STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabethtown Healthcare & Rehab Center	208 Mercer Mill Road Elizabethtown, NC 28337

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, Nurse Practitioner and the Medical Director's interviews, the facility failed to use the mechanical lift to transfer a non-weight bearing resident from a chair to the bed and instead used the stand and pivot method for transferring (A technique for moving where a resident stands with assistance and pivots on their feet then sits. This technique requires the ability to bear most of their body weight.) which resulted in a comminuted (the bone is broken into multiple small pieces) mildly displaced (bone fragments are slightly out of alignment) fracture of the distal tibia (large bone of the lower leg near the ankle) and proximal fibula (upper section of smaller bone in the lower leg just below the knee). This occurred for 1 of 3 residents reviewed for accidents (Resident #77). Findings included: Resident #77 was admitted to the facility on [DATE]. Diagnoses included osteoarthritis of the knee (a breakdown of the protective cartilage that lines the bones and joints), osteopenia (a loss of bone density causing the bone to weaken and an increased risk of fractures) and dementia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #77 was severely cognitively impaired and required extensive two-person assistance with transfers, and activities of daily living (ADLs). Resident #77 had no falls, a weight of 127 pounds, and received blood thinning medication. She was on Hospice services. The care plan dated 6/15/25 revealed Resident #77 had an ADL self-care deficit related to weakness, poor endurance, and poor cognition. Interventions included in part; total dependence with transfers using the mechanical lift with two-person assistance. A progress note dated 8/4/25 at 10:30 AM documented by the Hospice nurse revealed in part; this writer received notification today from the Hospice aide that Resident #77's right lower leg was noted to be bruised, swollen, and painful to touch this morning. Upon arrival Resident #77 was resting in bed with her eyes closed and aroused easily with verbal and tactile stimuli. She was oriented to person and unable to make her needs known and appeared weak and frail. Her right lower leg was bruised, bluish purple in color, swollen, and painful to touch She yelled out it hurts, it hurts when the area was touched and randomly when the area was not touched. Resident #77 was unable to state what happened to her right leg. The facility staff nurse (Nurse #2) was made aware of the right leg status. Resident #77 was medicated with Tylenol 650 milligrams during this visit for pain. Nurse Practitioner #1 is making rounds at the facility today and was notified. Resident #77 requires total assistance with all activities of daily living. A progress note dated 8/4/25 at 3:19 PM documented by Nurse #2 revealed Resident #77's x-ray impression revealed an acute nondisplaced oblique fracture of the proximal fibula, and distal tibia. Nurse Practitioner #1 was made aware. A progress note dated 8/4/25 at 6:32 PM documented by Nurse Practitioner #1 revealed in part; Resident #77 currently received hospice care. Nursing staff reported the presence of bruising on her right leg. Upon assessment, the right lower extremity exhibited mild swelling, and bluish discoloration consistent with bruising, and tenderness upon palpation. There was no active bleeding. The x-ray findings revealed an acute nondisplaced oblique fracture of the proximal fibula, and distal tibia. An orthopedic consult was ordered along with Tramadol 50 milligrams every 12 hours for pain. On 8/5/25 at 3:45 PM Resident #77 was transported by emergency medical services (EMS) to the hospital. A hospital note dated 8/5/25 at 10:56 PM revealed Resident #77 was seen in the emergency department, and vital signs were stable. X-rays showed oblique comminuted mildly displaced fracture of the distal tibial and proximal fibula. Orthopedics was consulted and recommended admission for pain control, there is no anticipated surgical intervention. A hospital orthopedic note dated 8/7/25 at 1:17 PM revealed Resident #77 was evaluated for a mildly displaced fracture of the distal tibial diaphysis and proximal fibular diaphysis. Impressions revealed fracture and osteoarthritis of the knee and osteopenia. Resident #77's Responsible Party stated Resident #77 had been non-ambulatory for several years, using a wheelchair and a slide board. She developed a urinary tract infection six months ago and has been bed bound since that time. The plan of care was to keep the splint in place and remain non-weight bearing. No orthopedic intervention was warranted at this time. Resident #77 returned to the facility. A facility investigation report on 8/5/25 revealed interviews were conducted with Nurse Aide #9 and #10 and concluded that the improper transfer of Resident #77 resulted in the fracture of the tibia and fibula. The Kardex audits concluded that several of the Kardex's needed to be updated and were updated today 8/5/25 by the Director of Nursing and the MDS nurse. Both Nurse Aide #9 and #10 were suspended until the investigation was complete. The timeline of events revealed:On 8/3/25 Resident #77 was up in her Geri chair most of the day at the nurses station. At approximately 7:00 PM Nurse Aide #9 and #10 went in to transfer

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, and staff interviews the facility failed to discard expired nutritional supplements stored for use in 1 of 1 reach-in refrigerator in the kitchen. This practice had the potential to affect residents with physician ordered nutritional supplements. The findings included:An observation of the reach-in refrigerator in the kitchen was completed on 9/2/25 at 11:15 AM and revealed 10 bottles of a nutritional supplement with the expiration date 04/2025. The DM stated the nutritional supplement was expired and should not have been in the reach-in refrigerator. She further stated the staff must have just missed them when checking for expired food that morning. An interview was completed with the Administrator on 9/5/25 at 11:00 AM. The Administrator stated she was surprised to hear that there were expired nutritional supplements found in the reach-in refrigerator, because the dietary staff was very diligent about discarding expired and leftover food items. She further stated that the Registered Dietitian had just inspected the kitchen a couple of weeks ago and he had not found any expired food items. The Administrator indicated her expectation was that there be no expired food items in the kitchen or nourishment rooms.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interviews, the facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EHB) during high contact care for a resident with a pressure ulcer, when a nurse and the Wound Aide were providing wound care without wearing gowns for 2 of 6 staff observed for infection control (Nurse #1 and the Wound Aide).The findings included:The facility policy titled, Enhanced Barriers dated 9/22 stated in part: EBP requires the use of gown and gloves when providing high contact care activities for residents identified as requiring EBP. High contact resident care activities were listed as: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs and assisting with toileting, device care or use, central lines, urinary catheter, feeding tube, tracheostomy and wound care, any skin opening requiring a dressing.An observation of the Wound Aide and Nurse #1 changing Resident #9's pressure wound dressing occurred on 9/4/25 at 9:48 AM in the presence of the Staff Development Coordinator (SDC). The observation revealed Nurse #1 and the Wound Aide were only wearing gloves and did not apply a gown prior to the dressing change or during the dressing change. An interview with the Wound Aide was completed on 9/4/25 at 10:00 AM. The Wound Aide stated she always puts a gown on when changing dressings, but she was just nervous and forgot.A telephone interview was completed with Nurse #1 on 9/5/25 at 9:43 AM. Nurse #1 stated she didn't think she had to wear a gown since the Wound Aide was the one changing the dressing and she was just assisting with helping position the resident on her side.An interview with the SDC was completed on 9/5/25/at 8:50 AM. The SDC stated he was just in the room to observe the dressing change but did not think about the staff wearing gowns until he turned around and saw the personal protection equipment (PPE) on the back of the door. He stated the Wound Aide and Nurse #1 should have been wearing protective gowns while changing the dressing.An interview with the Director of Nursing (DON) was conducted on 9/5/25 at 11:19 AM. The DON stated that Nurse #1 and the Wound Aide should have been wearing gowns during the dressing change. She further stated she would have expected the SDC to remind them if they forgot.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and resident and staff interviews, the facility failed to ensure the bedside call light system was functioning and provide an alternate means of communicating with staff for 2 of 2 residents who were dependent on staff for assistance with activities of daily living (ADL) (Resident #59, and Resident #20). Findings included: Resident #20 was admitted to the facility on [DATE] with diagnoses including congestive heart failure. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #20 was cognitively intact. He required limited one-person assistance with transfers and was wheelchair bound. Resident #59 was admitted to the facility on [DATE] with diagnoses including right lower leg fracture. The Minimum Data Set admission assessment dated [DATE] revealed Resident #59 was cognitively intact. He required extensive assistance with transfers and ADL and was wheelchair bound. Interviews and an observation were conducted on 9/2/25 at 12:00 PM with Resident #20 and Resident #59. Resident #20 and Resident #59 were roommates. Resident #20 stated the call light in their room did not work for three days from Friday 8/29/25 through Monday morning 9/1/25. Resident #20 stated when emergency medical services (EMS) brought his roommate (Resident #59) back from an outside appointment on Friday the call light cord got caught when Resident #59 was being transferred back to bed which caused the whole call light device system to be pulled away from the wall causing both call lights to not work. Resident #20 stated the call lights in the room were not repaired until Monday morning. He (Resident #20) indicated he and his roommate (Resident #59) both required staff assistance with transfers and care and were not provided another means or alternate device to alert staff if assistance was needed or in the event of an emergency. Resident #20 stated the nurses and aides did check on them during the time the call light was not working. Resident #59 indicated he was not provided an alternate device, but the nurses and nurse aides did come in and check on him during that time. During an observation on 9/2/25 at 12:05 PM the call light system in Resident #20 and Resident #59's room was observed to be working when the call light was activated. During an interview on 9/3/25 at 2:15 PM Nurse #1, the assigned nurse on 8/29/25 from 7:00 AM through 7:00 PM for Resident #20 and Resident #59 stated the call light in the resident's room was broken on 8/29/25 when EMS transferred Resident #59 either to or from his bed for an orthopedic appointment that morning. She stated the call light cords were pulled out of the wall and were not working and she verbally reported it to the Maintenance Director on Friday 8/29/25. Nurse #1 stated she checked on both residents at least every 2 hours during her shift. Nurse #1 stated when the call bells weren't functioning they had cow bells to put in the resident rooms for use, but she did not think to give a cow bell to Resident #20 or Resident #59. Nurse #1 stated she notified the assigned nurse aides that the call light was broken. Attempts were made on 9/3/25 at 3:40 PM and 9/5/25 at 1:05 PM to contact Nurse Aide #1 who was assigned to Resident #20 and Resident #59 on 8/29/25 from 7:00 AM through 7:00 PM. There was no response. During an interview on 9/3/25 at 2:30 PM the Maintenance Director stated he was not made aware that the call light system in the room Resident #20 and Resident #59 resided in was broken until Monday morning 9/1/25. He stated he was not notified on Friday, and he was at the facility until 5:30 PM on Friday 8/29/25. He stated if he had been notified on 8/29/25 he would have repaired the broken call light that day. He stated he was not in the facility over the weekend, but he could always be notified by phone on the weekends day or night if something needed to be repaired and he would have come in and repaired it. The Maintenance Director stated he was notified Monday morning (9/1/25) when he returned to work by the Director of Nursing and he fixed the call light right away. He stated it was an easy fix because he kept spare call lights on hand. He stated there was no system to notify Maintenance of needed repairs except through a phone call or finding him in the facility. He reported that he did not keep a record of when he was notified that something needed to be repaired or of what repairs were made. He stated cow bells were on hand and were kept at the nurses station to use if a call light issue occurred and stated the staff were aware that the cow bells were available for use. During an interview on 9/3/25 at 3:00 PM the Director of Nursing (DON) stated she was the assigned nurse for Resident #20 and Resident #59 on Friday night 8/29/25 from 7:00 PM through 7:00 AM. The DON stated the call light was not working and she emailed the Maintenance Director that night but stated she did not realize he could not check his emails outside of the facility and therefore he did not get the notification. She stated a cow bell was not offered but she checked on both residents every two hours throughout the night. During an interview on 9/4/25 at 12:30 PM Nurse #2 stated she was the assigned nurse for Resident #20 and Resident #59 on