STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgecombe Health Center by Harborview	1000 Western Boulevard Tarboro, NC 27886

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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 - Few	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** 50404 Based on record review, resident responsible party (RP) and staff interviews, the facility failed to include documentation in the medical record that the facility staff had spoken with the responsible party (RP) or resident regarding advance directives (Resident #110). This was for 1 of 5 residents reviewed for advance directive. The findings included: A review of the facility's policy titled Residents' rights Regarding Treatment and Advance Directives dated 3/1/22 and reviewed/revised on 3/1/24 revealed it is the policy of this facility to support and facilitate a residents' right to formulate an advance directive. On admission the facility will determine if the resident has executed an advance directive, and if not determine whether the resident would like to formulate an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Resident #110's medical record revealed Resident #110 was admitted to the facility on [DATE] with diagnoses that included stroke, hypertension, and thyroid disorder. The review also revealed the resident code status was a full code. There was no documentation in the record for education regarding formulation of an advanced directive and/or an opportunity to formulate an advance directive was offered. An interview with Resident #110's RP was held in the facility on 3/13/25 at 9:21 AM, at which time he stated, Resident #110 does not have an advanced directive in place. He went on to say a facility employee talked to him about advanced directives, but he was not interested at that time. He did not recall who spoke with him regarding advanced directives. An interview was completed on 3/13/25 at 8:48 AM with the facility Admission Director. She revealed she does not discuss advance directives with residents or responsible parties (RP) as that task would be the responsibility of the Admissions Nurse. An interview with the Admission Nurse was held on 3/13/25 at 9:05 AM, she stated she speaks to code status only as the Social Worker was responsible for discussing advance directives with residents and their RP. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Social Worker was held on 3/13/25 at 9:45 AM in which she stated typically the Admissions Director would be responsible for the advance directive discussion with residents and RPs. She would not have addressed advanced directives unless a coworker asked her to do so. An interview was completed with the facility Administrator on 3/13/25 at 9:55 AM. At that time, she revealed her expectation would have been that the Social Worker follows up with families that did not have advance directives in place upon admission to educate them and offer assistance and education to establish advance directives if desired. She went on to further state her expectation would have also been that the Social Worker document those conversations in the resident's chart.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff and Responsible Party (RP) interviews, the facility failed to provide a Centers for Medicare and Medicaid (CMS) Form 10123-Notice of Medicare Non-Coverage (NOMNC) within the required time frame. This was for 1 of 4 residents (Resident #129) reviewed for Beneficiary Notices. Findings included: Resident #129 was admitted to the facility on [DATE]. Review of Resident #129's NOMNC form revealed the effective date coverage of his current skilled nursing and therapy services service would end was 3/11/25. It further revealed Medicare would probably not pay for his skilled nursing and therapy services after that effective date, and Resident #129 might have to pay for any services he received. The form included Resident #129's rights to appeal the decision. It was dated as signed by Resident #129's RP on 3/12/25. On 3/12/25 at 9:43 AM an interview with the Social Worker (SW) indicated Resident #129 was being discharged from the facility that day. She stated she had multiple conversations with Resident #129's RP throughout Resident #129's stay in the facility regarding his discharge plan. She stated she had not had a chance to provide Resident #129's RP with a NOMNC until 3/12/25. She reported every time she went to provide the form to Resident #129's RP and have it signed, the RP had already left the facility. On 3/12/25 at 10:05 AM an interview with Resident #129's RP indicated she had multiple conversations with the SW regarding Resident #129's discharge from the facility and had caregivers in place for Resident #129 when he got home. She reported she would have liked to have been informed of her rights regarding Resident #129's discharge from the facility before the day of discharge. On 3/12/25 at 10:46 AM a follow up interview with Resident #129's RP indicated she had just spoken with the Business Office Manager, had all her questions answered, and would proceed with taking Resident #129 home that day. On 3/12/25 at 3:40 PM an interview with the Administrator indicated the SW should have ensured Resident #129's RP was provided with the NOMNC form prior to the day of Resident #129's discharge from the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for anticoagulant use, antiplatelet use, and discharge status for 4 of 27 resident assessments reviewed (Resident #109, Resident #138, Resident #80, and Resident #139). Findings included: 1. Resident #109 was admitted to the facility on [DATE]. Review of Resident #109's MDS assessment dated [DATE] revealed the resident was assessed as having received an anticoagulant medication during the lookback period. Review of Resident #109's medication administration record for December 2024 revealed the resident did not take an anticoagulant medication during the lookback period. During an interview on 3/11/25 at 11:24 AM the MDS Coordinator stated Resident #109 was not on an anticoagulant and the MDS dated [DATE] was coded incorrectly. During an interview on 3/11/25 at 11:46 AM the Administrator stated MDS assessments should accurately reflect the resident's status. 2. Resident #138 was admitted to the facility on [DATE]. Review of Resident #138's discharge planning progress note dated 1/9/25 revealed the social worker spoke with the responsible party and resident regarding resident's discharge and discharge planning. Resident #138 was being discharged from her managed care insurance on 1/10/25 and would be discharged home on 1/11/25. Review of Resident #138 discharge minimum data set assessment dated [DATE] revealed the discharge assessment was coded as an unplanned discharge. During an interview on 3/11/25 at 11:18 AM the MDS Coordinator stated Resident #138 had a planned discharge on 1/11/25 and it was coded incorrectly on the 1/11/25 discharge MDS. During an interview on 3/11/25 at 11:46 AM the Administrator stated MDS assessments should accurately reflect the resident's status. 41009 3. Resident #80 was admitted to the facility on [DATE]. A review of Resident #80's physician's orders revealed an order dated 1/3/25 for aspirin (an antiplatelet medication) 81 milligrams (mg) one tablet by mouth daily for transient ischemic attack (disrupted blood flow to the brain), venous insufficiency (impaired blood flow in the veins), and atrial fibrillation (an irregular heartbeat). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #80's February 2025 Medication Administration Record (MAR) revealed documentation aspirin 81 mg was administered to Resident #80 on 2/27/25 and 2/28/25. A review of Resident #80's March 2025 MAR revealed documentation aspirin 81 mg was administered to Resident #80 on 3/1/25 through 3/5/25. A review of Resident #80's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was not coded as taking any antiplatelet medications. On 3/13/25 at 8:22 AM an interview with the MDS Coordinator indicated she coded the medication section of Resident #80's MDS assessment dated [DATE]. She stated she did not code Resident #80 as taking antiplatelet medication on this MDS assessment because she had been instructed not to code aspirin as an antiplatelet medication unless the dosage was 325 mg. On 3/13/25 at 10:18 AM an interview with the Director of Nursing indicated the MDS Coordinator would know more about the coding of MDS assessments than she did. She stated MDS assessments should be an accurate reflection of the medications a resident was taking. On 3/13/25 at 10:23 AM an interview with the Administrator indicated MDS assessments should be coded accurately. 50404 4. Resident #139 was admitted to the facility on [DATE]. The discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #139 was discharged to a short-term general hospital. A progress note written by the Social Worker on 1/22/25 at 2:44 PM stated Resident #139 was discharged from the facility at 12:45 PM and was transported home by his friend. During an interview with the MDS Coordinator on 3/12/25 at 1:15 PM, she stated the MDS should have been coded to home and her coding was an error. An interview with the Director of Nursing was held on 3/12/25 at 1:23 PM, at that time she stated the resident was discharged home. During an interview on 3/12/25 at 1:26 PM, the Administrator stated her expectation would have been the MDS information was coded accurately.

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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** 48230 Based on observation, record review and staff interviews the facility failed to develop an individualized, person-centered comprehensive care plan to include the use of side rails (Resident #82 and Resident #119) and an anticoagulant (blood thinning) medication (Resident #129). This was for 3 of 27 residents whose comprehensive care plans were reviewed. Findings included: 1. Resident #82 was admitted to the facility on [DATE] with diagnoses including history of cerebral infarction (stroke). A review of Resident #82's record revealed an assessment titled side rail/entrapment risk evaluation dated 2/22/25 and completed by Nurse #1 revealed bilateral one quarter length side rails were to be used. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #82 was cognitively intact. The MDS indicated Resident #82 required partial to moderate assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #82 had impairment of one side of upper extremities and impairment of both lower extremities. The MDS indicated Resident #82's siderails were not used as a restraint. A care plan with the latest review date of 3/3/25 revealed no reference to use of side rails for Resident #82. An observation on 3/10/25 at 11:54 AM revealed Resident #82 lying in bed with bilateral one-quarter length side rails in the up position on the bed. An interview with the MDS nurse was conducted on 3/13/25 at 9:08 AM. The MDS nurse stated she was responsible for updating care plans with information she received from other departments such as Nursing. The MDS nurse revealed she was not aware side rails needed to be addressed in a resident's care plan. In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated she was not aware side rails needed to be addressed in a resident's care plan. In an interview with the Administrator on 3/12/25 at 1:15 PM she stated she was unaware side rail usage needed to be addressed in a resident's care plan. 2. Resident #119 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke). A review of Resident #119's record revealed an assessment titled side rail/entrapment risk evaluation dated 2/7/25 and completed by UM #1 revealed the resident was using bilateral quarter length side rails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #119 was severely cognitively impaired and was dependent on staff for bed mobility. The MDS indicated Resident #119's siderails were not used as a restraint. A care plan with the latest review date 1/10/25 revealed no reference to side rail usage for Resident #119. An observation on 3/11/25 at 1:17 PM revealed Resident #119 lying in bed with bilateral one quarter length side rails in the raised position. An observation on 3/12/25 at 11:39 AM revealed Resident #119 in bed with the one quarter length side rails in the raised position. An interview with the MDS nurse was conducted on 3/13/25 at 9:08 AM. The MDS nurse stated she was responsible for updating care plans with information she received from other departments such as Nursing. The MDS nurse revealed she was not aware side rails needed to be addressed in a resident's care plan. In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated she was not aware side rails needed to be addressed in a resident's care plan. In an interview with the Administrator on 3/12/25 at 1:15 PM she stated she was unaware side rail usage needed to be addressed in a resident's care plan. 41009 3. Resident #129 was admitted to the facility on [DATE] with a diagnosis of atrial flutter (an irregular heartbeat). A review of a physician's order for Resident #129 dated 2/1/25 revealed to administer Eliquis (an anticoagulant/blood thinning medication) 5 milligrams (mg) to Resident #129 by mouth twice daily for atrial flutter. A review of Resident #129's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #129 was taking anticoagulant medication and an indication for the medication was noted. A review of Resident #129's Medication Administration Record February 2025 (MAR) revealed documentation Eliquis 5mg was administered to Resident #129 as ordered by his physician. A review of Resident #129's comprehensive care plan dated last revised on 3/5/25 did not reveal a focus area for or address the risk of bleeding related to receiving anticoagulant/blood thinning medication. On 3/13/25 at 9:23 AM an interview with MDS Coordinator #2 indicated she completed the medication section of Resident #129's admission MDS dated [DATE]. She stated she coded this section to indicate Resident #129 was taking anticoagulant medication. She reported she would have been responsible for ensuring his comprehensive care plan reflected his use of this medication and she had not. She stated this was an error on her part. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/13/25 at 10:18 AM the Director of Nursing stated anticoagulants were high risk medications that required additional safety monitoring. She reported Resident #129's care plan should have reflected his use of the medication so all staff would be aware he was receiving it.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on observations, staff interviews, and record review the facility failed to attempt to use alternatives prior to installing side rails for 2 of 3 residents (Resident #82 and Resident #119) reviewed for side rails. Findings included: 1. Resident #82 was admitted to the facility on [DATE] with diagnoses including seizure disorder and history of cerebral infarction (stroke). A review of Resident #82's record revealed an assessment titled side rail/entrapment risk evaluation dated 2/22/25 and completed by Nurse #1 revealed there was no question on the evaluation regarding attempts to use alternatives before using side rails. Nurse #1 was not able to be reached for interview. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #82 was cognitively intact. The MDS indicated Resident #82 required partial to moderate assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #82 had impairment of one side of upper extremities and impairment of both lower extremities. The MDS indicated Resident #82's siderails were not used as a restraint. A care plan with the latest review date of 3/3/25 revealed no reference to use of side rails for Resident #82. An observation on 3/10/25 at 11:54 AM revealed Resident #82 lying in bed with bilateral one-quarter length side rails in the up position on the bed. An observation on 3/12/25 at 11:40 AM revealed Resident #82 sitting in his bed with the head raised at a 45-degree angle. The side rails were observed to be in the raised position. An interview with Unit Manager (UM) #1 on 3/11/25 at 2:02 PM revealed the Unit Managers completed the quarterly side rail/entrapment risk evaluations. UM #1 stated they did not attempt alternatives before using side rails. She further stated she was unaware this was a requirement. In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated they did not try interventions before using side rails as she was not aware this was a requirement. In an interview with the Administrator on 3/12/25 at 1:15 PM she stated alternative interventions to side rails were not tried before implementation as she was unaware that this was a requirement. 2. Resident #119 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #119's record revealed an assessment titled side rail/entrapment risk evaluation dated 2/7/25 and completed by UM #1 revealed no questions regarding attempting alternatives to side rails before implementing them. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #119 was severely cognitively impaired and was dependent on staff for bed mobility. The MDS indicated Resident #119's siderails were not used as a restraint. A care plan with the latest review date 1/10/25 revealed no reference to side rail usage for Resident #119. An observation on 3/11/25 at 1:17 PM revealed Resident #119 lying in bed with bilateral one quarter length side rails in the raised position. An observation on 3/12/25 at 11:39 AM revealed Resident #119 in bed with the one quarter length side rails in the raised position. An interview with Unit Manager (UM) #1 on 3/11/25 at 2:02 PM revealed the Unit Managers completed the quarterly side rail/entrapment risk evaluations. UM #1 stated she completed the quarterly evaluation on 2/27/25 for Resident #119. She further stated they did not attempt alternatives before using side rails. She further stated she was unaware this was a requirement. In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated they did not try interventions before using side rails as she was not aware this was a requirement. In an interview with the Administrator on 3/12/25 at 1:15 PM she stated alternative interventions to side rails were not tried before implementation as she was unaware that this was a requirement.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review and staff interviews, the facility failed to obtain a baseline thyroid function test for a resident who was taking Levothyroxine Sodium for 1 of 5 residents reviewed for unnecessary medications (Resident #123). Findings included: Resident #123 was admitted to the facility on [DATE]. Her active diagnoses included hypothyroidism. Review of Resident #123's physician order dated 11/1/24 revealed the resident was ordered Levothyroxine Sodium oral tablet 25 micrograms, give 1 tablet by mouth in the morning for hypothyroidism. Review of a consultant pharmacist recommendation to the physician dated 11/26/24 revealed the pharmacist recommended a baseline thyroid function test to be completed and repeated yearly while Resident #123 was taking Levothyroxine Sodium. The nurse practitioner wrote an order to obtain the lab as recommended. Review of a consultant pharmacist recommendation to nursing dated 12/18/24 revealed the pharmacist again recommended nursing obtain a baseline thyroid function test for Resident #123 per the order from the previous recommendation on 11/26/24 and place them in Resident #123's medical record. Review of Resident #123's medical record on 3/13/25 at 9:30 AM revealed Resident #123 did not have any thyroid function test results documented in the medical record. During an interview on 3/13/25 at 9:42 AM the Director of Nursing stated pharmacy recommendations come to her, and she places them in the physician's box to have the physician or designee respond to the recommendation. The baseline thyroid function test for Resident #123 was scheduled for 12/4/24 as a response to the 11/26/24 pharmacy recommendation and subsequent order from the nurse practitioner. It was ordered and placed in the lab book scheduled for 12/4/24. About a month later, the next recommendation on 12/18/24 came to her from pharmacy and she noted Resident #123's lab was not done on 12/4/24 and she did not know why. She rescheduled the lab for 12/23/24 and the appointment was placed in the lab book as well. She stated this lab was also not obtained and she did not know the reason why. She stated she expects labs like these, which are not stat labs, to be obtained within a few days of the order being written. She concluded this lab was missed and she did not know why. During an interview on 3/13/25 at 9:58 AM the Nurse Practitioner stated the turnaround for a routine lab should be 1 to 2 weeks. These were routine labs and there were no current reasons to think the thyroid-stimulating hormone level was off. He concluded there was no negative outcome for Resident #123 for these labs being missed. During an interview on 3/13/25 at 10:21 AM the Administrator stated labs should be completed as ordered.