 and 9/29/24. NA #1 said in her email that she never saw Nurse #1 on the unit the night shift from 11:00 PM on 9/28 to 9/29/24 at 7:00 AM and Resident #103 had not received his formula feeding. UM #2 indicated management, including Unit Manager #2, the Director of Standards, and the Advocate, started an investigation. She said they suspended Nurse #1 and talked with other staff who worked on the unit. They reviewed the video recording of the unit during the night shift from 9/28/24 at 11:30 PM through 9/29/24 at 6:30 AM and noted that they did not see Nurse #1 on Resident #103's hall during the whole shift. Unit Manager #2 said when management interviewed Nurse #1, she indicated when she usually went to feed Resident #103 at midnight, he had residual feeding in stomach, so she would not give him his formula. Unit Manager #2 revealed in a subsequent interview with management, Nurse #1 told the management team that because Resident #103 always had residuals, she would not go to assess him at midnight on the nights she worked. Nurse #1 told the management team that she did not think she needed to tell the doctor or obtain a doctor's order to hold the feeding. She was unable to tell management how often Resident #103 did not get his midnight formula. Unit Manager #2 recalled that Nurse #1's account of what occurred changed multiple times when she was interviewed. In a statement written by Nurse #1 on 9/30/24, she documented she did not provide Resident #103 with his ordered formula on the night of 9/29/24 at midnight because she thought he was full. She wrote she would not give him his feeding from time to time. In a written statement to management, taken by Unit Manager #2 and the Director of Nurses (DON) on 10/2/24, Nurse #1 stated she did not get a doctor's order to hold Resident #103's feeding because she thought a feeding could be held if the nurse observed a need to hold the feeding, such as if a resident had behaviors that interfered with the feeding being provided (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a further written statement to management, taken by Unit Manager #2 and the Director of Nurses (DON) on 10/9/24, Nurse #1 noted she did not give Resident #103 his feeding at midnight on 9/29/24. She thought that he was not able to tolerate his whole midnight feeding so she skipped it. She wrote that the signs he was not tolerating the feeding were that the feeding would stop flowing to his gastric tube or he would gag. She wrote that on 9/28/24 to 9/29/24, she did not assess him for residual formula or functionality of his feeding tube. She wrote it was not her usual way of behavior and was a mistake on her part. Nurse #1 documented if she skipped or made an adjustment to his feeding, she should have discussed with the team and have the team make a decision together. Multiple attempts to interview Nurse #1 were unsuccessful. Medical Doctor #2, Resident #103's primary care physician, was unable to be interviewed due to being out of the country at the time of the survey. In an interview on 12/13/24 at 11:36 AM, the Medical Director said she would expect to be notified if a nurse was not following an order due to their nursing judgment, especially if the situation happened repeatedly. The Medical Director stated that since the situation of holding Resident #103's bolus feedings was not an emergency, she would expect the nurse to call first so she could ascertain the current status of a resident. The Medical Director indicated the resident's primary doctor would want to know the residual amount and any other complicating factors first so the doctor could ask for more questions about the resident. She would expect the nurse to assess the resident before calling the doctor. In an interview on 12/12/24 at 3:28 PM, the Director of Standards said the facility substantiated that Nurse #1 did not give Resident #103 his formula tube feeding. She said Nurse #1 had not notified the physician of not giving the resident his formula and that the nurse no longer worked at the facility because of the incident. She stated that education was provided to nurses about following doctor's orders and notifying the doctor for orders. The Director of Standards was notified of Immediate Jeopardy on 12/12/24 at 6:35 PM. The Administrator was out of the facility and the Director of Standards was the Administrator on Duty. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. On 9/30/24 a neglect allegation was reported for Nurse #1 not administering Resident #103's tube feed. The nurse admitted during the investigation that she did not provide one of the tube feedings on the night shift 9/29/24 into 9/30/24 and did not notify the physician. She further revealed this was not the first time she did not administer the tube feeding as ordered. She indicated she used her nursing judgement when she did not administer the tube feeding as ordered and did not think to contact the physician or obtain an order to hold the tube feeding. Nurse #1 was removed from duty effective 9/30/24. The Director of Nursing notified Resident #103's physician of Nurse #1's failure to administer the tube feeding as ordered on 9/30/24. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately the DON reviewed weight information, provider's, and nurse's notes on all 43 residents who had orders for tube feeding and found no discrepancies with their feedings and no expressed concerns by their treating physicians. The Director of Nursing met with the physicians during morning rounds on 10/01/24 and inquired if they had concerns regarding tube feedings. No concerns were expressed. 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. On 10/8-10/16/24 all nurses were inserviced by the Director of Nursing and the Unit Nurse Managers on giving tube feedings, medications, and treatment as ordered by the physician and if there were any changes needed to that, it would require an assessment and a new provider order obtained. On 12/13/24 all medical staff (nurses and physicians) were re-inserviced on: If changes are needed to an existing order or a new order is needed, communicate the concerns with the physician. It is never ok to disregard a physician's order. You can get clarification on an order, provide feedback regarding orders and voice concerns you have regarding orders to include significant changes. This was completed by the Medical Director and the Unit Nurse Managers. The Medical Director and Director of Nursing will track education to ensure no staff will work on the floor after 12/13/24 until the education is received. The Unit Nurse Managers and Floor Shift Nurse Supervisors will provide the training to those reporting to work after 12/13/24. Newly hired staff will be educated by their direct supervisors and training rosters will be submitted to Staff Development to be entered into their training records effective 12/13/24. Alleged date of immediate jeopardy removal: 12/14/24 On 12/13/24, the credible allegation of the IJ removal plan was validated through interviews with nurses, nursing assistants, cooks, a Home Life Specialist, a Social Worker, and an Administrative Assistant. All staff had participated in abuse/neglect in-service and nursing staff participated in tube feed/following physician orders and notification of physician in-service in addition to the abuse in-service. All staff interviewed had signed an in-service attendance sheet on 12/13/24. The immediate jeopardy removal date of 12/14/24 was validated.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, Resident's Representative interview, and staff interviews, the facility failed to maintain documentation of grievances by failing to: (1) document the steps taken to investigate a grievance expressed on behalf of the resident, (2) document the findings and conclusion reached based on the investigation, and (3) document that the results of the investigation were reported to the Resident's Representative with a written grievance decision for 4 of 4 residents reviewed for grievances (Resident #125, #8, #33 and #46). Findings included: Review of the facility policy dated last reviewed 6/18/2019 titled Resident Representative Grievance policy read in part: (1) A grievance may be filed on behalf of a resident by the Resident Representative, (8) The Resident Representative will receive a written response within five working days of the grievance presentation (10) documentation for each step of the grievance will be in writing and will include at least the following: a description of the grievance to include the date, time and to whom the grievance was reported, all parties involved and actions taken. 1. Resident #125 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #125 was severely cognitively impaired and required substantial assistance for ambulation (walking). On 12/10/2024 at 11:21 am, a review of an incomplete grievance form dated 11/25/2024 during an annual care plan meeting for Resident #125 and written by Home Life Specialist #2 reported Resident #125's Representative voiced concerns related to Resident #125 decline in walking and requested physical therapy to assist Resident #125 in maintaining his ability to walk. The grievance form reported physical therapy declined. The following areas on Resident #125's grievance form were blank with no information recorded: department the grievance referred to, findings from grievance investigation, actions taken, date completed by name of investigator and Administrator, person filing grievance informed of results, name of staff informing person filing grievance and the date. In a phone interview with Resident #125's Representative on 12/16/2024 at 9:23 am, she stated she had not officially been told anything different from the facility related to her grievance. She explained Home Life Specialist #2 informed her on 12/12/2024 that he had heard unofficially physical therapy was not working with Resident #125 to walk. She also stated when the physician called her that week (unable to recall date), the physician informed her Resident #125's ability to walk would be discussed in a team meeting. She said she had asked the physician to attend the team meeting and had not heard from the facility about the team meeting. Attempts to contact Home Life Specialist #2 for an interview were unsuccessful. In an interview on 12/12/24 at 3:28 pm, the Director of Standards said grievance forms should be completely filled out with how the grievance was investigated and that the person filing the grievance was notified. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Berry Neuro-Medical Treatment Center	400 Old Smithfield Road Goldsboro, NC 27533

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	In a phone interview with the Administrator on 12/16/2024 at 11:36 am, she stated grievances form should be completed, and grievances were investigated and resolved within five days unless there was a medical condition to consider. She explained there was an extension on the time frame to complete the grievance for Resident #125 due to requesting physical therapy to complete an evaluation on Resident #125. She said Resident #125's physical therapy evaluation was conducted on 12/6/2024, and she had not reviewed or discussed the evaluation with physical therapy. She stated she had not contacted Resident #125's Representative related to concerns voiced in the grievance dated 11/25/2024 and she didn't know if Home Life Specialist #2, physical therapy or the physician had contacted Resident #125's Representative. 50234 2. Resident #8 was admitted to the facility on [DATE]. Review of a grievance form dated 10/15/24 written by Home Life Specialist #3 revealed Resident #8's guardian had concerns related to Resident #8's medications, rehabilitation therapy, and wanting to speak with the dietitian and the physician. Home Life Specialist #3 documented she referred the concerns to recreation therapy, rehabilitation therapy, and psychology. She noted only the recreation therapy department had contacted the guardian. The form contained areas to document the findings from the grievance investigation, the name of the investigator into the grievance, the date the investigation was completed, and that the person expressing the grievance was notified of the results of the facility's actions. All these areas on the form were blank. In an interview on 12/12/24 at 3:28 PM, The Director of Standards said Home Life Specialist #3 no longer worked at the facility and she had the grievance forms that were left by Home Life Specialist #3. She said the forms should have been completely filled out with how the grievance was investigated and that the person filing the grievance was notified. In an interview on 12/13/24 at 10:21 AM, Home Life Specialist #2 said Home Life Specialist #3 no longer worked at the facility. He said when a concern was reported, the Home Life Specialist will attempt to address the concern immediately. After the investigation of the concern, the Home Life Specialist was responsible for calling the person who filed the grievance to make sure it was resolved. He said all grievance information should be documented on the form. 3. Resident #46 was admitted to the facility on [DATE]. Review of a grievance form dated 10/22/24 revealed Resident #46's representative expressed a concern to Home Life Specialist #3 about receiving a call that Resident #46 may have needed surgery and when he attempted to call the facility to discuss her condition, no one called him back. Home Life Specialist #3 documented the actions taken were to refer the matter to the Medical/Health and Wellness nurse, Nurse #9, on 10/22/24 to call the resident's representative. All other areas to document the findings from the grievance investigation, the name of the investigator into the grievance, the date the investigation was completed, and that the person expressing the grievance was notified of the results of the facility's actions were blank. (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	In an interview on 12/12/24 at 3:28 PM, The Director of Standards said Home Life Specialist #3 no longer worked at the facility and she had the grievance forms that were left by Home Life Specialist #3. She said the forms should have been completely filled out with how the grievance was investigated and that the person filing the grievance was notified. In an interview on 12/13/24 at 10:21 AM, Home Life Specialist #2 said Home Life Specialist #3 no longer worked at the facility. He said when a concern was reported, the Home Life Specialist will attempt to address the concern immediately. After the investigation of the concern, the Home Life Specialist was responsible for calling the person who filed the grievance to make sure it was resolved. He said all grievance information should be documented on the form. In an interview on 12/13/24 at 11:08 AM, Nurse #9 said he was contacted by Home Life Specialist #3, who asked him to call Resident #46's representative about her possible surgery need. He said he called the representative as a favor to Home Life Specialist #3 and was not aware the representative had filed a grievance, just that the representative had requested information. Nurse #9 said he did not document the conversation with the representative. 4. Resident #33 was admitted to the facility on [DATE]. Review of a grievance form dated 11/18/24 revealed Resident #33's representative called Home Life Specialist #3 and filed a grievance requesting information about what was done to resolve a nursing incident and medical follow up. Home Life Specialist #3 documented she referred the grievance to the nursing department on 11/18/24. Unit Manager #2 documented that the findings from the grievance investigation were that initially Resident #33's doctor ordered regular vital signs to be taken and to monitor the resident. The form indicated nurses (no names specified) spoke with the representative that day (11/19/24) and the representative asked for x-rays to be done for the resident. The form documented that the nurses relayed the representative's request to the doctor who stated he did not feel that an x-ray was necessary and for the nurses to continue to monitor the resident. All other areas to document the actions taken, the name of the investigator into the grievance, the date the investigation was completed, and the person expressing the grievance was notified of the results of the facility's actions were blank. In an interview on 12/12/24 at 3:28 PM, The Director of Standards said Home Life Specialist #3 no longer worked at the facility and she had the grievance forms that were left by Home Life Specialist #3. She said the forms should have been completely filled out with how the grievance was investigated and that the person filing the grievance was notified. In an interview on 12/13/24 at 10:21 AM, Home Life Specialist #2 said Home Life Specialist #3 no longer worked at the facility. He said when a concern was reported, the Home Life Specialist would attempt to address the concern immediately. After the investigation of the concern, the Home Life Specialist was responsible for calling the person who filed the grievance to make sure it was resolved. He said all grievance information should have been documented on the form. In an interview on 12/13/24 at 2:51 PM with Unit Manager #2, she said she had investigated the incident and had spoken with the representative about the doctor's opinion of the representative's request for x-rays. She said she did not document the information on a grievance form.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review, and staff and Medical Director interviews, the facility failed to protect the residents' right to be free from neglect when Nurse #1 did not provide the necessary care and services as assessed and ordered by the physician to Resident #103. On 9/28/24 Nurse #1 did not provide Resident #103 his bolus tube feeding (a way to send formula through a tube directly into the stomach) because she thought he was full. Nurse #1 was aware of the physician's orders, she deliberately disregarded them, and she independently made the decision to deviate from the physician's orders and deprive the resident of his assessed nutritional needs. Nurse #1 revealed this was not a new practice for her and she had done this previously for the resident an undetermined number of times. When staff purposefully disregard physician's orders and make treatment decisions on their own, it places all residents at risk of serious harm and/or death. This deficient practice affected 1 of 7 residents reviewed for tube feedings (Resident #103). Immediate jeopardy began on 9/28/24 when Nurse #1 disregarded the physician's orders and did not provide the resident with his bolus tube feeding. Immediate jeopardy was removed on 12/14/24 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 to ensure education is completed and monitoring systems put in place are effective. The findings included: Review of Nurse #1's personnel file revealed she was employed in February 2013. Nurse #1's personnel file documented orientation training of the facility policies and procedures which included written tests on these policies and procedures. Resident #103's care plan dated 2/15/22 revealed a focus that he received all his nutrition and hydration by his gastric tube due to aspiration with recent pneumonia. Interventions included to administer formula per physician's order. Resident #103 was readmitted to the facility 3/17/24 with diagnoses which included esophageal dysmotility (esophagus does not move in a coordinated way), recurrent aspiration pneumonia, dysphagia (difficulty swallowing), a gastric tube (feeding tube), and a history of weight loss. Resident #103's physician order dated 4/11/24 revealed he was to receive a 2-Calorie formula bolus (poured directly into the gastric tube through a syringe or through gravity) one carton 4 times a day at midnight, 6:00 AM, noon, and 6:00 PM and to Check residuals before accessing the gastric tube and hold the bolus for one hour if residuals were greater than 30 cc (cubic centimeters). Resident #103's Treatment Administration Record (TAR) for 8/01/24 through 9/30/24 revealed Nurse #1 initialed the TAR for having administered Resident #103's 12 midnight and 6:00 AM bolus tube feeding twenty-seven times during that time period. There were no notes on the TAR to indicate the resident had to have his feeding held for any reason by Nurse #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #103's nursing progress notes from 8/1/24 to 9/30/24 did not document any notes that Nurse #1 had to hold Resident #103's tube feeding for residuals, nausea, vomiting, or gagging. In an interview on 12/12/24 at 8:55 AM, Nurse Aid (NA) #1 said she reported that Nurse #1 didn't provide Resident #103 his formula (bolus tube feeding) during the night shift from 9/28/24 at 11:00 PM through 9/29/24 at 7:00 AM. NA #1 said she sent an email to Unit Manager #2 on 9/29/24 after her shift (time sent not available), reporting her concerns that Resident #103 was not fed by Nurse #1. NA #1 said this was not the first time Nurse #1 had not fed Resident #103. NA #1 said she had witnessed Nurse #1 not providing Resident #103 his feedings multiple times since she started working on his unit approximately one year ago. NA #1 stated there had been so many times she couldn't count them or remember exact dates when this occurred. NA #1 explained she and Nurse #1 were the regularly assigned staff to work the overnight shift on the unit. NA #1 indicated she was working directly with Resident #103 one-on-one during the night shift on 9/28/24-9/29/24 and she saw signs that the resident was hungry including making whining noises and getting noticeably uncomfortable, touching his stomach and fidgeting. NA #1 said she could hear his stomach growling throughout the night. NA #1 revealed she had never observed Resident #103 have any signs of distress or behaviors when receiving his bolus tube feeding. NA #1 recalled she told NA #9, who was the NA on the next shift on 9/29/24 that Nurse #1 had not fed Resident #103. The interview further revealed NA #1 had reported her concerns to other staff, including NA #10, and charge nurses on previous occasions (names of nurses and dates reported not recalled), but she said nothing ever seemed to be done. Attempts to interview NA #9 were unsuccessful. In an interview on 12/13/24 at 2:15 PM, NA #10 said she could not remember anyone who reported to her that residents were not receiving their tube feedings. An incident report written by Unit Manager #2 dated 9/30/24 alleged that Nurse #1 did not give Resident #103 his midnight or 6:00 AM formula feeding and was not seen on the unit all night long. The allegation continued to say that Nurse #1 did not provide the 6:00 AM feeding as ordered as well and the resident was not fed until 8:00 AM. The incident report noted the nurse had not given the resident his feedings several times in the past as well. In an interview on 12/13/24 2:51 PM, Unit Manager (UM) #2 stated she had received an email on 9/30/24 from NA #1, who was working with Resident #103 during night shift (11:00 PM to 7:00 AM) the weekend of 9/28/24 and 9/29/24. NA #1 said in her email that she never saw Nurse #1 on the unit on the night shift from 11:00 PM on 9/28 to 9/29/24 at 7:00 AM and Resident #103 had not received his formula feeding. UM #2 indicated management, including Unit Manager #2, the Director of Standards, and the Advocate, started an investigation. She said they suspended Nurse #1 and talked with other staff who worked on the unit. They reviewed the video recording of the unit during the night shift from 9/28/24 at 11:30 PM through 9/29/24 at 6:30 AM and noted that they did not see Nurse #1 on Resident #103's hall during the whole shift. Unit Manager #2 said when management interviewed Nurse #1, she indicated when she usually went to feed Resident #103 at midnight, he had residual feeding in stomach, so she would not give him his formula. Unit Manager #2 revealed in a subsequent interview with management, Nurse #1 told the management team that because Resident #103 always had residuals, she would not go to assess him at midnight on the nights she worked. Nurse #1 told the management team that she did not think she needed to tell the doctor or obtain a doctor's order to hold the feeding. She was unable to tell management how often Resident #103 did not get his midnight formula. Unit Manager #2 recalled that Nurse #1's account of what occurred changed multiple times when she was interviewed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a statement written by Nurse #1 on 9/30/24, she documented she did not provide Resident #103 with his ordered formula on the night of 9/29/24 at midnight because she thought he was full. She wrote she would not give him his feeding from time to time. In a written statement to management, taken by Unit Manager #2 and the Director of Nurses (DON) on 10/2/24, Nurse #1 stated she did not get a doctor's order to hold Resident #103's feeding because she thought a feeding could be held if the nurse observed a need to hold the feeding, such as if a resident had behaviors that interfered with the feeding being provided In a further written statement to management, taken by Unit Manager #2 and the Director of Nurses (DON) on 10/9/24, Nurse #1 noted she did not give Resident #103 his feeding at midnight on 9/29/24. She thought that he was not able to tolerate his whole midnight feeding so she skipped it. She wrote that the signs he was not tolerating the feeding were that the feeding would stop flowing to his gastric tube or he would gag. She wrote that on 9/28/24 to 9/29/24, she did not assess him for residual formula or functionality of his feeding tube. She wrote it was not her usual way of behavior and was a mistake on her part. Nurse #1 documented if she skipped or made an adjustment to his feeding, she should have discussed with the team and the team would make a decision on what to do. Multiple attempts to interview Nurse #1 were unsuccessful. In an interview on 12/12/24 at 2:48 PM, NA #6 stated she thought she remembered NA #1 telling her about her concerns that Resident #103 did not receive his bolus tube feedings but didn't remember any details, including what date it was discussed. She did not think it was neglect or that it was necessary to report NA #1's concerns. Attempts to interview NAs #2 and #7, who also worked the 9/28/24-9/29/24 shift from 11:00 PM- 7:00 AM on Resident #103's unit were unsuccessful. The Registered Dietician's (RD) progress note for Resident #103 dated 8/24/24 indicated his current weight was 104 pounds, a decrease in 30 days and 180 days, with no significant weight changes. The usual body weight (UBW) range was 109-112 pounds. The RD noted the gastric feeding was held on 8/22/24 due to residuals greater than 30 cc. The medical team was aware of his weight loss and were monitoring this closely. The RD noted she may consider adding a 1/2 carton bolus to meet his nutritional needs. The RD's quarterly Nutrition assessment dated [DATE] indicated Resident #103 weighed 106.2 pounds and had no significant weight changes. She noted his estimated nutritional needs were 1344-1536 calories a day with greater than or equal to 48 grams of protein a day. The assessment noted that his tube feeding order would provide 1900 calories a day with 80 grams of protein. The RD noted Resident #103's weight fluctuated between 107-110 pounds and that his current tube feeding order exceeds his estimated needs and should promote weight stability and gradual weight gain. His desired body weight (DBW) had been changed to 100 pounds from 115 pounds the past quarter. She noted he had some nausea and an upset stomach and was started on a new medication for gastric reflux on 9/13/24. His estimated needs were being met due to no tube feeding or tolerance issues reported per staff. Resident remained taking nothing by mouth. The RD noted she would continue to monitor his weight stability and follow up with the medical team. She recommended to continue his current tube feeding orders in order to monitor his weight stability and tube feeding tolerance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/11/24 at 4:19 PM, the RD said Resident #103 was a patient assigned to her and she knew him well. The RD indicated Resident #103 had a history of complicated gastrointestinal issues that required monitoring. The RD stated she was not made aware of Resident #103 not receiving all of his bolus feedings when it was reported to the facility this September and it would have been important information for her to know because if Resident #103 was not receiving all of his feedings throughout the day and night, he would not get enough calories. The RD noted Resident #103 had some gradual weight loss, his weight would fluctuate due to different situations, such as going to the hospital, but said his bolus feedings would exceed his caloric and protein needs if he was getting all of it. The RD further stated she had not recommended the additional bolus feeding mentioned in her note (8/24/24) at that time because his weight was beginning to stabilize. Medical Doctor #2, Resident #103's primary care physician, was unable to be interviewed due to being out of the country at the time of the survey. In an interview on 12/13/24 at 11:36 AM, the Medical Director said she would expect to be notified if a nurse was not following an order due to their nursing judgment, especially if the situation happened repeatedly. The Medical Director stated since the situation of holding Resident #103's bolus feedings was not an emergency, she would expect the nurse to call first so she could ascertain the current status of a resident. The Medical Director indicated the resident's primary doctor would want to know the residual amount and any other complicating factors first so the doctor could ask for more information about the resident. She would expect the nurse to assess the resident before calling the doctor. The Medical Director indicated it was necessary to call the physician about any order changes so the resident did not have any negative effects such as weight loss. In an interview on 12/12/24 at 3:28 PM, the Director of Standards stated the facility substantiated that Nurse #1 neglected Resident #103 by not providing him with his formula feeding. She stated that education was provided to nurses about following doctor's orders and with nurse aides about reporting suspicions of abuse and neglect. She said Nurse #1 no longer worked at the facility because of the incident. The Director of Standards was notified of Immediate Jeopardy (IJ) on 12/12/24 at 6:35 PM. The Administrator was out of the facility and the Director of Standards was the Administrator on Duty. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to protect Resident #103's right to be free from neglect when Nurse #1 deliberately disregarded the physician's order for bolus tube feeding when she withheld the resident's tube feeding on multiple occasions depriving the resident of his nutritional needs. Resident #103 was non-verbal, vulnerable, and received all nutrition from a bolus tube feed. His dietary orders were as follows: 2 Cal formula bolus 1 carton 4 times a day at midnight, 6:00 AM, 12:00 AM, 12:00 PM, and 6:00 PM. On 9/30/24 a neglect allegation was reported for Nurse #1 not administering Resident #103's tube feed. The nurse admitted she did not provide one of the tube feedings because it was her opinion the resident was still full from his earlier feeding. When asked if she assessed the resident, she revealed she did not assess nor consult with the physician. She further revealed this was not the first time she did not administer the tube feeding as ordered. NA #1 indicated she worked with Nurse #1 on the unit Resident #103 resided on. She indicated she saw Nurse #1 not administer the bolus feeding as ordered so many times she couldn't count. She reported she could hear the resident's stomach growling. Nurse #1 was removed from duty effective 9/30/24. The Director of Nursing notified Resident #103's physician of Nurse #1's failure to administer the tube feeding as ordered on 9/30/24. Immediately the DON reviewed weight information, provider's, and nurse's notes on all 43 residents who had orders for tube feeding and found no discrepancies with their feedings and no expressed concerns by their treating physicians. The Director of Nursing met with the physicians during morning rounds on 10/01/24 and inquired if they had concerns regarding tube feedings. No concerns were expressed. On 12/13/24 attempts were made to report Nurse #1 to the Board of Nursing but was unable to due to them only accepting information during business hours. A report will be made by the Director of Nursing on Monday morning, 12/16/24. 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. On 10/8-10/16/24 all nurses were in-serviced by the Director of Nursing and the Unit Nurse Managers on giving tube feedings, medications, and treatment as ordered by the physician and if there were any changes needed to that, it would require an assessment and a new provider order obtained. On 10/3-10/17/24 Certified Nursing Assistants were educated on the importance of reporting their concerns and ensuring it gets to the appropriate people to assist with resolving issues/concerns. This was completed by the floor shift nurse supervisors and Unit Nurse Managers. On 12/13/24 all medical staff (nurses and physicians) were re-inserviced on: If changes are needed to an existing order or a new order is needed, communicate the concerns with the physician. It is never ok to disregard a physician's order. You can get clarification on an order, provide feedback regarding orders and voice concerns you have regarding orders to include significant changes. This was completed by the Medical Director and the Unit Nurse Managers. The Medical Director and Director of Nursing will track education to ensure no staff will work on the floor after 12/13/24 until the education is received. The Unit Nurse Managers and Floor Shift Nurse Supervisors will provide the training to those reporting to work after 12/13/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/13/24 all staff were in serviced on abuse, neglect, exploitation, and rights infringements with emphasis on Neglect to include a failure to follow a physician's order is neglect, a failure to report that meals are withheld to include tube feedings from an individual without a physician's order to hold the meal is neglect, and if you witness, hear or suspect that it has occurred and fail to report, you are as guilty as the person committing the act and will be held accountable through the Just Culture Process. (Just culture is a system that encourages accountability and fair treatment of employees in an organization. It's based on the idea that people make mistakes, and that employees should feel safe reporting safety issues without fear of punishment.) Training was conducted by Standards Director, Chief Financial Officer, Unit Nurse Managers, Floor Shift Nurse Supervisors and Department Supervisors campus wide. Each manager and supervisor will track education to ensure no staff will work on the floor after 12/13/24 until the education is received. The Managers, Supervisors and designee will provide the training to those reporting to work after 12/13/24. Once training is complete, rosters will be turned into Staff Development to be added to their training record. Newly hired staff will be educated by their direct supervisors effective 12/13/24. Alleged date of immediate jeopardy removal: 12/14/24 On 12/13/24, the credible allegation of the IJ removal plan was validated through interviews with nurses, nursing assistants, cooks, a Home Life Specialist, a Social Worker, and an Administrative Assistant. All staff had participated in abuse/neglect in-service and nursing staff participated in tube feed/following physician orders in-service in addition to the abuse in-service. All staff interviewed had signed an in-service attendance sheet on 12/13/24. In addition, Resident #s 19, 20, 27, 33, 56, 62, and 73's tube feedings were observed and orders checked for accuracy. All tube feedings were running or on hold as ordered. The immediate jeopardy removal date of 12/14/24 was validated.

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O'Berry Neuro-Medical Treatment Center	400 Old Smithfield Road Goldsboro, NC 27533

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the use of anticoagulants (medications that increased the time it takes for blood to clot) for 1 of 31 residents whose MDS assessments were reviewed (Resident #63). Findings included: Resident #63 was admitted to the facility on [DATE] and diagnoses included coronary artery (heart) disease. Physician orders dated 10/17/2024 included Apixaban (an anticoagulant used to reduce the risk of forming blood clots) 5 milligrams (mg) every twelve hours. The October 2024 Medication Administration Record (MAR) recorded Resident #63 received Apixaban 5 mg every twelve hours from 10/17/24 to 10/31/24. The November 2024 MAR recorded Resident #63 received Apixaban 5 mg every twelve hours from 11/1/2024 to 11/30/2024. The quarterly MDS assessment dated [DATE] indicated Resident #63 was receiving an antiplatelet (a medication to prevent platelets from sticking together and forming blood clots). In an interview with MDS Nurse #1 on 12/12/2024 at 12:07 pm, she explained Apixaban was a blood thinner and was classified as an anticoagulant and not an antiplatelet. She stated Resident #63's MDS assessment dated [DATE] coded for antiplatelets was a data entry error and would need to be corrected. In an interview with Unit Manager #1 on 12/12/2024 at 12:11 pm, she stated Apixaban was not an antiplatelet. She said the medication was an anticoagulant, and Resident #63's MDS assessment was miscoded for the use of antiplatelets. In an interview with the Director of Nursing on 12/12/2024 at 6:15 pm, he stated MDS Nurse #1 should have coded Resident #63's MDS assessment for the use of anticoagulants instead of antiplatelets.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to develop a comprehensive care plan in the area of the use of blood thinner and/or anticoagulants (a medication that increases the time it takes for blood to clot) (Resident #63) and in the area for seizures and the use of antiepileptic medications (Resident #101) for 2 of 31 residents whose comprehensive care plan was reviewed. Findings included: 1. Resident #63 was admitted to the facility on [DATE] and diagnoses included coronary artery (heart) disease. Physician orders dated 10/17/2024 included Apixaban (an anticoagulant used to reduce the risk of forming blood clots) 5 milligrams (mg) every twelve hours. The October 2024, November 2024 and December 2024 Medication Administration Record (MAR) recorded Resident #63 received Apixaban 5 mg every twelve hours from 10/17/24 to 12/11/2024. The quarterly MDS assessment dated [DATE] indicated Resident #63 was receiving an antiplatelet (a medication to prevent platelets from sticking together and forming blood clots). Resident #63's care plan dated reviewed 11/14/2024 did not include a focus for the use of blood thinners and/ or anticoagulants. In an interview with MDS Nurse #1 on 12/12/2024 at 12:07 pm, she explained she was responsible for creating and updating Resident #63's care plan. She stated Resident #63 was receiving anticoagulant, and Resident #63's care plan should have included the use of anticoagulants. MDS Nurse #1 was unable to provide an explanation why anticoagulants were not included in Resident #63's care plan. In an interview with Unit Manager #1 on 12/12/2024 at 12:11 pm, she stated MDS Nurse #1 was responsible for updating Resident #63's care plan. She said since Resident #63 was receiving Apixaban, a blood thinner, Resident #63 was a risk for bleeding, and the use of anticoagulants should have been included in Resident #63's care plan. In an interview with the Director of Nursing on 12/12/2024 at 6:15 pm, he stated Resident #63's care plan was reviewed at care plan meetings, and Resident #63's care plan should have included a focus for the use of blood thinner and/or anticoagulants. 49159 2. Resident #101 he was readmitted on [DATE]. His diagnoses included seizures (sudden, abnormal burst of electrical activity in the brain that causes temporary changes in behavior, muscle tone, or awareness). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician order dated 4/8/24 revealed Resident #101 was prescribed Lacosamide 50 milligrams (mg) by mouth every 12 hours for seizures. Resident #101's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and was coded for seizures. Review of Resident #101's medication administration record (MAR) dated December 2024 revealed he was receiving an anti-seizure medication. Review of Resident #101's care plan dated 7/19/21 and revised on 10/3/24 revealed he did not have a care plan for seizures/anti-seizure medication. An interview was conducted on 12/11/24 at 9:49 AM with Unit Manager #1. She stated this resident should have been care planned for seizures/anti-seizure medication. She was unable to offer a reason why Resident #101 did not have a care plan for seizures/anti-seizure medication. An interview was conducted on 12/12/24 at 4:25 PM with the Director of Nursing (DON). He stated he expected all residents to have appropriate care plans in place. An interview was conducted with the Director of Standards on 12/12/24 at 4:33 PM. She stated it was the facility's expectation that all residents had person-centered care plans to ensure the wellbeing of individual residents. She further stated that care plans help to guide the facility in service provision, and they should be adhered to.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review, and staff, and Registered Dietician (RD) interviews, the facility failed to administer tube feedings via a gastrostomy tube (a tube to provide formula directly to the stomach) as ordered by the physician for 1 of 7 residents reviewed with tube feeding orders (Resident #103). The findings included: Resident #103 was initially admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE] with diagnoses that included esophageal dysmotility (esophagus did not move in a coordinated way), recurrent aspiration pneumonia, dysphagia (difficulty swallowing), a gastric tube, and history of weight loss. Resident #103 quarterly Minimum Data Set (MDS) dated [DATE] indicated he had no speech, rarely or never understood others and was rarely or never understood. He had severe cognitive impairment. He required the use of a feeding tube for nutrition and consumed more than half his calories through the feeding tube daily. The MDS indicated he had not had any significant weight gain or loss. Resident #103's care plan updated 2/15/22 revealed a focus that he received all his nutrition and hydration by his gastric tube due to aspiration with recent pneumonia. Interventions included to administer formula per physician's order. Resident #103's physician order dated 4/11/24 revealed he was to receive a 2-Calorie formula bolus (poured directly into the gastric tube through a syringe or through gravity) one carton 4 times a day at midnight, 6:00 AM, noon, and 6:00 PM and to Check residuals before accessing the gastric tube and hold the bolus for one hour if residuals were greater than 30 cc (cubic centimeters). An incident report written by Unit Manager #2 dated 9/30/24 alleged that Nurse #1 did not give Resident #103 his midnight or 6:00 AM formula feeding on 9/28/24-9/29/24. The allegation continued to note the resident did not receive his tube feeding until 8:00 AM. The incident report noted Nurse #1 had not given the resident his feedings several times in the past as well. In a statement written by Nurse #1 on 9/30/24, she documented she did not provide Resident #103 with his ordered formula on the night of 9/29/24 at midnight because she thought he was full. She wrote she would not give him his feeding from time to time. In an interview on 12/12/24 at 8:55 AM, Nurse Aid (NA) #1 said she reported that Nurse #1 didn't provide Resident #103 his formula all night on the 11:00 PM- 7:00 AM shift on 9/28/24 through 9/29/24. NA #1 said Nurse #1 had not fed him so many times she couldn't count them or remember exact dates when this occurred. NA #1 indicated on 9/28/2409/29/24 overnight shift, she was working directly with Resident #103 one-on-one. She saw signs that the resident was hungry including making whining noises and got noticeably uncomfortable, touching his stomach and fidgeting. NA #1 said she could hear his stomach growling throughout the night. NA #1 revealed she had never observed Resident #103 have any signs of distress or behaviors when receiving his bolus tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a written statement to management, taken by Unit Manager #2 and the Director of Nurses (DON) on 10/2/24, Nurse #1 stated she did not get a doctor's order to hold Resident #103's feeding because she thought a feeding could be held if the nurse observed a need to hold the feeding, such as if a resident had behaviors that interfered with the feeding being provided. In a further statement to management on 10/9/24, Nurse #1 noted she did not give Resident #103 his midnight feeding. She thought that he was not able to tolerate his whole midnight feeding so she skipped it. She wrote that the signs he was not tolerating the feeding were that the feeding would stop flowing to his gastric tube or he would gag. She wrote that on 9/28-9/29/24, she did not assess him. Attempts to interview Nurse #1 were unsuccessful. The Registered Dietician's (RD) progress note for Resident #103 dated 8/24/24 indicated his current weight was 104 pounds, a decrease in 30 days and 180 days, with no significant weight changes. His usual body weight (UBW) range was 109-112 pounds. The RD noted the gastric feeding was held on 8/22/24 due to residuals greater than 30 cc. The medical team was aware of his weight loss and were monitoring closely. The RD noted she may consider adding a 1/2 carton bolus to meet his nutritional needs. The RD's quarterly Nutrition assessment dated [DATE] indicated Resident #103 weighed 106.2 pounds and had no significant weight changes. She noted his estimated nutritional needs were 1344-1536 calories a day with greater than or equal to 48 grams of protein a day. The assessment noted that his tube feeding order would provide 1900 calories a day with 80 grams of protein. The RD noted Resident #103's weight fluctuated between 107-110 pounds and that his current tube feeding order exceeds his estimated needs and should promote weight stability and gradual weight gain. His desired body weight (DBW) had been changed to 100 pounds from 115 pounds the past quarter. She noted he had some nausea and an upset stomach and was started on a new medication for gastric reflux on 9/13/24. His estimated needs were being met due to no tube feeding or tolerance issues reported per staff. The resident remained taking nothing by mouth. The RD noted she would continue to monitor his weight stability and follow up with the medical team. She recommended to continue his current tube feeding orders in order to monitor his weight stability and tube feeding tolerance. In an interview on 12/11/24 at 4:19 PM, the RD said Resident #103 was a patient assigned to her and she knew him well. She said he had a history of complicated gastrointestinal issues that required monitoring. She said she was not made aware of Resident #103 not receiving all of his feedings. She said he had some gradual weight loss, his weight would fluctuate due to different situations, such as going to the hospital, but said his bolus feedings would exceed his caloric and protein needs if he was getting all of it. If Resident #103 was not receiving all of his feedings throughout the day and night, he would not get enough calories. She had not recommended the additional bolus feeding mentioned in her note at that time because his weight was beginning to stabilize.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41387 Based on record review and staff interviews, the facility failed to complete and/or record accurate nurse staffing information of hours worked for licensed and unlicensed nursing staff on the census daily staffing form for 3 of 3 resident buildings whose census daily staffing forms were reviewed (Building 1, Building 2, and Building 4). Finding included: A review of the census daily staffing forms for November 1-30, 2024 and December 1, 2024 to December 9, 2024 for the three resident buildings included the following: a. Building 1: There were no census daily staffing forms for November 1-30, 2024 and December 1, 2024 to December 9, 2024. b. Building 2: The census daily staffing forms did not include the number of licensed and unlicensed staff and actual hours worked for each shift for November 1, 6, 7, 8, 12, 15,17, 18, 19, 20, 21, 26, 27, and 28, 2024 and December 4 and 9, 2024. There were no census daily staffing forms for November 2, 3, 13,14, 22 and 30, 2024 and December 1,2,3,5,6 and 7, 2024. c. Building 4: There was no calculation of the hours worked by the licensed and unlicensed staff on the census daily staffing forms for November 1, 4, 5, 6, 7, 8, 12, 13, 14, 18, 19, 21, 22, 25 and 26, 2024 and December 2, 3, 4, 5, 6 and 9, 2024. There were no census daily staffing forms for November 2, 3, 9, 10, 11, 15, 16, 17, 20, 23, 24, 27, 28, 29 and 30, 2024 and December 1, 7 and 8, 2024. In an interview with Unit Manager #3 of Building 1 on 12/12/2024 at 5:00 pm, she stated Building 1 had not been completing a census daily staffing form before 12/12/2024. She stated she was not aware a census daily staffing form needed to be completed until 12/11/2024 when the Director of Nursing asked for Building 1's census daily staffing sheets and there were none for November 1-30, 2024 and December 1 through December 9, 2024. An attempt to interview Secretary #1 of Building 1 was unsuccessful. In a phone interview with Unit Manager #1 of Building 2 on 12/16/2024 at 9:41am, she stated a census daily staffing form that included the census, number of licensed and unlicensed staff and the actual hours worked were to be completed by one of the following: the floor shift supervisor, home life specialist or the secretary. She explained currently Building 2 was without one floor shift supervisor and the home life specialist was to complete the census daily staffing form in the absence of the floor shift supervisor. She stated the secretary checked the census daily staffing form for accuracy and had not brought to her attention any census daily staffing forms from November 1-30, 2024 or December 1-9, 2024 that were inaccurate and/or not completed. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	In a phone interview with Home Life Specialist #4 in Building 2 on 12/16/2024 at 10:10 am, she explained when there was no floor shift supervisor, she was responsible for completing the census daily staffing form for Building 2. She stated the secretary of Building 2 was to make sure that the census daily staffing sheet was accurately completed and stated there was no reason for the census daily staffing form not to be completed daily. In a phone interview with Secretary #3 of Building 2 on 12/16/2024 at 11:08 am, she stated she was responsible for collecting the census daily staff form each morning and storing the forms in her office. She explained she had not been informed to ensure that the census daily staffing form was accurate and completed with the number of licensed and unlicensed staff and calculations of actual hours worked before filing . She did not know to inform Unit Manager #1 that the census daily staffing form was incomplete. She stated the floor shift supervisor and the home life specialist in the absence of the floor shift supervisor was responsible for completing the census daily staffing form. In a phone interview with Unit Manger #2 of Building 4 on 12/16/2024 at 9:49 am, she explained there were two different census forms that each building completed and did recall the use of a census daily staffing form. She stated the floor shift supervisor and the home life specialist were responsible for completing the census daily staffing form and calculating the licensed and unlicensed actual hours worked. She stated the secretary monitored the census daily staffing sheets for accuracy and completeness. In a phone interview with Nurse #7 (floor shift supervisor) for Building 4 on 12/16/2024 at 11:32 am, she stated the reason the November 1-30, 2024 and December 1-9, 2024 census daily staffing forms were incomplete or not completed was due to Building 4 not always having a floor shift supervisor scheduled or the floor shift supervisor forgetting to complete the census daily staffing form. She explained when there was not a floor shift supervisor, the home life specialist was to complete the census daily staffing form. She stated she collected the census daily staffing form each morning and placed the form in the secretary's mailbox or office. She stated she did not complete the census daily staffing form if it was observed not completed for all shifts because she was not present to account that the staff actually worked scheduled hours. In a phone interview with Secretary #2 for Building #4 on 12/16/2024 at 11:16 am, she stated she was responsible for storing the census daily staffing forms, and she kept them in a book. She stated she had not received any instructions on how to complete the census daily staffing form and would not know if the form was complete or incomplete when placed in the office for filing. She stated she did not know who was responsible for completing the census daily staffing form. In an interview with the Director of Nursing on 12/12/2024 at 6:15 pm, he explained he was responsible to ensure the accuracy of the census daily staffing forms and stated he had not been monitoring the staff for completion of the census daily staffing forms. He explained he had learned during the recertification survey that each of the three resident buildings were not completing the census daily staffing forms, and the staff of each resident building were conducting and posting the census daily staffing differently. He stated the census daily staffing form should have been accurate in representing the licensed and unlicensed staff hours worked and the resident census for each building. He also stated it was the responsibility of the secretary of each resident building to ensure the census daily staffing form was accurately completed, collected and stored.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41387 Based on record review and staff interviews, the facility failed to document on residents' controlled medication records that two different nurses ensured accurate reconciliation and accounting of controlled medications for 1 of 1 medication cart reviewed for controlled medication records (Cluster 1 Hall 2 medication cart). Findings included: The facility's Diversion Prevention Policy dated last reviewed 9/9/2020 stated documentation of access and inventory was performed by both off going and ongoing personal during shift change by use of an ancillary form, a controlled substance shift change accountability record. A review of residents' controlled medication records for Cluster1 Hall 2 medication cart on 12/11/2024 indicated there was no nurse signature for an oncoming shift, an off going shift or the same nurse signed as the oncoming and off going nurse for a shift on the following dates on the residents' controlled medication record: - Resident #81's Phenobarbital 64.8 milligrams (mg) controlled medication record on December 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. - Resident #123's Tramadol, 50 mg controlled medication record on December 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. - Resident #123's Vimpat, 150 mg controlled medication record on December 1, 2, 4, 5, 6, 7, 8, 9 and 10. - Resident #74's Vimpat, 150 mg controlled medication record on December 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. -Resident #128's Klonopin 0.5 mgcontrolled medication record on December 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. In an interview with Nurse #10 on 12/12/2024 at 7:17 am, she stated she reconciled and accounted for residents' controlled medications on Cluster 1 Hall 2 medication cart by counting the controlled medications at the beginning and end of her shift with another nurse and signed the residents' controlled medication record after performing the controlled medication count. She explained where to sign on the new controlled medication record to document accounting for the controlled medications was confusing, and she had signed Cluster 1 Hall 2 controlled medication record incorrectly. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Nurse #11 on 12/12/2024 at 7:17 am, she stated the facility started a new controlled medication record that documented reconciliation and accounting for residents' controlled medications on Cluster 1 Hall 2 medication cart. She explained as the only night nurse for Cluster 1 that consisted of four different halls and medication carts, she counted residents' controlled medications on the Cluster 1 Hall 2 medication cart and signed as the oncoming and off going nurse for the 11pm to 7 am shift on the controlled medication record. She stated usually the nursing staff worked 12-hour shifts, and there was no one to account for the controlled medications with her during the 11p-7am shift. She stated that the controlled medication record documented there was an accurate number of the residents' controlled medications on Cluster 1 Hall 2 medication cart and residents' controlled medications were to be reconciled and accounted for by two different nurses. In an interview with Unit Manager #3 on 12/12/2024 at 5:00 pm, she explained two different nurses (the oncoming nurse and the off going nurse) were to count to ensure the accuracy of residents' controlled medications on the Cluster 1 Hall 2 medication cart at the change of each shift or when the medication cart keys were transferred to another nurse. She stated the two nurses conducting the count of controlled medications were to sign the residents' controlled medication record to document each count of the controlled medications. She said she had not been monitoring residents' controlled medication records to ensure there was documentation that two different nurses accounted for the controlled medications at the change of shift for Cluster 1 Hall 2 medication cart. In an interview with the Director of Nursing on 12/12/2024 at 6:15 pm, he stated the account of residents' controlled medications on Cluster 1 Hall 2 medication cart required two different nurses to reconcile that the number of controlled medications on the medication cart was accurate at the change of the shift or when transferring medication cart keys to another nurse. He stated signatures on the residents' controlled medication record with each account of the controlled medications represented accuracy and who had counted the controlled medications for the shift. He explained when there was no nurse signatures on residents' controlled medication record or the same nurse signature as the oncoming nurse and off going nurse at the change of a shift, the residents' controlled medication record for Cluster 1 Hall 2 medication cart was incomplete and inaccurate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observation and staff interviews, the facility failed to secure medications in an unlocked medication room and unlocked medication cart (Building 1 Hall 4 medication room and medication cart), failed to dispose of an expired medication (Building 2 Hall 2 medication cart), failed to maintain a temperature range of 36 to 46 degrees Fahrenheit (F) for refrigerated medications and monitor the internal temperature of medication refrigerators (Building 2 Hall 2 and Building 4 Hall 3 medication rooms) for 3 of 6 medication rooms and medication carts reviewed for medication storage. Findings included: 1. On [DATE] at 12:47 pm, Building 1 Hall 4 medication room was observed unlocked with no staff observed in the medication room, and the medication cart located inside the unlocked Building 1 Hall 4 medication room was observed unlocked when a resident's medication drawer on the medication cart was able to be pulled open. A continuous observation of the Building 1 hall 4 medication room began until Nurse #12 reported to the Building 1 Hall 4 medication room. Housekeeper #1 was observed walking by the unlocked medication room during the continuous observation. On [DATE] at 12:49 pm, Nurse #12 reported to the Building 1 Hall 4 medication room and stated the Building 1 Hall 4 medication room was unlocked because she had left the medication room without locking the door to go collect laboratory tests on a resident. She explained the Building 1 Hall 4 medication room door was to be locked when not occupied. When Nurse #12 checked to ensure the medication cart inside Building 1 Hall 4 medication room was locked, Nurse #12 pulled a resident's medication drawer open and stated the medication cart that also contained residents' controlled medications was not locked. Nurse #12 stated she had completed administering her medications, and when she received orders for laboratory and radiology test for a resident, she left Building 1 Hall 4 medication room without locking the door and the medication cart to address those orders. She stated Building 1 Hall 4 medication room and medication cart should have been locked before exiting, and residents' medications were left unsecured. In an interview with the Unit Manager #3 on [DATE] at 3:44 pm, she explained that residents' controlled medications required a secured double locking system that the locked Building 1 Hall 4 medication door and the medication cart provided. She stated Nurse #12 should have ensured Building 1 Hall 4 medication room and medication cart located inside the Building 1 Hall 4 medication room was locked to secure residents' medications before leaving the Building 1 Hall 4 medication room. In an interview with the Director of Nursing on [DATE] at 6:15 pm, he stated Building 1 Hall 4 medication room and the medication cart located inside Building 1 Hall 4 medication room should be locked at all times when no in use by Nurse #12 to secure residents' medications. 49159 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34A002	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Berry Neuro-Medical Treatment Center	400 Old Smithfield Road Goldsboro, NC 27533

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation of the medication cart in Building 2 on Hall 2 was conducted on [DATE] at 12:01 PM. One bottle of Sterilid eye wash for Resident #58 was found in the medication cart. The eye wash bottle expired [DATE]. An interview on [DATE] at 12:01 PM with Nurse #2 was conducted. She stated it should have been removed from the medication cart when it expired. An interview was conducted with the Director of Nursing (DON) on [DATE] at 4:25 PM. He stated his expectation was that nurses check all medications on the carts for expiration. An interview was conducted with the Director of Standards on [DATE] at 04:33 PM. She stated she expected nursing staff to ensure medications and items on the medication carts not to be outdated (expired). 3 a. On [DATE] at 12:01 PM an observation was conducted of the medication refrigerator in Building/Cluster 2 Hall 2. During the observation, this surveyor removed the thermometer located inside the medication refrigerator and viewed the registered reading was 50F. There was no temperature log observed for [DATE]. An interview was conducted on [DATE] at 12:05 PM with Nurse #2. She stated she was unsure why the temperature logs were not completed or who was responsible for monitoring the medication refrigerator temperatures and completing the temperature logs. 3 b. On [DATE] at 9:02 AM an observation was conducted of the medication refrigerator in Building/Cluster 4 Hall 3. The observation revealed temperature log for December was incomplete except for [DATE] and [DATE]. An interview on [DATE] at 9:02 AM was conducted with Nurse # 5. She stated she was not aware of who takes care of the refrigerator temperature logs. An interview was conducted on [DATE] at 4:25 PM with the Director of Nursing (DON). Temperature checks should be done daily by nursing staff and recorded on the temperature log sheet. An interview was conducted on [DATE] at 4:33 PM with the Director of Standards. She stated temperature logs should be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34A002	A. Building B. Wing	12/16/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50234 Based on record reviews and staff interviews, the facility failed to have a complete and accurate medication and treatment administration record for 1 of 7 residents reviewed for medical record accuracy (Resident #103). The findings included: Resident #103's physician order dated 4/11/24 revealed he was to receive a 2-Calorie formula bolus (poured directly into the gastric tube)1 carton 4 times a day at midnight, 6:00 AM, noon, and 6:00 PM and to check residuals before accessing the gastric tube and hold the bolus for 1 hour if residuals were greater than 30 cc (cubic centimeters). Resident #103's Treatment Administration Record (TAR) for September 28-30, 2024 revealed Nurse #1 signed she provided Resident #103 his ordered tube feeding at midnight and 6:00 AM. There were no notes on the TAR to indicate the resident had to have his feeding held for any reason by Nurse #1. In a statement written by Nurse #1 on 9/30/24, she said she did not provide Resident #103 with his ordered formula on the night of 9/29/24 at midnight because she thought he was full. She wrote she would not give him his feeding from time to time (no dates noted). Attempts to interview Nurse #1 were unsuccessful. In an interview on 12/13/24 at 2:51 PM, Unit Manager #2, who was Nurse #1's supervisor, said Nurse #1 admitted to management during an investigation that she signed the TAR indicating she provided the tube feeding on 9/29/24 even though the tube feeding was not given to Resident #103.