STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345045	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY , BLOWING ROCK, North Carolina, 28605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 07/28/25 through 07/31/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D1A31-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 07/28/25 through 07/31/25. Event ID# 1D1A31-H1. The following intakes were investigated: 826017, 826019, 826022, 826024, 826029, 826030. 16 of the 16 complaint allegations did not result in deficiency.	F0000		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with the Medical Director and staff, the facility failed to prevent a medication error when Nurse #2 administered a medication to a resident without a physician's order. On 6/21/25, Resident #92 received a 300 milligram (mg) dose of gabapentin (nerve pain medication) that was left in a medication cup labeled with Resident #94's last name. The deficient practice occurred for 1 of 6 residents reviewed for unnecessary medications (Resident #92). Findings included: Resident #92 was admitted to the facility on 6/13/25 with diagnoses including volvulus (abnormal twisting of	F0658	F0658 – Services Provided Meet Professional Standards 1. Plan of Correction for F0658 – Services Provided Meet Professional Standards 1. Corrective action for resident(s) affected by the deficient practice: On 6/21/2025, Resident #92 received a 300 mg dose of gabapentin intended for another resident. Upon discovery, the Assistant Director of Nursing (ADON) was immediately notified by Nurse #2. Vital signs and neurological status were assessed and found to be at baseline. The on-call physician was contacted, and the incident was documented in the physician communication log. Resident #92 and their family were informed of the error. A follow-up assessment was conducted by the Nurse Practitioner on 6/23/2025, confirming no adverse effects. The medication error incident report was completed, and the nurse involved received immediate counseling and re-education on medication administration protocols. 2. Corrective action for residents with the potential to be affected by the deficient practice: All current residents have the potential to be affected	08/23/2025

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

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F0658 SS = D	Continued from page 1 intestine) and aftercare following digestive system surgery, and chronic pain. The admission Minimum Data Set (MDS) assessment dated 6/19/25 revealed Resident #92's cognition was moderately impaired. A review of Resident #92's active physician order summary as of 6/21/25 revealed no order was in place for the administration of gabapentin. Resident #94 was admitted to the facility on 6/4/25 with diagnoses including fibromyalgia (a chronic disorder causing pain) and Parkinson's disease. A review of Resident #94's MAR revealed a physician's order for gabapentin 300 mg give one capsule three times a day was scheduled to be administered at 9:00 AM, 2:00 PM, and 9:00 PM. A review of the medication error incident report documented by Nurse #2 revealed on 6/21/25 at approximately 6:00 PM, Resident #92 received gabapentin 300 mg that was intended for Resident #94. The error report indicated Resident #92's family member was in the room and questioned Nurse # 2 if gabapentin was a new order. Nurse #2 administered the gabapentin and afterwards the family member presented Resident #92's order summary that did not include gabapentin. Nurse #2 reviewed Resident #92's MAR and medical chart and confirmed gabapentin 300 mg was administered in error and was ordered for Resident #94. The report indicated the immediate action taken by Nurse #2 was to call the Assistant Director of Nursing (ADON) and instructed to call the on-call physician and report the medication error to the on-coming nurse. Nurse #2 left two messages for the on-call physician, obtained vital signs, and checked neurological status and noted Resident #92 was at baseline. Nurse #2 made a note in the physician's communication folder and notified the family member of the medication error. A review of Nurse #2's progress note documented on 6/21/25 at 8:44 PM revealed gabapentin 300 mg was given to Resident #92 instead of Resident #94. After reviewing the medical chart and MAR, Nurse #2 notified the ADON of the medication error and was instructed by the ADON to notify the on-call physician for orders.	F0658	Continued from page 1 by medication administration errors. A facility-wide audit of medication administration practices was initiated on 8/14/2025 by the Assistant Director of Nursing (ADON). Education initiated 8/14/2025 to include the "6 rights" with emphasis and importance on verifying the resident's identity and medication orders prior to administration. No other residents were identified affected. 3. Measures/Systemic changes to prevent reoccurrence of deficient practice: Beginning 8/14/2025, all licensed nursing staff, including agency personnel, will undergo mandatory re-education on the "Six Rights" of medication administration as well as completing Medication Administration Observations. Education to include, any medications not administered immediately are to be discarded. Education to be included and re-emphasized during orientation to include licensed staff and agency. Education to be completed by 8/22/2025, any employee that has not received education will not be able to work until education is completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning on 8/11/2025 the DON and/or designee will conduct weekly audits of medication administration utilizing the Quality Assurance Tool Medication Administration for a random sample of 10 residents for three weeks, followed by monthly audits for two months. Audit results will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will be addressed through retraining and corrective action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Compliance Date: 08/23/2025 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan	

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F0658 SS = D	Continued from page 2 Nurse #2 noted Resident #92's vital signs and neurological status were at baseline and would continue to monitor for changes. An interview was conducted on 7/30/25 at 2:26 PM with Nurse #2. Nurse #2 revealed she had removed Resident #94's gabapentin from the medication package and went to administer the dose scheduled at 2:00 PM on 6/21/25. Nurse #2 recalled Resident #94 was either not in the room or in bathroom and stated she was unable to administer the gabapentin. She went back to the medication cart and wrote Resident #94's last name on a medication cup and put it in the medication cart to give later. She started administering medications to the other residents and when she got to Resident #92 saw the medication cup with the gabapentin and thought it was Resident #92's name on the cup because the last names were similar. She reviewed Resident #92's MAR for medication that was scheduled and added it to the cup with the gabapentin. Resident #92's family member was in the room and Nurse #2 stated she explained what each pill was to Resident #92 and when she named gabapentin the family member questioned if Resident #92 got gabapentin, then stated, "maybe it was started at the hospital," Nurse #2 revealed she administered the gabapentin and did not check the physician orders to confirm gabapentin was listed. Nurse #2 revealed Resident #92 did not question the medications and took the gabapentin at approximately 5:30 or 6:00 PM on 6/21/24. Nurse #2 revealed it was approximately 15 to 30 minutes later when Resident #92's family member informed her gabapentin was not on the list of medications and that was when she recalled the gabapentin was for Resident #94. Nurse #2 revealed she called the ADON and was told to notify the on-call physician and let them know what happened and provide guidance and get vital signs. Nurse #2 described Resident #2 was alert and oriented at her baseline and had no abnormal vital signs. She left two messages for on-call physician and wrote a note in the physician's communication book, confirmed with the family member gabapentin was given in error, and informed the oncoming nurse what happened. Nurse #2 stated she did not observe Resident #92 was over sedated from the time the gabapentin was administered till the end of her shift around 8:00 PM. A review of Resident #92's vital signs revealed the following: - 6/21/25 at 7:46 PM heart rate 70 (normal 60 to 100) beats per minute (bpm): blood pressure 120/68 (normal	F0658	Continued from page 2 of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F0658 SS = D	Continued from page 3 120/80); respiratory rate 17 (normal 12 to 20) breaths per minute: oxygen saturation 95% (normal 95 to 100) on room air. - 6/21/25 at 9:59 PM heart rate 76 bpm: blood pressure 134/65: respiratory rate 17 breaths per minute. - 6/22/25 at 7:06 AM heart rate 66 bpm: blood pressure 116/70: respiratory rate 18 breaths per minute: oxygen saturation 98% on room air. - 6/22/25 at 8:52 AM heart rate 83 bpm: blood pressure 117/48: respiratory rate 18 breaths per minute: - 6/22/25 at 9:26 PM heart rate 86 bpm: blood pressure 137/49: respiratory rate 18 breaths per minute. - 6/23/25 at 8:04 AM heart rate 85 bpm and blood pressure 129/54. A progress note dated 6/22/25 at 9:00 AM documented by Nurse #2 revealed Resident #92 vital signs were stable, the resident was alert and ate breakfast. A nurse progress note dated 6/22/25 revealed Resident #92 had no complaints of pain or discomfort. An interview was conducted on 07/30/25 at 4:28 PM with ADON. The ADON stated she was the on-call supervisor on 6/21/25 and received a call about the medication error for Resident #92. The ADON revealed she guided Nurse #2 to complete the medication error incident report and notify the physician, resident, family, and/or the Responsible Party. A review of the Nurse Practitioner (NP) progress note dated 6/23/25 revealed Resident #92 was seen for a follow-up visit. The NP noted Resident #92 was alert and dressed and prepared to eat lunch. The NP's physical exam of Resident #92 noted she was alert, engaged and made good eye contact, and in no acute distress. Vital signs were noted as blood pressure 117/61, respiratory rate 18, and heart rate 78. During an interview on 07/31/25 at 1:01 PM, the Medical Director stated a 300 mg dose of gabapentin given in error he would expect side effects of increased drowsiness or lethargy for approximately 24 hours. The Medical Director revealed it was his professional	F0658		

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F0658 SS = D	Continued from page 4 opinion that the 300 mg dose of gabapentin given in error was not a significant amount or caused a negative outcome for Resident #92 and stated he was made aware of the medication error. A second interview was conducted on 07/31/25 at 10:03 AM with the ADON. The ADON stated the expectation was for Nurse #2 to follow the rights of medication administration that included to ensure the right medication was given to the right resident. The ADON stated the resident's name and medication orders were reviewed on the MAR before administering. The ADON stated Nurse #2 was expected to discard a medication if a resident was not available and should not have left the gabapentin in a cup inside the medication cart to avoid a medication error. An interview was conducted on 07/31/25 at 3:53 PM with the Administrator. The Administrator revealed Nurse #2 should have discarded the gabapentin when she was unable to administer it to Resident #94. The Administrator revealed the expectation was for Nurse #2 to review Resident #92's physician orders and MAR before administering gabapentin.	F0658		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of	F0761	F0761 – Label/Store Drugs and Biologicals 1. Plan of Correction for F0761 – Label/Store Drugs and Biologicals 1. Corrective action for resident(s) affected by the deficient practice: On 07/28/2025, an opened tube of Miconazole nitrate cream and an opened tube of Zinc oxide cream were found unattended on the window sill in Resident #80's room. These medications were not labeled for self-administration and had not been assessed for such. Upon discovery, both items were immediately removed and secured in the medication cart by nursing staff. Resident #80 was interviewed and confirmed he had not used the medications. A nursing assessment confirmed no adverse effects or safety concerns. The Assistant Director of Nursing (ADON) reviewed the resident's record and confirmed no authorization for self-administration was present. 2. Corrective action for residents with the potential to be affected by the deficient practice:	08/23/2025

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F0761 SS = D	Continued from page 5 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to secure an opened tube of antifungal ointment and an opened tube of zinc oxide cream for 1 of 1 resident reviewed for medication storage (Resident #80). Resident #80 was admitted to the facility on 02/28/24. The quarterly Minimum Data Set (MDS) assessment dated 07/11/25 coded Resident #80 with intact cognition. A review of Resident #80's medical records revealed he had never been assessed for self-administration of medication. During an observation conducted on 07/28/25 at 12:59 PM, one opened tube of Miconazole nitrate cream (an over-the-counter antifungal medication used to treat fungal infections of the skin, such as athlete's foot, jock itch, and ringworm) with the concentration of 2%, and an opened tube of Zinc oxide (a topical cream used to treat and prevent diaper rash) with the concentration of 20% were observed left unattended on top of the window sill in Resident #80's room and ready to be used. An interview was conducted with Resident #80 on 07/28/25 at 1:02 PM. He stated both medications had been sitting on the window sill since he moved into the room. He added both medications did not belong to him and denied he had ever used any of the topical medication so far. During a joint observation and subsequent interview with Nurse #1 and Medication Aide #1 (MA) on 07/28/25 at 1:06 PM, MA #1 stated she saw both medications in Resident #80’s room for a few days but was not sure they had to be secured in the medication cart. Nurse #1 stated it was her second day working in the facility. She oversaw MA #1, but she was working at the adjacent 200 Hall. She did not know there were medications left unattended in Resident 80’s room and added both	F0761	Continued from page 5 All current residents have the potential to be affected by improperly stored medications. On 7/28/2025, the ADON initiated a facility-wide audit of resident rooms to identify any unsecured medications. Any medications found outside of designated storage areas were removed and properly secured. Residents requesting to self-administer medications were assessed for the ability to self-administration, and documentation was updated accordingly. There were no residents identified to self-administer medications. Staff to be re-educated on the policy prohibiting unattended medications in resident rooms unless formally approved for self-administration. 3. Measures/Systemic changes to prevent reoccurrence of deficient practice: Beginning 08/11/2025, all licensed nurses and medication aides will receive re-education on medication storage policies, including the requirement to secure all medications in locked carts unless explicitly authorized for self-administration. Education to be included and re-emphasized during orientation to include nursing staff and agency. Education to be completed by 8/22/2025, any employee that has not received education will not be able to work until education is completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Starting week of 8/11/2024 the ADON and/or designee will conduct weekly audits utilizing the Quality Assurance Tool Drug Storage by obtaining a random sample of 10 resident rooms for four weeks, followed by monthly audits for three months. Audit results will be reviewed during the monthly Quality Assurance meetings. Any non-compliance will be addressed through immediate corrective action and retraining. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Compliance Date: 08/23/2025 To remain in compliance with all federal and state regulations, the facility has taken or will take the	

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F0761 SS = D	Continued from page 6 medications should be kept in the medication cart. An interview was conducted with the Assistant Director of Nursing (ADON) on 07/28/25 at 1:18 PM. She stated both medications should be kept in the medication cart. It was her expectation for the facility to remain free of unattended medications. During an interview conducted on 07/28/25 at 1:23 PM, the Administrator stated both medications should be kept in the medication cart. She expected the staff to be more attentive when providing care or conducting medication pass to ensure the facility was free of unattended medications. An interview was conducted with the Medical Director on 07/31/25 at 1:00 PM. He stated all the medications should be kept securely in medication carts or medication storage rooms. It was his expectation for the facility to remain free of unattended medications.	F0761	Continued from page 6 actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	F812 1. For dietary services, a corrective action was obtained on 7/28/2025. Based on nourishment room observations and interviews, it was noted the facility had failed to store food properly in 1 of 3 nourishment rooms. Upon observation egg salad noted passed expiration date, orange juice labeled incorrectly, and improperly sealed and labeled soup. On 7/28/2025 expired and improperly labeled items thrown out. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 7/30/2025 the Dietary Service Director and Senior Nutrition Service Coordinator completed a walk-through of the nourishment rooms to ensure nourishments rooms met standards to store, prepare, and serve sanitary food/beverages. 3. Systemic changes In-service education was provided to Dietary Staff, Nursing Staff, and Environmental Service Staff initiated on 8/15/2025.	08/23/2025

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F0812 SS = E	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to label and date leftover food and failed to discard food items by the expiration or used by date for 1 of 3 nourishment room refrigerators (300/400 hall) reviewed for food storage. This practice had the potential to cause foodborne illnesses. Findings included: An observation and interview were conducted on 07/28/25 at 10:50 AM with the Certified Dietary Manager (CDM) for review of the nourishment room refrigerator. The following were observed in the nourishment room refrigerator designated for the 300 and 400 hall used to store food brought into the facility for residents: a. A 12-ounce unopened container of egg salad with a use by date of 7/19/25. The CDM stated the date on the egg salad container indicated it should have been discarded on 7/19/25. b. A 10-ounce opened container of orange juice with a use by date of 6/25/25. The container did not have a resident name. The CDM revealed the orange juice should have been discarded on 6/25/25 as indicated on the container use by date and labeled with the resident's name. c. A opened reusable plastic storage container of soup with a handwritten date of 7/16/25. The container was half full and did not include the name of the resident it was for. The CDM stated the container of soup should have the name of the resident, the date it was purchased/made, and a used by date. The CDM stated soup was good for 7 days and should have been discarded on 7/23/25. During an interview on 07/30/25 at 5:49 PM, the CDM revealed dietary staff restocked the nourishment room refrigerators daily and were expected to discard expired and out of date items including food brought in for residents. The CDM revealed typically the nurse or Nurse Aide (NA) received food brought in for residents and expected to label the item with the name of the resident, the date it was received, and the use by date. The CDM stated it was a team effort between dietary and nursing staff to ensure out of date food was discarded. An interview was conducted on 07/31/25 at 2:59 PM with Nurse Aide (NA) #1. NA #1 revealed typically the nurse or the NA on the hall were given food brought in for	F0812	Continued from page 7 Topics included: · Procedures and policies for handling personal food. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. Dietary Service Direction or assignee will monitor procedures for proper food storage in nourishment rooms daily x 2 weeks then weekly x 4 weeks using the Nourishment Room QA Tool which will observe that all supplements are labeled, dated, within proper dates, and stored properly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Date of Compliance 8/23/2025 To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all deficiencies cited have been or will be corrected by the dates indicated.	

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F0812 SS = E	Continued from page 8 residents and responsible for labeling the resident's name and the date the food was placed in the nourishment room refrigerator. NA #1 revealed residents' food was good for 3 days when stored in nourishment room refrigerator and if she observed items pass the use by date or expired food, she discarded it. During an interview on 07/31/25 at 3:59 PM, the Administrator stated dietary staff were responsible for checking the expiration and use by dates on food items being stored in the nourishment room refrigerators and to discard if out of date. The Administrator revealed food brought in the facility was labeled with the resident's name and discarded according to the use by date.	F0812		