

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2025
NAME OF PROVIDER OR SUPPLIER Emerald Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 54 Red Mulberry Way Lillington, NC 27546	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2025
NAME OF PROVIDER OR SUPPLIER Emerald Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 54 Red Mulberry Way Lillington, NC 27546	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with resident, staff, and Physician, the facility failed to communicate with the physician and obtain further instructions 1) regarding steps to take when a rehabilitation resident was refusing to cooperate with safety recommendations while experiencing difficulty and pain while transferring in the manner she was attempting and which was not recommended by therapy and 2) when the resident screamed during the transfer, reported pain following the transfer, and requested to go to the hospital. This was for 1 of 3 residents reviewed for accidents (Resident # 1).The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE] after undergoing a total left knee replacement on 7/3/25 and finding she could not care for herself at home. Additionally Resident # 1 had diagnoses of rheumatoid arthritis, gout, osteoporosis, and muscle weakness.Review of an EMS (Emergency Medical System) report revealed that prior to Resident # 1 residing at the facility, she had problems with her left knee post operatively and had called emergency medical services while residing at home on 8/22/25 after feeling a pop in her left knee and being uncomfortable bearing weight on the leg.Review of the facility physician's 8/29/25 admission note revealed Resident # 1 had x-rays completed in the hospital Emergency Department after the resident felt the pop post operatively on 8/22/25 and there was no evidence of hardware failure.Review of 8/28/25 physician orders revealed Resident # 1 was prescribed acetaminophen 500 milligrams 2 tablets every eight hours on a scheduled basis. Additionally, per physician orders on 8/29/25 Resident # 1 was started on Celecoxib 200 milligrams every day (This is a medication used to relieve pain and inflammation.)Review of Resident # 1's initial 8-28-25 physical therapy evaluation revealed the Physical Therapist # 1 documented the following information. The resident had originally gone to rehabilitation following her 7/3/25 knee replacement and then returned home. She had been upgraded to weight bearing as tolerated at 6 weeks post operative. While home there was a day when she stood up and it sounded like her knee was breaking and painful. X-rays had been done and nothing was broken. She had been admitted to the facility on [DATE] for further therapy.Review of Resident # 1's admission Minimum Data Set assessment, dated 9/2/25, revealed Resident # 1 was cognitively intact. She had no behavioral problems. Transfers were not attempted during the assessment period. She had required substantial to maximum assistance to go from a seated position to a standing position.Physical Therapist # 1 was interviewed on 9/23/25 at 12:20 PM and again on 9/24/25 at 4:19 PM and reported the following information. Resident # 1 was evaluated by her initially to need a mechanical lift. She did improve to the point where she could do a scoot transfer. The resident's arm rests were able to be removed from her wheelchair, and she was instructed on lateral incremental scoot transfers. This entailed using her arms and to some degree her legs in order to move her bottom over in increments until she had maneuvered from one surface to the other. She could also use this technique with the toilet since her arm rests could be removed. At times she could be more tired at night and if she was not able to do incrementally and safely transfer by scooting then the staff were to use a mechanical lift. This information had been relayed to the nursing staff.Nurse Aide (NA) # 3 had cared for Resident # 1 from 7:00 AM to 3:00 PM on 9/5/25. NA # 3 was interviewed on 9/24/25 at 4:35 PM and reported the following information. She had periodically cared for Resident # 1 prior to 9/5/25. Prior to 9/5/25 Resident # 1 was a one person assist to transfer. On 9/5/25 she helped get Resident # 1 out of bed shortly before lunch and the resident could not stand that day. Therefore she (NA # 3) obtained help and used the mechanical lift to get her out of bed.During an interview with Resident # 1 on 9/24/25 at 9:58 AM the resident reported that she in general had pain from her rheumatoid arthritis. On the dayshift of 9/5/25 she had not been experiencing pain at her surgical knee site during the day, but she had chronic pain related to her arthritis. The resident reported her right knee (which had not been replaced) was bone on bone due to her arthritis.Review of progress notes revealed the following entry by Nurse # 1 made on 9/6/25 at 4:52 AM. I was called into [Resident # 1's room] by [NA # 1] to assist her getting [Resident #1] into the bed at 2130 hrs (9:30 PM). [NA #1] suggested that we use [mechanical] lift but the pt (patient) refuse saying that how PT (physical therapy) wanted her to do and she was going to follow the order. After several attempts [NA # 1] again suggested the [mechanical lift] and again she refused saying that all she needed to do was to grab the grab bar and pull herself up and then turn and sit down. Unfortunately, when she stood up and turn she c/o (complained of) pain to her left knee. There was no swelling or discoloration to her left knee and the pt (natient) did not fall. Later that night I was told that she wanted to see me but when I got there she was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2025
NAME OF PROVIDER OR SUPPLIER Emerald Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 54 Red Mulberry Way Lillington, NC 27546	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2025
NAME OF PROVIDER OR SUPPLIER Emerald Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 54 Red Mulberry Way Lillington, NC 27546	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with resident, staff, and Physician the facility failed to 1) assist a resident, who had been experiencing problems following surgery, in a transfer manner recommended by physical therapy and 2) failed to stop and communicate with the physician and the Director of Nursing for further directions when a resident was refusing a safe transfer technique before proceeding to attempt the transfer. This was for 1 of 3 residents reviewed for accidents (Resident #1).The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE] after undergoing a total left knee replacement on 7/3/25 and finding she could not care for herself at home. Additionally, Resident # 1 had diagnoses of rheumatoid arthritis, gout, osteoporosis, and muscle weakness. Review of an EMS (Emergency Medical System) report revealed that prior to Resident # 1 residing at the facility, she had problems with the left knee post operatively and had called emergency medical services while residing at home on 8/22/25 after feeling a pop in her left knee and being uncomfortable bearing weight on the leg.Review of the facility physician's 8/29/25 admission note revealed Resident # 1's x-rays had been done in the Emergency Department after the resident felt the pop post operatively on 8/22/25 and there was no evidence of hardware failure.Review of 8/28/25 physician orders revealed Resident # 1 was prescribed acetaminophen 500 milligrams 2 tablets every eight hours on a scheduled basis. Review of Resident # 1's Medication Administration Record revealed the acetaminophen was scheduled to be given at 6:00 AM, 2:00 PM, and 10:00 PM. Additionally, per physician orders on 8/29/25 Resident # 1 was started on Celecoxib 200 milligrams every day. (This is a medication used to relieve pain and inflammation.)Review of Resident # 1's admission Minimum Data Set assessment, dated 9/2/25, revealed Resident # 1 was cognitively intact. She had no behavioral problems. Transfers had not been attempted during the assessment period. She had required substantial to maximum assistance to go from a seated position to a standing position.Resident # 1's care plan, initiated on 8/29/25, included the information that Resident #1 was to have physical therapy and occupational therapy. According to the care plan, the resident was a transfer with one person assist.On 9/23/25 at 5:15 PM the DON (Director of Nursing) provided a copy of the resident's electronic Kardex used by the Nurse Aides regarding care assistance needed. The Kardex noted the resident was a transfer with assist of 1 person. Start date was noted to be 9/9/25. According to the DON, the information prior to the update on 9/9/25 could not be viewed once the update occurred.Review of Resident # 1's initial 8-28-25 physical therapy evaluation revealed Physical Therapist # 1 documented the following information. The resident had originally gone to a rehabilitation facility following her 7/3/25 knee replacement and then returned home. She had been upgraded to weight bearing as tolerated at 6 weeks post operative. While home there was a day when she stood up and it sounded like her knee was breaking and painful. X-rays had been done and nothing was broken. She had been admitted to the facility on [DATE] for further therapy. Physical Therapist # 1 was interviewed on 9/23/25 at 12:20 PM and again on 9/24/25 at 4:19 PM and reported the following information. Resident # 1 was evaluated by her initially to need a mechanical lift. The facility had a way to communicate the type of transfer residents needed. After the initial evaluation, the type of transfer was communicated verbally to a resident's primary nurse. Also, the therapist, who did the initial evaluation, completed communication paperwork for nursing and rehabilitation and gave it to the rehabilitation director. A general clinical meeting was held daily Monday through Friday which included administrative nursing staff and rehabilitation staff. At the meeting, the rehabilitation director reported what type of transfer the resident was assessed to need. Every Tuesday, the rehab department also had a meeting and discussed progress within their own department. If a resident had graduated to a different mode of transfer this was discussed and then conveyed the next day in clinical meeting so that nursing staff would also know. At time of Resident # 1's initial evaluation, Resident # 1 was recommended to need a mechanical lift transfer. She did improve to the point where she could do an incremental scoot transfer. The resident's arm rests were able to be removed from her wheelchair, and she was instructed on lateral incremental scoot transfers. This entailed using her arms and to some degree her legs in order to move her bottom over in increments until she had maneuvered from one surface to the other. She could also use this technique with the toilet since her arm rests could be removed. She could also stand and take some steps forward but it had not been recommended that she rotate around and pivot on her operative leg. At times she could be more tired at night and if she was not able assist in scooting from surface to surface safely then the staff were to</p>		