STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Court Nursing and Rehabilitation Center	128 Snow Hill Road Ayden, NC 28513

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and staff interviews, the facility failed to designate a qualified Infection Preventionist (IP) who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. This had the potential to affect all residents in the facility.Findings included:In an interview on 5/5/2026 at 12:10 pm with Director of Nursing (DON), in the presence of the Regional Nurse Consultant, the DON stated the Infection Preventionist position was currently vacant, however she and the Assistant Director of Nursing (ADON) shared in the responsibilities of Infection Preventionist. She stated they both completed the programs out of state and she would work on retrieving the documentation. DON could not remember the name of the infection prevention and control program she completed in Ohio but stated it was similar to the Statewide Program for Infection Control and Epidemiology (SPICE) program offered in North Carolina.On 5/6/2026 at 10:00 am in an interview with the DON in the presence of ADON and the Regional Nurse Consultant, the DON stated that she had been unable to locate documentation for herself or the ADON but she believed the Staff Development Coordinator (SDC) completed the Statewide Program for Infection Control and Epidemiology (SPICE) and would get the documentation.In a subsequent interview with the DON on 5/6/2026 at 3:16 pm she stated that she was unable to obtain documentation to show that there was a qualified Infection Preventionist at the facility.The Administrator was not available for interview during the survey.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with the Resident Representative, staff, Medical Director, and Nurse Practitioner (NP), the facility failed to ensure a resident had an indication and a diagnosis for the use of an antipsychotic medication and failed to administer the antipsychotic medication on an as needed basis as specified in the hospital discharge summary. This was for 1 of 6 residents reviewed for chemical restraints (Resident #32).The findings included: Resident #32's hospital Discharge summary dated [DATE] revealed a physician's order for Olanzapine (antipsychotic) 2.5 mg take 1 tablet by mouth at bedtime as needed (if agitated at night causing increased fall risk). Resident #32 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease unspecified, chronic pain, hyperlipidemia (condition characterized by high levels of lipids (condition of high cholesterol or fats in the blood), and radiculopathy of the cervical region (the cervical spine is compressed or inflamed which results in radiating pain, numbness, or muscle weakness from the neck down to the shoulder and arm). Review of Resident #32's electronic medical record (EMR) revealed a signed informed consent dated 4/10/26 by the Resident Representative for the use of antipsychotic medication. Review of Resident #32's physician order dated 4/9/26 revealed an order for Olanzapine (antipsychotic) 2.5 milligrams (mg) to be administered at bedtime for if agitated at night causing increased fall risk. A review of Resident #32's April 2026 Medication Administration Record (MAR) documented Olanzapine 2.5 mg was administered from 4/9/26 through 4/30/26 at bedtime. A review of Resident #32's May 2026 MAR documented Olanzapine 2.5 mg was administered from 5/1/26 through 5/7/26 at bedtime. A review of Resident #32's admission Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #32 was cognitively intact. She was coded for antipsychotic medications. Resident #32's care plan dated 4/20/26 revealed a focus for psychotropic drugs with interventions which included administering medications as ordered by physician, evaluating effectiveness and side effects of medications for possible reduction/elimination of psychotropic drugs, and pharmacy review of medications monthly and/or as ordered. A phone interview was conducted on 5/12/26 at 12:05 pm with the Nurse Practitioner (NP). The NP stated Resident #32 was admitted to the facility from the hospital with an order for Olanzapine. The NP further stated she continued the Olanzapine order for agitation and reported increased falls and considered these conditions to be supporting indications for the medication. The NP stated the nursing staff had not reported any agitation, behaviors, or falls for Resident #32 following admission to the facility. When asked whether the Olanzapine was intended to be administered as a scheduled medication or on an as-needed (PRN) basis, the NP stated, the medication should have been administered on a PRN basis for agitation. The NP further stated she did not have concerns regarding Resident #32 receiving the Olanzapine every night. When asked whether the Olanzapine should have been discontinued due to no documented signs or symptoms of agitation, behaviors, or falls, the NP replied, no. In a phone interview conducted on 5/12/26 at 1:58 pm, the Medical Director stated he did not typically use Olanzapine on a PRN basis; however, Resident #32 was admitted to the facility from the hospital with an order for Olanzapine. The Medical Director stated Resident #32 had received the medication during her hospital stay and the Nurse Practitioner (NP) continued the medication upon her admission to the facility. The Medical Director stated the medication order should have been entered correctly to reflect PRN administration of Olanzapine for Resident #32; however, he expressed no concern regarding the resident receiving the medication daily because Resident #32 experienced decreased agitation and no falls while residing in the facility. When asked whether the Olanzapine should have been discontinued due to no documented signs or symptoms of agitation, behaviors, or falls, the Medical Director replied, the outcome was good with the medication.

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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 a Minimum Data Set Assessment for Antipsychotic Medication Review for 1 of 21 residents reviewed for unnecessary medications (Resident #32). The findings included: Resident #32 was admitted to the facility on [DATE] with a diagnosis of unspecified Alzheimer's disease. Review of Resident #32's physician order dated 4/9/26 revealed an order for Olanzapine (antipsychotic) 2.5 milligrams (mg) to be administered at bedtime. A review of Resident #32's April 2026 Medication Administration Record (MAR) documented Olanzapine 2.5 mg was administered from 4/9/26 through 4/15/26 at bedtime. A review of Resident #32's admission Minimum Data Set Assessment (MDS) dated [DATE] revealed she received antipsychotic medications. The Antipsychotic Medication Review Section was coded as not receiving antipsychotic medication since admission. During an interview with MDS Coordinator #1 on 5/5/26 at 1:10 pm, she stated she completed this section of the admission MDS and should have indicated Resident #32 had received antipsychotic medications since admission. She verified the Minimum Data Set Assessment was inaccurate and that antipsychotic use should have been coded. During an interview on 5/6/26 at 4:45 pm with the Facility Nurse Consultant and the Director of Nursing (DON), both stated Resident #32's MDS assessments should have been coded accurately to reflect the use of antipsychotic medication since admission.

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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 interviews with facility staff, pharmacy staff, Nurse Practitioner, and Medical Director, the Pharmacy Consultants failed to identify and report medication irregularities related to antipsychotic medication (primarily used to manage symptoms of psychosis, such as hallucinations, delusions, and paranoia) that included a medication transcription error and no adequate indication and diagnosis for use. This deficient practice affected 1 of 6 residents reviewed for unnecessary medications (Resident #32). The findings included: Resident #32's hospital Discharge summary dated [DATE] revealed a physician's order for olanzapine (antipsychotic medication) 2.5 milligrams (mg) take 1 tablet by mouth at bedtime as needed (if agitated at night causing increased fall risk). Resident #32 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease. The resident had no mental health diagnoses. A physician's order dated 4/9/26 for Resident #32 indicated olanzapine 2.5 mg at bedtime for if [sic] agitated at night causing increased fall risk. An admission Medication Regimen Review (MRR) was conducted by Pharmacy Consultant #2 for Resident #32 on 4/10/26 with no potential clinically significant medication issues noted. Pharmacy Consultant #2 identified the resident was on olanzapine and recommended a Dyskinesia (a movement disorder characterized by involuntary and uncontrollable muscle movements) Identification System Condensed User Scale (DISCUS) evaluation. There were no other recommendations made related to Resident #32's olanzapine. In a phone interview with the Pharmacy Regional Clinical Manager on 5/12/26 at 1:16 pm, she stated Pharmacy Consultant #2 was unavailable for interview. Resident #32's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was cognitively intact. She was coded for antipsychotic medications. A review of Resident #32's April and May 2026 Medication Administration Records (MARs) documented olanzapine 2.5 mg was administered once daily from 4/9/26 through 5/7/26 at bedtime. A DISCUS evaluation was completed on 4/13/26 with no concerns identified. An MRR dated 5/6/26 completed by Pharmacy Consultant #1 indicated no drug irregularities were identified and no recommendations were made related to Resident #32's olanzapine. During a phone interview conducted on 5/12/26 at 1:16 pm Pharmacy Consultant #1 he stated he completed an MRR on 5/6/26 for Resident #32 and made no recommendations regarding the resident's antipsychotic medication (olanzapine). Pharmacy Consultant #1 stated he was unable to locate a documented supporting diagnosis for the antipsychotic medication in Resident #32's electronic medical record on 5/6/26; however, he reviewed the hospital discharge summary (dated 4/9/26) on 5/6/26 and noted documentation of worsening mentation, agitation, decline in functioning over the past several months, and recurrent falls. Pharmacy Consultant #1 stated he used that information to support the continued use of the antipsychotic medication and therefore did not make a recommendation. Pharmacy Consultant #1 further stated that if he had not located this information in the hospital discharge summary, he would have recommended obtaining a supporting diagnosis and a psychiatric evaluation to justify continuation of the antipsychotic medication. When asked whether the olanzapine was intended to be administered as a scheduled medication or on an as-needed (PRN) basis, Pharmacy Consultant #1 stated he was not sure and indicated he should have clarified the medication order with the Nurse Practitioner (NP). The Director of Nursing (DON) was interviewed via phone on 5/12/16 at 2:57 pm. The DON indicated there were no pharmacy recommendations requesting additional diagnoses to support the use of the olanzapine. A phone interview was conducted on 5/12/26 at 12:05 pm with the NP. The NP stated Resident #32 was admitted to the facility from the hospital with an order for olanzapine. The NP further stated she continued the olanzapine order for agitation. When asked whether the olanzapine was intended to be administered as a scheduled medication or on an as-needed (PRN) basis, the NP stated the medication should have been administered on a PRN basis for agitation as ordered from the hospital physician. The NP stated (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had not received a recommendation from the Pharmacy Consultant indicating the need for an additional diagnosis or other documented clinical indication to support the continued use of olanzapine. In a phone interview conducted on 5/12/26 at 1:58 pm, the Medical Director stated Resident #32 was admitted to the facility from the hospital with an order for as needed (PRN) olanzapine. The Medical Director stated Resident #32 had received the medication during her hospital stay and the NP continued the medication upon the resident's admission to the facility. The Medical Director stated the Pharmacy Consultant should have identified and recommended whether an additional supporting diagnosis, beyond Alzheimer's disease, was necessary to support the continued use of the medication. The Medical Director stated the medication order should have been entered correctly to reflect PRN administration of olanzapine for Resident #32 and the Pharmacy Consultant should have questioned this irregularity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to implement infection prevention and control practices when a nurse provided tracheostomy care and did not wear a gown. This deficient practice occurred for 1 of 3 staff observed for infection control practices (Nurse #1).Findings included:A review of the facilities Infection Control Manual version date 04/2023 and page revision date of 06/13/2024 revealed:Enhanced Barrier Precautions (EBP) are used in conjunction with Standard Precautions to reduce the risk of MDRO (multidrug resistant organism) transmissions during high-contact resident care activities. Includes the use of both gowns and gloves. EBP are meant to be in place for the duration of the resident's stay or until resolution of a wound or discontinuation of an indwelling medical device occurs.Enhanced Barrier Precautions apply to residents with any of the following:Infection with a CDC (The Centers for Disease Control and Prevention)-targeted MDRO when Contact Precautions do not otherwise apply.Colonization with a CDC-targeted MDROWounds with or without the presence of an MDRO infection.Presence of indwelling medical devices with or without the presence of an MDRO infection or colonization.MDROs for which EBP applies are based on local epidemiology. At a minimum they should include resistant organisms targeted by the CDC but may also include other epidemiologically important MDROs.Resident #36 was readmitted to the facility on [DATE] with a tracheostomy. A tracheostomy is a surgically created opening (stoma) in the windpipe (trachea).On 5/4/2026 at 10:30 am a blue sign was observed to be on outside of the door for Resident #36 that stated Enhanced Barrier Precautions. The Enhanced Barrier Precautions signage instructed staff to wear a gown and gloves for high contact activities such as device care for tracheostomy. The PPE was available outside of the room on a cart.On 5/4/2026 at 2:00 pm Nurse #1 was observed to perform tracheostomy care for Resident #36. He performed hand hygiene and put on gloves; however, he did not put on any additional personal protective equipment (PPE) such as gown as required for Enhanced Barrier Precautions.An interview with Nurse #1 on 5/4/2026 at 2:16 pm immediately following procedure revealed that he was aware resident was on Enhanced Barrier Precautions. When asked why he did not wear gown Nurse #1 replied oh yeah.On 5/4/2026 at 3:42 pm an interview was conducted with the Director of Nursing (DON). She acknowledged that Nurse #1 needed additional education around infection control practices and PPE. She stated that Nurse #1 should have worn a gown and gloves while doing tracheostomy care for Resident #36.On 5/6/2026 at 10:52 am an interview with the Assistant Director of Nursing (ADON) was conducted. ADON stated it was necessary to wear PPE since Resident #36 was on Enhanced Barrier Precautions. She stated that Nurse #1 should have worn a mask and gown in addition to the gloves on 5/4/2026 while providing tracheostomy care. The ADON told you mask on the previous version.An interview with the Medical Director on 5/6/2026 at 12:44 pm revealed that although he was not that familiar with performing tracheostomy care, he expected that nursing staff should do the procedure according to whatever policies or protocols were in place.