STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldsboro Rehabilitation and Healthcare Center	1700 Wayne Memorial Drive Goldsboro, NC 27534

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 - Immediate jeopardy to resident health or safety 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, Nurse Practitioner and Physician, the facility failed to provide the necessary supervision to prevent an avoidable accident for a resident who had severe cognitive impairment, was on a pureed diet, had a diagnosis of dysphagia (difficulty swallowing), and required staff assistance with eating due to his inability to control the speed and/or quantity of food that entered his mouth (Resident #132). On Saturday, 10/11/25 around 8:30 AM, Nurse Aide #8 left a meal tray in front of Resident #132 so she could pass the remaining meal trays. Shortly after meal trays were passed, Nurse Aide #1 found Resident #132 unresponsive and not breathing. Nurse Aide #1 called for help and code blue (life threatening medical emergency) was called. Cardiopulmonary Resuscitation (CPR) was performed by nursing staff until Emergency Medical Services (EMS) took over when they arrived at the facility. EMS was able to obtain the resident's pulse, and Resident #132 was transferred to the hospital. Resident #132 was intubated (a hollow, plastic tube placed into the windpipe to keep airways open) after he experienced a second cardiac arrest in the emergency department and was transitioned to the Intensive Care Unit (ICU). Hospitalists suspected the resident suffered a severe anoxic brain injury (occurs when the brain does not receive oxygen) and the decision was made on 10/16/25 to transition Resident #132 to comfort measures only. The resident was transferred to hospice care on 10/17/25 and expired on 10/18/25. His death certificate indicated the cause of death was occlusion of airway by bolus of food (when food blocks the throat). This deficient practice affected 1of 3 residents reviewed for accidents.Findings included:Resident #132 was readmitted to the facility on [DATE] with diagnoses including stroke, dementia, and dysphagia. A physician order dated 8/4/22 indicated Resident #132 was a full code status and required CPR during a medical emergency. A physician order dated 7/28/25 revealed that Resident #132 received a regular diet, puree texture, nectar thick liquids, double portions, and pudding at every meal. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #132 was severely cognitively impaired, did not have any swallowing difficulties coded, and required setup/clean up assistance with eating. A care plan last reviewed on 8/28/25 revealed that Resident #132 had an activities of daily living (ADL) self-care performance deficit related to decreased mobility. Interventions included that Resident #132 was dependent on staff for eating, and staff needed to observe intake during meals. The undated Kardex (a summary of resident's needs for nursing staff to review) for Resident #132 revealed that he was dependent on staff for eating and staff were instructed to observe his intake of meals. Speech Therapy notes were reviewed from August through October of 2025. The following details written by the Speech Therapist (ST) related to Resident #132's eating assistance/behaviors were as follows:- 9/3/25: A Nurse Aide was reminded to feed Resident #132 due to impulsive self-feeding.- 9/4/25: Training for Nurse Aides regarding swallowing recommendations was ongoing. Resident #132 remained at high risk of aspiration (when food or liquid goes into your airway and lungs) given the severity of cognitive deficits and extreme impulsiveness with self-feeding.- 9/5/25: Resident #132 continued to be extremely impulsive when feeding himself secondary to severe cognitive deficits. Ongoing training with nursing staff regarding swallowing recommendations included feeding Resident #132 to decrease aspiration risks, small bites, liquid wash following each bite, and nectar thick liquids with a cup only. Response to the training with Nurse Aides was good. - 9/11/25: Discussed Resident #132's status with nursing who reported improved adequacy of intake with decreased coughing by following the Speech Therapist's instructions with no overt signs or symptoms of aspiration. - 9/16/25: Nursing staff were aware of the need for supervision during eating due to Resident #132's impulsivity. An interview was conducted with the Speech Therapist on 12/10/25 at 12:40 PM. She revealed that Resident #132 was referred to her services on 8/19/25 due to coughing and congestion with meals. She performed an assessment and determined that pureed foods with nectar thick liquids were most appropriate. Resident #132 needed to be positioned upright while eating and for 20 minutes after. The Speech Therapist stated that Resident #132 needed a slowed eating rate due to cognition and an impulsive very rapid eating pattern. He also required a drink between each bite to slow down the eating process. From 8/19/25 through 9/16/25, the Speech Therapist stated she educated every Nurse Aide that she could during lunch and supper meals about Resident #132 needing supervision during meals due to his impulsivity and high risk of aspiration/choking. They all expressed understanding. If staff were not present with the meal tray in front of Resident #132, he would eat rapidly and not stop coughing a lot. If he was left unsupervised, the Speech Therapist stated that there was a risk of aspiration, and he could

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Pharmacist interviews, the facility failed to have a copy of a monthly medication regimen review (MRR) available for review for 1 of 5 residents reviewed for unnecessary medications (Resident #4). Findings included: Resident #4 was readmitted to the facility on [DATE] with diagnoses that included hypertension, hyperlipidemia, stroke, peripheral vascular disease, chronic kidney disease, depression and insomnia. Review of Resident #4's medical record revealed that a monthly pharmacist medication regimen review was missing for the month of October 2025. An interview was conducted with the Pharmacist #1 on 12/11/25 at 2:03 PM. She revealed that Pharmacist #2 was traveling out of state and unavailable for interview. Resident #4's pharmacy documentation for October 2025 could not be found. Pharmacist #1 stated that Pharmacist #2 told her she had paper notes related to the October 2025 medication regimen review (MRR) for Resident #4; however, Pharmacist #1 could not locate any documentation to confirm the October MRR was completed. The Director of Nursing (DON) was interviewed on 12/11/25 at 3:24 PM and revealed she received monthly MRRs and recommendations from Pharmacist #2. Residents without any recommendations were included in a general list, and specific recommendations for residents were written out on a separate communication form. The DON stated that the October MRR provided to her by Pharmacist #2 did not have Resident #4's name included on the list. The DON stated that an MRR should be completed by a licensed Pharmacist at least monthly for all residents in the facility. The Administrator was interviewed on 12/11/25 at 4:08 PM. She revealed that the October 2025 MRR for Resident #4 should have been completed in a timely manner by the Pharmacy representative.

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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 implement their infection prevention program policies and procedures when Nurse Aide (NA) #4 and NA #5 failed to apply personal protective equipment (PPE) during urinary catheter care for a resident on Enhanced Barrier Precautions (EBP). This deficient practice was for 2 of 2 staff members observed for infection control practices (NA #4 and NA #5). The findings included:The facility's Infection Prevention and Control Program (IPCP) policy last revised 10/2018 indicated that the facility was responsible for establishing and maintaining an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. The policy further noted the importance of infection prevention, which included education of staff to ensure they adhere to proper techniques and procedures.The facility's Enhanced Barrier Precautions (EBP) policy last revised 7/26/22 revealed EBP was to be utilized for all residents with an indwelling medical device which included a urinary catheter. The policy further noted that personal protective equipment (PPE) for EBP was necessary when performing high-contact care activities which included urinary catheter care and required staff to wear gloves and gown when the care was provided.On 12/11/25 at 10:39 am Resident #109 had signage posted at the entrance of the room that alerted staff that the resident was on EBP. The signage noted that providers and staff must wear gloves and gowns for the following high-contact resident care activities which included urinary catheter care. A clear plastic supply holder was observed hung on the door and was stocked with PPE, which included disposable gowns and disposable gloves. A continuous observation of urinary catheter care was conducted on 12/11/25 from 10:40 am through 10:47 am for Resident #109. NA #4 and NA #5 were observed to perform hand hygiene, don clean gloves, and began to perform urinary catheter care for Resident #109. NA #4 and NA #5 performed Resident #109's urinary catheter care without the required gown in place. An immediate interview was conducted with NA #5 on 12/11/25 at 10:48 am who revealed she had been educated on EBP and the need to use PPE when performing urinary catheter care. NA #5 stated she just forgot to use the gown when she assisted NA #4 with Resident 109's urinary catheter care. During an interview with NA #4 on 12/11/25 at 10:49 am she revealed a gown was supposed to have been worn when she provided urinary catheter care to Resident #109. NA #4 stated she was nervous and forgot to put on the gown when the care was provided. An interview was conducted with the Infection Preventionist, who was also the facility's Director of Nursing, on 12/11/25 at 1:34 pm. The Infection Preventionist stated that all facility staff, including NA #4 and NA #5, had received education regarding EBP and the use of PPE when specific tasks were performed. The Infection Preventionist stated the staff were responsible for looking at every resident room entered for signage to see if the resident was on EBP and to use the appropriate PPE as noted. The Administrator was interviewed on 12/11/25 at 4:10 pm and revealed that NA #4 and NA #5 should have donned and doffed the required PPE according to the signage on the door for Resident #109 when they provided the urinary catheter care.