STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0558 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 observation, and resident and staff interviews, the facility failed to place a resident's call light device within reach to allow for the resident to request assistance as needed for 1 of 1 dependent resident reviewed for accommodation of needs (Resident #13). Findings included: Resident #13 was readmitted to the facility on [DATE] with diagnoses of multiple sclerosis (a chronic autoimmune disease affecting the central nervous system that leads to disruption of nerve signals traveling to the muscles of the body), and post-polio syndrome (a condition that can develop in people who previously had polio leading to a gradual decline in muscle function). Review of Resident #13's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired and was dependent on staff for all activities of daily living (ADL). Review of Resident #13's care plan last revised on 8/5/25 revealed a focus of the resident being at risk for falls with interventions including to be sure the call light is within reach and to encourage Resident #13 to use it to call for assistance if needed. An observation and interview were conducted with Resident #13 on 9/29/25 at 12:15 PM. Resident #13 was lying in her bed on her back. The resident's pancake call bell was clipped to her upper right chest between the shoulder and the breast. During the observation, Resident #13 stated her call bell was not in the right position as she could only use it if it is directly under the side of her neck. Resident #13 revealed that due to having multiple sclerosis and having had polio as a child, she had control of only her neck muscles so she could tilt her head slightly and press the pancake bell with the side of her jaw. Resident #13 indicated she was able to yell out to staff passing by, but her voice was not very loud due to the symptoms of multiple sclerosis. A continuous observation of Resident #13 was conducted on 10/1/25 starting at 1:39 PM. The resident was lying in her bed on her back. The bed was positioned so the head of the bed was pulled away from the wall and was facing the door. The bed was on the door side of the room, and Resident #13 did not have a roommate although there was another bed in the room. Resident #13's pancake call bell was lying on the floor between the bed and the wall. At 2:00 PM, Nurse #14 entered Resident #13's room. While in the room she checked the level of urine in Resident #13's catheter bag and proceeded to empty it. Nurse #14 then gave Resident #13 a drink that she requested. At 2:04 PM Nurse #14 left the room without having checked if Resident #13 had her call bell available. At 2:22 PM two staff members entered the room. The staff members were the Speech Therapist (ST) and Resident #13's assigned Nursing Assistant (NA #1). The ST went to the side of the bed where the pancake call bell was lying on the floor, she picked it up and positioned it on Resident #13 under her jaw on the right side and clipped it in place on the resident's nightgown. NA #1 was entering the room with the mechanical lift. In a follow-up interview with Resident #13 on 10/2/25 at 9:17 AM, she revealed staff left the room without ensuring she had her call bell correctly placed at least once daily. Resident #13 further revealed that being without her call bell made her feel terrible and helpless, like the staff don't care. In an interview with NA #1 on 10/1/25 at 2:24 PM she stated she had dressed Resident #13, left the room and took the lunch cart back to the kitchen and was planning to come right back with the mechanical lift to get Resident #13 out of bed to attend activities. NA #1 revealed she sat down for a few minutes to rest after returning the lunch cart to the kitchen but did not think she was gone that long, and Resident #13 could have yelled out for help if needed. NA #1 indicated she had been trained to make sure a dependent resident had their call bell within reach before she left a resident's room. In an interview with Nurse #14 on 10/1/25 at 2:54 PM, she stated she did not look to see if Resident #13 had her call bell within reach when she was in the room emptying her catheter. Nurse #14 further stated she was nervous at the time and did not look for the call bell. Nurse #14 revealed she had been trained to ensure a dependent resident had their call bell within reach before she left a resident's room. The ST was interviewed on 10/1/25 at 3:04 PM. The ST stated she made it a habit to check if residents have their call bells in reach as she walked through the facility. She further stated she noticed Resident #13 did not have her call bell readily available and entered the room for the purpose of locating it and placing it where Resident #13 could use it. In an interview with Unit Manager (UM #1) on 10/1/25 at 3:09 PM she stated all staff who entered a resident's room should ensure the resident had their call bell within reach before leaving that resident's room, even if the staff member believed they would be right back. UM #1 further stated Resident #13 was capable of yelling out for help if needed. The Director of Nursing (DON) was interviewed on 10/2/25 at 8:44 AM. The DON stated residents should have their call bell in reach at all times, even if there was a staff member in the room with the resident and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Pre-admission Screening and Resident Review (PASARR) status, medication, and falls for 3 of 22 resident MDS assessments reviewed (Resident #43, Resident #4, Resident #53). Findings included: 1. Resident #43 was admitted to the facility on [DATE]. Her active diagnoses included cerebral infarction. Review of Resident #43's PASARR Level II Determination Notification letter dated [DATE] revealed an expiration date of [DATE]. Review of Resident #43's admission MDS assessment dated [DATE] revealed she was coded as not currently considered by the state Level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on [DATE] at 1:36 PM the Social Worker stated on [DATE] Resident #43 had a Level II PASARR determination which expired on [DATE]. She was reassessed and currently had a Level II PASARR determination with no end date. During an interview on [DATE] at 1:40 PM MDS Nurse #2 stated Resident #43's MDS dated [DATE] was marked in error and should have been coded as having a Level II PASARR determination. During an interview on [DATE] at 3:14 PM the Administrator stated the PASARR status should be accurately reflected in resident MDS assessments. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses that included history of cerebrovascular accident (CVA, stroke). Review of Resident #4's physician orders revealed an order dated [DATE] for Aspirin oral tablet chewable 81 milligrams (mg) to be given one time a day for CVA. Review of Resident #4's [DATE] medication administration records (MAR) revealed Aspirin chewable 81 mg was given daily. Review of Resident #4's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was not coded as receiving an antiplatelet medication. In an interview with MDS Nurse #1 on [DATE] at 12:11 PM she stated Resident #4's MDS assessment should have been coded as receiving antiplatelet medication as Aspirin fell in that category of medications. MDS Nurse #1 further stated the error in coding was made due to human oversight. In an interview with the Administrator on [DATE] at 3:44 PM, she stated the MDS assessment should have been coded correctly, showing the resident received antiplatelet medication (Aspirin). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3a. Resident #53's Pre-admission Screening Resident Review (PASRR) Level II Determination Notice dated [DATE] revealed in part her Level II screening determined Nursing Facility Placement was appropriate. Resident #53 was admitted to the facility on [DATE] with a diagnosis of progressive neurological (nervous system) condition. Resident #53's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. On [DATE] at 10:18 AM an interview with the facility's Regional Director of Clinical Reimbursement indicated the MDS Nurse who coded Resident #53's admission MDS assessment dated [DATE] no longer worked for the facility. She reported the coding on Resident #53's admission MDS assessment was not accurate. b. A nursing progress note for Resident #53 dated [DATE] at 11:17 PM written by Nurse #10 revealed Resident #53 was found on the floor in her bathroom. She had a small laceration to her forehead. She was sent to the hospital emergency room (ER) for an evaluation. A nursing progress note for Resident #53 dated [DATE] at 12:21 PM written by Nurse #11 revealed Resident #53 returned from the hospital ER. The laceration to her forehead had been repaired with sutures. Resident #53's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed she had no falls since her prior MDS assessment. On [DATE] at 8:12 AM an interview with MDS Nurse #2 indicated she coded the falls section of Resident #53's discharge MDS assessment dated [DATE]. She reported she would have reviewed nursing progress notes to assist with coding the section. She stated Resident #53's fall with injury on [DATE] should have been captured on her discharge MDS assessment. MDS Nurse #2 stated she had missed this and did not know why. She went on to say the coding that Resident #53 had no falls since her prior MDS assessment would not be accurate. On [DATE] at 1:21 PM an interview with the Administrator indicated resident's MDS assessments should be coded accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0644 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 record review and resident and staff interviews, the facility failed to obtain further approval and screening through a Level II evaluation process in accordance with the Pre-admission Screening and Resident Review (PASRR) Level II Determination Notification. This was for 1 of 2 residents (Resident #53) reviewed for PASRR.Findings included:Resident #53's Pre-admission Screening Resident Review (PASRR) Level II Determination Notice dated [DATE] revealed Nursing Facility Placement was appropriate for a limited nursing facility stay, lasting no more than thirty (30) calendar days. The PASRR expiration date was [DATE]. Resident #53 was admitted to the facility on [DATE] with a diagnosis bipolar affective disorder (a chronic mental health condition characterized by extreme mood swings).Resident #53's current comprehensive care plan revealed a focus area dated as initiated on [DATE] for Level II PASRR. The goal was for Resident #53 to show no change in mental status through the next review. An intervention was to monitor for and document any changes in mental status.Resident #53's PASRR Level II Determination letter dated [DATE] revealed nursing facility placement was appropriate for Resident #53. The letter had no expiration date. No specialized services were required.On [DATE] at 2:25 PM an interview with Resident #53 indicated she was receiving all the care she needed in the facility. She reported she didn't have any concerns.On [DATE] at 9:53 AM an interview with the Social Worker (SW) indicated although Resident #53 was admitted with a Level II PASRR, the letter itself didn't get scanned into Resident #53's electronic record, so she did not realize it had an expiration date. She reported she did a 100 percent (%) audit of PASRRs at the end of [DATE] or the first of [DATE], which she does periodically, and she discovered Resident #53's PASRR was expired so she then initiated a new Level II review for Resident #53. The SW stated she would have been responsible for tracking all resident's PASRR statuses ensuring they were current and addressing any that had expiration dates. She reported a corrective action plan had been initiated to ensure this didn't happen again.On [DATE] at 10:04 AM an interview with the Administrator indicated the facility should be monitoring for all resident's PASRR status, verifying that each resident's PASRR status was accurate, and if there was an expiration date, ensuring that rescreening was done in a timely manner.On [DATE] at 2:25 the facility provided the following corrective action plan:Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:On [DATE], resident #53's PASRR was found to be expired. The facility submitted the PASRR Preadmission Screening and Resident Review) for resident #53 on [DATE].Address how the facility will identify other residents having the potential to be affected by the same deficient practice:All residents have the potential to be affected by the deficient practice. On [DATE] the facility made the decision to conduct a 100% audit on all residents to include Preadmission Screening and Resident Review (PASRRs); to ensure proper level of care and quality was being provided to all residents by ensuring each resident had a current PASRR and no expired PASRR existed in the facility. Findings of the audit revealed that there were no other residents identified without a current PASRR. No others expired PASRRs were found during the audit. The audit was completed by the Assistant Director of Nursing on [DATE].Address what measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur:The Assistant Director of Nursing educated the Social Worker and Admissions Director to check PASRRs on admission and check all current PASRRs monthly to make sure no PASRR is expired. This education was completed on [DATE].The Assisted Director of Nursing will educate any new Social Worker and Admissions Director upon hire; to check PASRRs on admission and check all current PASRRs monthly to make sure no PASRR is expired.Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained:The Assistant Director of Nursing will do monthly PASRR audits to make sure there are no expired PASRRs for 3 months. The Executive Director will present these findings to the QAPI committee, monthly for 3 months.Corrective action plan completion date: [DATE].On [DATE] at 2:30 PM the facility's corrective action plan was validated through a review of the facility's initial 100% audit, a review of the facility's education in-service training record dated [DATE] titled PASSR, interviews with the SW, the Assistant Director of Nursing and the Admissions Director, the facility's monthly audits, and the facility's QAPI meeting minutes. The corrective action plan completion date of [DATE] was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 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** Based on record review and staff interviews, the facility failed to develop a comprehensive care plan that included Pre-admission Screening Resident Review (PASRR) Level II (Resident #53 and Resident #43) and hospice (Resident #8) for 3 of 20 comprehensive care plans reviewed.Findings included: 1. Resident #53's Pre-admission Screening Resident Review (PASRR) Level II Determination Notice dated 9/17/24 revealed in part her Level II screening determined Nursing Facility Placement was appropriate. Resident #53 was admitted to the facility on [DATE] with a diagnosis of progressive neurological (nervous system) condition. Resident #53's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #53's current comprehensive care plan revealed her Level II PASRR status was not reflected in her care plan until a focus area was initiated by the facility's Social Worker (SW) on 3/24/25. On 10/1/25 at 10:26 AM an interview with MDS Nurse #1 indicated the Social Worker (SW) would be responsible for ensuring a resident's Level II PASSR status was reflected in the comprehensive care plan. On 10/1/25 at 10:56 AM an interview with the SW indicated she normally was not responsible for ensuring that a resident's Level II PASRR status was included in their comprehensive care plan. She reported the MDS Nurses did this. She stated she might have added this to Resident #53's care plan on 3/24/25 because she had not seen it there. On 10/1/25 at 11:24 AM an interview with the Assistant Director of Nursing indicated that because the SW was responsible for overseeing the facility's PASRR process, she would be responsible for ensuring a PASRR Level II status was reflected on a resident's comprehensive care plan. On 10/2/25 at 1:21 PM an interview with the Administrator indicated Resident #53 was admitted to the facility with a Level II PASRR. She reported this should have been reflected in her comprehensive care plan before 3/24/25. 2. Resident #43 was admitted to the facility on [DATE]. Her active diagnoses included cerebral infarction. Review of Resident #43's Level II PASARR Determination Notification letter dated 8/21/25 revealed an expiration date of 9/20/25. Resident #43's Level II PASARR Determination Notification letter dated 9/22/25 revealed it had no expiration. Review of Resident #43's care plan dated 9/4/25 revealed no care plan for the Level II PASARR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/25 at 2:43 PM MDS Nurse #1 stated Level II PASARR should be in the care plan, and it was not for Resident #43. She stated that ensuring Level II PASARR was on the care plan was the responsibility of both MDS and Social Work. During an interview on 10/1/25 at 2:49 PM the Social Worker stated Resident #43 had a Level II PASARR determination which should be captured on the care plan. She stated when the Level II PASARR determination notification letter came to the facility it was not uploaded into the system, which was possibly why it was missing on the care plan. During an interview on 10/1/25 at 2:54 PM the Administrator stated Level II PASARRs should be care planned. 3. Resident #3 was admitted to the facility on [DATE] with diagnoses that included dementia. Review of the hospice provider notes indicated Resident #8 was accepted into hospice care services on 7/30/25. Resident #8's care plan last revised on 8/5/25 did not reveal a focus area, goal, or intervention regarding hospice care services. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #8 was receiving hospice care services. An interview on 9/30/25 at 2:30 PM was held with MDS Nurse #2, she stated hospice care services should have been included in the care plan for Resident #8. MDS Nurse #2 indicated she was responsible for this task and should have added it to the care plan. During an interview with the Director of Nursing on 9/30/25 at 2:45 PM, she revealed her expectation would have been that hospice care services were included in the care plan for Resident #8. An interview was conducted with the Administrator on 9/30/25 at 2:55 PM. She stated she would have expected the care plan to have been updated by the MDS Nurse when the family agrees to hospice care services for any resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to revise the comprehensive care plan to accurately reflect the code status (Resident #12), a pressure ulcer (Resident #13) and the discontinuation of bed rails (Resident #7). This was for 3 of 20 comprehensive care plans reviewed. 1. Resident #12 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease dependent on hemodialysis. Review of Resident #12's medical record revealed an advance directive physician's order dated [DATE] indicating he was a full code, meaning he wished to have cardiopulmonary resuscitation (CPR) performed should his heart stop. Review of a hard copy of Resident #12's advance directive kept in a book at the nurses' station indicated Resident #12 was made a full code on [DATE]. Review of Resident #12's care plan, last revised [DATE] revealed his code status as being Do Not Resuscitate (DNR), meaning he would not want CPR performed should his heart stop. Review of Resident #12's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was moderately cognitively impaired. In an interview with Unit Manager #1 (UM #1) on [DATE] at 11:58 AM she stated the MDS Nurses were responsible for keeping the code status in a resident's care plan updated. In an interview with MDS Nurse #1 on [DATE] at 12:03 PM she stated the Social Worker (SW) would have been responsible for updating Resident #12's code status on the care plan. An interview was conducted with the Assistant Director of Nursing (ADON) on [DATE] at 12:18 PM. The ADON indicated the MDS Nurses were responsible for updating a resident's code status on their care plan. In an interview with the Director of Nursing (DON) on [DATE] at 12:25 PM she stated the MDS Nurses were responsible for updating the code status in a resident's care plan. The DON further stated the care plan should have included the correct code status for Resident #12. In an interview with the SW on [DATE] at 1:46 PM she stated the MDS Nurses were responsible for changing a resident's code status on the care plan. The SW further stated she could change it if she noticed it was incorrect. An interview was conducted with the Administrator on [DATE] at 3:41 PM. The Administrator indicated the MDS Nurses were responsible for changing or updating a resident's care plan to reflect the accurate code status. She was unaware Resident #12's care plan had an inaccurate code status. The Administrator stated that a resident's care plan should include the most up to date code status for a resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #13 was readmitted to the facility on [DATE] with diagnoses that included a Stage 4 pressure ulcer of the sacrum. Review of Resident #13's quarterly MDS assessment dated [DATE] indicated she was at risk to develop pressure ulcers. Review of Resident #13's comprehensive care plan last revised [DATE] revealed a focus of having had actual impairment to skin integrity related to impaired mobility to include a stage 4 pressure ulcer to her sacrum and a post-surgical abdominal wound. The goal was for Resident #13 to maintain or develop clean and intact skin by the review date. Interventions included treatments as ordered. The care plan did not include a stage 3 pressure ulcer to the right buttocks. Review of Resident #13's physician's orders revealed an order dated [DATE] for wound care to the stage 3 pressure wound on the right buttocks that read: cleanse wound with wound cleanser, place iodoform packing strips in collagen powder, pack wound, cover with large sacral dressing, apply skin prep around wound every day shift and as needed. In an interview with MDS Nurse #1 on [DATE] at 12:31 PM she stated the stage 3 pressure wound to the right buttock should have been added to the impairment in skin integrity care plan with the stage 4 pressure ulcer to her sacrum and the abdominal surgical wound. She further stated MDS Nurses were responsible for this update after they learned of new wounds in morning meeting. MDS Nurse #1 was unsure why the stage 3 pressure ulcer was not added to Resident #13's care plan. In an interview with the ADON on [DATE] at 12:55 PM she stated the stage 3 pressure ulcer to right buttock should have been added to the impairment in skin integrity care plan with the other two wounds. The ADON indicated the MDS Nurses would be responsible for this addition to the care plan. In an interview with the Administrator on [DATE] at 12:58 PM, she stated the stage 3 pressure ulcer to the right buttock should have been added to the skin integrity care plan with the stage 3 pressure ulcer and abdominal surgical wound by the MDS Nurse. 3. Resident #7 was admitted to the facility on [DATE] with a diagnosis of stroke. Resident #7's current comprehensive care plan revealed a focus area for the use of bed rails. The goal dated as last revised on [DATE] by Minimum Data Set (MDS) Nurse #1 was for Resident #7 to be free from injury and to improve in positioning with bed rails through the next review date. Resident #7's significant change MDS assessment dated [DATE] revealed bed rails were not used in bed as a restraint. On [DATE] at 10:30 AM Resident #7 was observed in bed. No bed rails were observed on his bed. On [DATE] at 8:10 AM Resident #7 was observed in bed. No bed rails were observed on his bed. On [DATE] at 8:46 AM an interview with Nurse Aide (NA) #7 indicated she cared for Resident #7 on [DATE] and [DATE] on the 7AM-3PM shift. She stated she did not usually care for him. She reported Resident #7 did not have bed rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:48 AM an interview with Nurse Aide #8 indicated she regularly cared for Resident #7 on the 7AM-3PM shift 5 days per week for the last 4 to 5 months. She reported she did not recall Resident #7 having bed rails. On [DATE] at 10:32 AM an interview with MDS Nurse #1 indicated Resident #7 would have been due for a care plan review in [DATE]. She stated if a resident had bed rail use reflected on their comprehensive care plan and the bed rails were removed, nursing could communicate this with her and she could revise the care plan, or nursing could do this themselves. She did not indicate that she recalled a discussion regarding the removal of Resident #7's bed rails. On [DATE] at 11:19 AM an interview with the Assistant Director of Nursing (ADON) indicated Resident #7 did have bed rails at one time. She reported on [DATE], she made the determination that Resident #22 was no longer able to utilize the rails, and they were no longer appropriate for him. She indicated she had asked for maintenance to remove the bed rails. She stated she shared this at the morning meeting on [DATE] with the Interdisciplinary Team. The ADON went on to say the MDS Nurses were present at that meeting, and she would have thought MDS would have updated Resident #7's comprehensive care plan to reflect Resident #7 no longer using bed rails. On [DATE] at 1:21 PM an interview with the Administrator indicated Resident #7 used bed rails at one time, but his cognition had changed, and he could no longer safely use these. She stated once this decision had been made, and the rails were removed from his bed, his comprehensive care plan should have been updated to accurately reflect this.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, and Nurse Practitioner (NP) interviews the facility failed to remove a topical pain patch in accordance with the physician's order. This was for 1 of 2 residents (Resident #82) reviewed for professional standards.Findings included:Resident #82 was admitted to the facility on [DATE] with a diagnosis of pain.The nursing admission Data Collection form for Resident #82 dated 9/24/25 at 6:02 PM completed by Nurse #10 revealed Resident #82 was alert and oriented times 4 (to person, place, time and situation).A physician's order for Resident #82 dated 9/26/25 revealed lidocaine (topical pain medication) patch 4 percent (%) apply to shoulders and chest topically one time a day for pain apply 3 patches - one on each shoulder and chest and remove per schedule. There was no physician's order for Resident #82 to self-administer medications.On 9/29/25 at 11:10 AM an observation was conducted in conjunction with an interview with Resident #82. During the observation, Resident #82 used both hands to pull down the front of her gown in response to a question from the surveyor regarding whether or not she had any wounds or skin conditions. This revealed one lidocaine topical patch on her chest and one on each shoulder, for a total of 3 lidocaine patches, dated 9/28/25 with the initials of Nurse #11. In an interview at that time Resident #82 stated she received the patches once daily. She reported they were supposed to be on for 12 hours, and then off for 12 hours. She indicated the nurse put the patches on in the morning, and then she took them off herself whenever.Resident #82's Medication Administration Record (MAR) revealed documentation indicating that on 9/28/25 and 9/29/25 at 9:00 AM Nurse #11 applied lidocaine 4% patches topically to Resident #82's shoulders and chest in accordance with the physician's order. It further revealed documentation indicating that on 9/28/25 at 8:59 PM Nurse #10 removed the lidocaine 4 % patches from Resident #82's shoulders and chest in accordance with the physician's order.On 9/29/25 at 1:58 PM a telephone interview with Nurse #10 indicated when she had gone in to remove the lidocaine patches from Resident #82's chest and shoulders on 9/28/25, Resident #82 told her she would remove them herself. Nurse #10 stated she had never gone back to check to be sure Resident #82 had actually removed them.On 9/29/25 at 1:30 PM an observation of Resident #82 revealed one lidocaine topical patch on her chest and one on each shoulder dated 9/29/25 with the initials of Nurse #11.On 9/29/25 at 1:38 PM an interview with Nurse #11 indicated she applied the lidocaine 4% patches topically to Resident #82's shoulders and chest on 9/28/25 in the morning. She reported she dated and initialed the patches. She stated she also applied the patches to Resident #82 on 9/29/25, and initialed and dated the patches. Nurse #11 went on to say when she applied the patches to Resident #82 on 9/29/25, she noticed that the patches she applied on 9/28/25 were still on. She stated she recalled this happening before, and she had notified Unit Manager #1 because the patches were supposed to be removed from Resident #82 each evening. Nurse #11 reported she had not notified Unit Manager #1 on 9/29/25.On 9/29/25 at 1:45 PM an interview with Unit Manager #1 indicated she did not recall Nurse #11 ever notifying her that Resident #82's lidocaine patches were not being removed in the evening in accordance with the physician's order.On 9/29/25 at 1:49 PM an interview with the Director of Nursing indicated Nurse #10 should have removed Resident #82's lidocaine patch herself in accordance with the physician's order.On 10/02/2025 at 12:20 PM an interview with NP #1 indicated that while no harm would have occurred to Resident #1 from not having her lidocaine patch removed, there was a reason the physician's order for the lidocaine patch included a removal time. She reported the patch was only effective for a certain amount of time. She stated Nurse #10 should have removed Resident #82's lidocaine patch in accordance with the physician's order.On 10/2/25 at 1:21 PM an interview with the Administrator indicated Nurse #10 should have removed Resident #82's lidocaine patch herself in accordance with the physician's order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0688 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, record review, and resident and staff interviews, the facility applied a resting hand splint (a brace used to keep the hand, wrist, and fingers in a neutral position preventing stiffness and contractures) without a physician's order, therapy instructions or in accordance with a splint wearing schedule. This deficient practice was for 1 of 3 residents reviewed for position and mobility (Resident #38).Findings included:Resident #38 was admitted to the facility on [DATE] with a diagnosis of right-hand contracture. Resident #38's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired. She had functional limitation of range of motion on both sides of her upper and lower extremities. She received 2 days of occupational therapy beginning on 9/9/25. She was not in a restorative nursing program. Resident #38 did not receive splint or brace assistance.Resident #38's medical record did not reveal a physician's order for a resting hand splint.Resident #38's current comprehensive care plan revealed a focus area dated as initiated on 9/19/25 for alteration in musculoskeletal status related to contractures. The goal was for Resident #38 to remain free from injuries or complications from contractures through the next review. An intervention was to monitor and document as needed any sign or symptom or complication related to contracture formation or joint changes.On 9/29/25 at 3:01 PM Resident #38 was observed in her room. A resting hand splint was observed on her nightstand. An interview with Resident #38 at that time indicated she did not know what the splint was for or when she wore it.On 10/1/25 at 12:36 PM Resident #38 was observed in her room. A resting hand splint was observed on her nightstand.On 10/1/25 at 12:37 PM an interview with Nurse #11 indicated she was caring for Resident #38 that day and was familiar with her. She reported Resident #38 was admitted to the facility with a resting hand splint for her right hand that night shift applied to Resident #38. She stated Resident #38 had been wearing her splint when she took over her care this morning at 7:00 AM, but it was halfway off. Nurse #11 stated she reapplied the splint, but a short time later when she went back into Resident #38's room, Resident #38 had it off again. She reported she was waiting for Resident #38 to finish her lunch, and them she would reapply the splint. She indicated Resident #38 was not being seen by therapy, because she was a long term care resident. Nurse #11 stated there was no physician's order for Resident #38's right hand splint, or any splint wearing schedule, but she just assumed that Resident #38 was supposed to be wearing the splint during the day and having it removed at night.On 10/2/25 at 8:13 AM a telephone interview with Nurse Aide (NA) #9 indicated she was assigned to care for Resident #38 on the shift beginning at 11:00 PM on 9/30/25 and ending at 7:00 AM on 10/1/25. She reported Resident #38 had been wearing a right hand splint during that shift, but she had not applied it to Resident #38. She reported she did not know who applied the splint. NA #9 stated if a resident was supposed to have a splint applied, it showed up as a task for her in the computer. She reported she did not recall seeing application of a splint for Resident #38.On 10/2/25 at 9:21 AM a telephone interview with Nurse #12 indicated she was assigned to care for Resident #38 on the shift beginning at 11:00 PM on 9/30/25 and ending at 7:00 AM on 10/1/25. She stated she really couldn't remember if she had applied a splint to Resident #38. She reported if a resident was supposed to wear a splint, it would appear for her on the resident's Treatment Administration Record (TAR) so she would know when to apply and remove it and could document the application and removal.A review of Resident #38's TAR did not reveal any information regarding the application or removal of a right resting hand splint.On 10/1/25 at 2:20 PM an interview with the Therapy Director indicated she was familiar with Resident #38 and had been working with Resident #38 since her admission. She reported Resident #38 was receiving Occupational Therapy services. She stated Resident #38 had been admitted to the facility with a right-hand contracture, but not a resting hand splint. She indicated she had ordered the resting hand splint for Resident #38 and been working with this during Resident #38's therapy sessions. The Therapy Director stated Resident #38 was not tolerating her splint and had only been wearing it for less than 30 minutes while supervised during therapy sessions. She reported until Resident #38 could tolerate the splint for more than 1 hour, Resident #38 would not be released to the restorative nursing program with a splint wearing schedule. She stated about a week before Resident #38 was released to wear the splint regularly, an order would be placed, she would train the nursing staff on the application of the splint, monitoring for any skin breakdown and provide a splint schedule that specified how many hours a day the splint was to be worn. The Therapy Director reported while it would not cause Resident #38 any harm for nursing to have applied the splint, Resident #38 had not been released to wear it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews the facility failed to follow professional standards of practice and infection prevention measures when Unit Manager #2 (UM #2) failed to remove soiled gloves, perform hand hygiene and don clean gloves during tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) through the front of the neck to create an artificial airway and assist with breathing) care for 1 of 1 residents reviewed for tracheostomy care (Resident #17). Findings included: Resident #17 was admitted to the facility on [DATE] with a diagnosis of quadriplegia and tracheostomy status. Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. Resident #17 was coded in the MDS as receiving tracheostomy care in the facility. Resident #17's care plan with a revision date of 6/22/25 revealed him to have a tracheostomy. A continuous observation of tracheostomy care was conducted on 10/2/25 starting at 8:14 AM. Unit Manager #2 (UM #2) entered the resident's room, performed hand hygiene and donned a gown and gloves. UM#2 then removed the soiled split gauze from behind the tracheostomy flange and threw it in the trash. UM#2 then opened the clean split gauze and placed it behind the tracheostomy flange. At 8:18 AM, UM#2 removed the soiled inner cannula and threw it away. She proceeded to open the new sterile inner cannula and insert it into the tracheostomy. UM #2 then removed the soiled gloves, performed hand hygiene, removed her gown, put it into the trash, removed the trash bag, tied it closed and removed it from the room. UM #2 proceeded to take the trash bag and dispose of it. In an interview with UM #2 on 10/2/25 at 8:27 AM, she indicated she thought she was performing tracheostomy care correctly. UM #2 was unaware she should have changed gloves and performed hand hygiene between soiled and clean parts of the procedure. In an interview with the Infection Preventionist (IP) on 10/2/25 at 8:45 AM The IP indicated she would expect Nurses to think critically about the procedures they were performing. In this case, UM #2 should have considered the possibility of spreading disease causing organisms to the resident's airway by not removing soiled gloves after handling the soiled split gauze and soiled inner cannula, performing hand hygiene and donning new gloves to place the clean split gauze and clean inner cannula. The Administrator was interviewed on 10/2/25 at 9:01 AM. The Administrator stated to decrease the risk of spreading disease causing organisms to the residents' airway, UM #2 should have split tracheostomy care into clean and soiled parts. She further stated UM #2 should have donned clean gloves, removed the soiled split gauze and soiled inner cannula, removed the soiled gloves, performed hand hygiene, donned clean gloves and placed the clean split gauze and clean inner cannula.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 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** Based on observations, record review, staff and resident interviews, the facility failed to attempt alternatives prior to installing side rails, complete a siderail assessment, assess entrapment risk, review the risks and benefits of side rails with the resident and obtain informed consent, complete a care plan for side rail usage and obtain a physician's order prior to siderail use for 1 of 3 residents (Resident #57) reviewed for side rails.Findings included: Resident #57 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a chronic, progressive neurological disorder that affects movement and other bodily functions). Review of Resident #57's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #57 was cognitively intact, did not have side rails as a restraint and was independent with bed mobility. Review of Resident #57's care plan last revised 9/8/25 revealed no care plan indicating the use of bilateral quarter length side rails. Review of Resident #57's medical record revealed no assessment for use of side rails, no assessment for entrapment risk, no signed consent reviewing the risks and benefits of side rail use, or physician's order for use of side rails. Resident #57 was observed lying in bed with bilateral quarter length side rails in the raised position on 9/29/25 at 10:50 AM. Resident #57 was observed lying in bed with bilateral quarter length side rails in the raised position on 10/1/25 at 2:27 PM. In an interview with Unit Manager (UM) #1 on 10/2/25 at 11:02 AM she stated Physical Therapy completed a side rail assessment and let the Director of Nursing (DON) know when someone was approved for the use of side rails and the DON had maintenance put them on the resident's bed. UM#1 indicated she had never completed a nursing side rail assessment for any resident. In an interview with the Assistant Director of Nursing (ADON), who was acting as Director of Nursing (DON) on 10/2/25 at 11:12 AM, she stated therapy should always evaluate a resident for side rail usage first. The ADON further stated that after therapy approved a resident for side rails, a Nurse would complete a nursing side rail assessment which included entrapment risk assessment, obtain consent from the resident or their responsible party, obtain a physician's order and add side rail usage to the resident's care plan. The ADON revealed she was unable to locate a side rail assessment including entrapment risk, signed consent form, physicians order or care plan for Resident #57's side rail usage. The ADON was unsure why Resident #57 was overlooked. In an interview with Resident #57 on 10/2/25 at 11:25 AM he stated he had Parkinson's disease that caused him to have decreased muscle control. Resident #57 further stated he had side rails on his bed since admission and used them for positioning, mobility and the side rails were especially helpful when getting out of bed. A telephone interview was conducted with the Director of Therapy on 10/2/25 at 11:30 AM. The Director of Therapy stated she was under the impression side rails were not allowed in the building and therapy only assessed for side rails if a newly admitted resident had side rails at home. An interview was conducted with the Physical Therapist (PT) on 10/2/25 at 12:18 PM. The PT revealed she did not complete side rail assessments. The PT was unsure who was responsible for assessing residents for the safe use of side rails. In an interview with the Administrator on 10/2/25 at 12:45 PM she stated residents were assessed by therapy for the use of side rails. She further stated that after they were approved for side rails by therapy, nursing completed a nursing assessment, obtained a physician's order, reviewed risks and benefits with the resident or their responsible party and put in a request for maintenance to put side rails on the resident's bed. The Administrator was unsure why Resident #57 had bilateral quarter length side rails on his bed and had not been assessed for safe usage including entrapment risk by therapy or nursing, why no consent form was completed, no physicians order obtained, and no care plan entered regarding side rail usage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1000 Tandal Place Knightdale, NC 27545

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 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 policies and procedures for hand hygiene when the business office manager failed to perform hand hygiene while passing a meal tray. This was for 1 of 8 staff members observed for hand hygiene practices (Business Office Manager). Findings included: A review of the facility policy titled Hand Hygiene with a review date of 2/5/21 stated in part: Hand hygiene should be performed after contact with inanimate objects (including medical equipment) in the immediate patient vicinity, and, before initiating a clean procedure. The policy definition of hand hygiene stated: cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). An observation was started on 9/29/25 at 11:51 AM. The facility Business Office Manager was observed entering a resident's room to deliver the resident's lunch tray. The Business Office Manager set the tray on the resident's overbed tray table next to a urinal with approximately 2 inches of straw-colored urine in it. The Business Office Manager then asked the resident if it was ok for the Business Office Manager to move the resident's urinal and the resident agreed. The Business Office Manager picked up the urinal and moved it to the bedside table. Afterwards, the Business Office Manager asked the resident if he could help him with anything else and the resident requested the Business Office Manager remove the lid from his lunch plate and open his carton of milk. The Business Office Manager proceeded to take the lid off of the lunch plate and open the carton of milk without performing hand hygiene first. The resident then asked the Business Office Manager to place a straw in the milk carton, and the Business Office Manager proceeded to do so. In an interview with the Business Office Manager on 9/29/25 at 11:56 PM he stated he hadn't thought touching the urinal then opening the milk and the straw was an infection control issue as he touched the body of the urinal, not the handle of the urinal that the resident would have touched. The Business Office Manager further stated he was unaware that putting the lunch tray on the overbed table with the urinal was an infection control issue. In an interview with the Infection Preventionist (IP) on 9/29/25 at 12:16 PM, she stated the Business Office Manager should have set the lunch tray in a different location, donned clean gloves, moved the urinal, removed the gloves, performed hand hygiene and then proceeded to help the resident with his tray. The IP indicated by touching the urinal, then opening the milk and the straw, the Business Office Manager could have transferred disease causing bacteria from the urinal to the milk carton and/or straw. In a follow-up interview with the Business Office Manager on 9/29/25 at 12:23 PM he stated he was a new employee of less than 4 weeks. He further stated he had training on hand hygiene and infection control upon hire. On 9/29/25 at 12:41 PM, the IP provided documentation that the Business Office Manager had been training on infection control and hand hygiene upon hire on 9/8/25. In an interview with the Director of Nursing (DON) on 9/29/25 at 12:35 PM she stated the Business Office Manager should have set the lunch tray in a different location before donning gloves, moving the urinal, removing the gloves and performing hand hygiene before moving the tray to the overbed table and assisting with opening the milk carton and placing a straw in it. In an interview with the Administrator on 9/29/25 at 3:23 PM, she stated the business office manager should have set the lunch tray on a clean surface away from the urinal. She further stated he should have donned clean gloves, moved the urinal off of the overbed table, removed the gloves and performed hand hygiene before continuing to assist the resident with his lunch tray. The Administrator indicated cross-contamination could have occurred between the urinal and the milk carton and straw.