STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carolina Rehab Center of Burke	3647 Miller Bridge Road Connelly Spring, NC 28612

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 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 physician assistant (PA) and staff interviews, the facility failed to maintain accurate advance directives throughout the medical record for 1 of 5 residents reviewed for advance directives (Resident #46). Resident #46 was admitted to the facility on [DATE].Review of an admission progress note dated 8/7/2025 indicated Resident #46 was alert and oriented to person, place, time and situation. Review of Resident #46's Physician's orders, revealed an order dated 8/7/2025 that read code status (DNR). Review of a provider progress note dated 8/8/2025 indicated Resident #46 was seen by the Physician Assistant (PA) and the PA discussed advance directives with Resident #46 and verified Resident #46 wanted to be a Do Not Resuscitate (DNR) and that a MOST form and goldenrod (DNR form) was signed. Resident #46's advance directives care plan, initiated on 8/10/2025 specified the Resident was Full Code. Care plan goals listed as: Honor residents advance directive choices, referral to physician as needed for advanced directive changes, review advance directives with resident as needed. Review of the Code Book (a binder that contained paper copies of residents' advance directives and code status) revealed Resident #46's paper medical record contained a signed Medical Orders for Scope of Treatment (MOST) form that indicated Resident #46's preference for a Do Not Resuscitate (DNR) status in the event he had no pulse and was not breathing. The form was signed by Resident #46 and dated 8/8/2025. Review of the profile page of Resident #46's electronic health record revealed Resident #46's code status was listed as a DNR. During an interview on 8/18/2025 at 1:14 PM Nurse #4 stated a Resident's advance directives/code status was located on a resident's profile in the electronic medical record, or a paper copy in the Code Book at the nurse's station. Nurse #4 verified Resident #46 had DNR listed on his profile in his electronic medical record and had a MOST form and DNR form in the Code Book. During an interview on 8/19/2025 at 9:23 AM Nurse #6 stated when a resident was admitted if they don't have advance directives in place, they are a full code until advanced directives could be discussed with the resident or the residents Responsible Party (RP). Nurse #6 recalled when Resident #46 admitted , no advance directives arrived with the resident, the following day the PA had a discussion with Resident #46 and the MOST form and DNR form was completed and signed. Nurse #6 stated she thought the MDS nurses updated the advance directive care plan when a resident's code status changed. Nurse #6 stated she thought the Unit Managers passed on the change in code status. During an interview on 8/19/2025 at 10:15 AM Nurse #5 stated you could find residents' Code status in the Code Book or in their electronic medical record. Nurse #5 stated if a resident had a change in condition, the nurse was responsible for updating the new order in the computer so the resident's profile would be correct and stated it was reported at shift change. Nurse #5 stated she thought the unit managers would report the change in status. Nurse #5 stated she was not aware that an email needed to be sent to the Social Worker if a resident had a change in code status. During an interview on 8/19/2025 at 9:43 AM the MDS Nurse stated the Social Worker was responsible for updating advance directive care plans. During an interview on 8/19/2025 at 9:45 AM the Social Worker stated when a resident had a change in code status, she was normally notified by the unit manager and then updated the care plan. The Social Worker verified Resident #46's care plan read Full Code, but there was an order for DNR, and Resident #46's electronic medical record read DNR. The Social Worker stated she had not been notified of the change, but it would be corrected. During an interview on 8/19/2025 at 9:49 AM Unit Manager #1 stated an email should be sent to the Social Worker when a resident had a change in code status, so the care plan can be updated. The Unit Manager #1 stated any nurse or unit manager could send the email to the Social Worker. During an interview on 8/19/2025 at 11:13 AM the Physician Assistant (PA) stated she had a discussion with Resident #46 regarding his advance directives on 8/8/2025. The PA stated the MOST form was discussed with Resident #46 in detail and Resident #46 understood and wanted to be a DNR. The PA stated she expected a resident's code status to be correct and match throughout the entire paper and electronic medical record. During an interview on 8/19/2025 1:15 PM the Director of Nursing (DON) stated when a resident has a change in code status that typically the nurse will go in and change the order and make sure the paper forms are completed. The DON stated most of the time she was notified, and it would be discussed in the morning meeting, and the Social Worker could make needed changes to the care plan. The DON stated that any nurse or unit manager should let the Social Worker know and the nurse who changed the order was responsible. The DON stated a resident's code status should match throughout the entire medical record

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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 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 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 record reviews, and Responsible Person and staff interviews, the facility failed to ensure a resident's Do Not Resuscitate (DNR) goldenrod form (a portable physician's order printed on goldenrod colored paper that communicates an individual's wishes regarding resuscitation efforts for emergency responders) and Medical Orders for Scope of Treatment (MOST) form (outlines health care and end-of-life care instructions) stating DNR and Do Not Intubate (DNI) (intubation is a medical procedure where a tube is inserted into the airway to support breathing) were provided to Emergency Medical Services (EMS) upon emergent transfer to the hospital on Sunday 6/22/25. As a result of the resident having no advance directive information conveyed to the hospital, the resident was listed as a full code (all possible life saving measures), was intubated and placed on a mechanical ventilator (a machine that moves air in and out of the lungs) as part of his treatment. The resident's Responsible Person stated that Resident #101 was very specific about not wanting to be resuscitated or intubated and wished to have comfort measures only due to having to previously witnessed a family member intubated and not wanting that for himself. The facility later provided the hospital with resident's DNR and MOST form paperwork, he was extubated (medical procedure where the breathing tube is removed from the airway), and comfort measures were put into place as per his advance directive wishes. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #101).Findings included: Resident #101 was admitted to the facility on Friday 6/20/25 with diagnoses including dementia, history of falls, and muscle weakness. A physician order located in the electronic health record dated 6/20/25 revealed Resident #101's code status was DNR. A telephone interview conducted with the Director of Marketing on 8/19/25 at 9:10 PM revealed she reviewed Resident #101's completed and signed original portable DNR goldenrod form and MOST form showing he was a DNR and DNI inside the facility's medical records box on 6/22/25. A change in condition progress note written by Nurse #1 dated 6/22/25 revealed Resident #101 had a change in condition that included altered level of consciousness and a fall. Resident #101 was located on the floor at his bedside, lying face down with profuse bleeding from right forehead, pressure was applied to head, and Emergency Medical Services (EMS) was called to transport the resident to the hospital emergently. Attempted to contact Nurse #1 for interview and she was unable to be reached. The EMS record dated 6/22/25 revealed EMS was dispatched for emergency response related to a fall with possible head injury. EMS arrived on the scene to find Resident #101 lying face down on the floor with staff holding pressure to the resident's head with a towel. Facility staff advised that while they were passing trays to other residents outside Resident #101's room they heard him fall and went in to find him on the floor. Facility staff stated that when they first arrived Resident #101 was awake and speaking to them and as time progressed, he became less responsive to any stimuli. Resident #101 had equal and reactive pupils but were noted to be sluggish, he would open eyes to painful stimuli but had no other responses. Vital signs were obtained and were within normal limits. Facility staff handed the crew a packet of paperwork that had a face sheet and a medication list. EMS questioned the facility staff regarding code status of Resident #101 and any related paperwork. The facility staff on scene advised that Resident #101 was full code to the best of their knowledge as they had no other paperwork. EMS confirmed and facility staff advised they had not been told or given paperwork to suggest anything other than a full code status. Resident #101 was transferred to the stretcher and secured with assistance from facility staff on scene and without incident. The hospital was notified of incoming trauma patient and updates provided. Resident #101 was monitored throughout transport with no significant changes noted. Bleeding remained controlled with no changes noted. Vital signs were monitored throughout transport with no significant changes noted. Resident #101 was transferred into room with assistance from hospital staff on scene without incident. Report was given to hospital staff on scene and facility paperwork was copied by hospital registration for staff. Attempts to contact EMS for interviews were unsuccessful. Hospital records dated 6/22/25 revealed Resident #101 presented for evaluation after an unwitnessed fall at his rehabilitation living facility. Facility staff found Resident #101 unresponsive and not communicating. Upon EMS arrival, Resident #101 was responsive to pain only and had a large scalp laceration. On hospital arrival, Glasgow Coma Scale (clinical tool used to measure level of consciousness) was 4 (score of 8 or less indicates more severe injury) and Resident #101 was promptly intubated, placed on mechanical ventilation, and stabilized. However, later when the paperwork was brought from the facility it was realized that Resident #101 was a DNR and DNI. Resident #101 was extubated, family

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews and observation, the facility failed to post census information for 322 of 323 days reviewed for daily nurse staffing (October 2024, November 2024, December 2024, January 2025, February 2025, March 2025, April 2025, May 2025, June 2025, July 2025 and 8/1/2025-8/19/2025). Review of the daily nurse staffing sheets from 10/1/2024 through 8/18/2025 revealed there was no census information entered. Observation of the daily nurse staffing sheet dated 8/19/2025 revealed the census was entered. During an interview on 8/19/2025 at 11:30 AM the Scheduler stated she was responsible for completing and posting the daily nurse staffing sheet. The Scheduler stated she had been in her current position for about two years and was not aware until 8/19/2025 that the census needed to be completed on the daily nurse staffing sheet and the Director of Nursing (DON) had informed her this morning that the census needed to be completed on the daily nurse staffing sheet for all three shifts. The Scheduler stated she had completed the census section today and would continue to fill the form out completely. During an interview on 8/19/2025 at 1:00 PM the DON stated she was not aware the census had to be completed for all three shifts, or that it had not been completed on any daily nurse staffing sheets since 10/1/2025. The DON stated the Scheduler would enter the census on the daily nurse staffing sheets from now on. During an interview on 8/19/2925 at 1:15 PM the Administrator stated she was unaware the census had not been entered on the daily nurse staffing sheets. The Administrator stated she thought it was adjusted throughout the day as residents were admitted and discharged . The Administrator stated she expected the daily nurse staffing sheets to be filled out completely and correctly.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observations and staff interviews, the facility failed to discard expired vials of influenza vaccine in 1 of 3 medication rooms (Jasmine medication room), failed to date an opened insulin pen and discard loose pills in 1 of 4 medication carts (Dogwood medication cart).The findings included:1.An observation of the [NAME] medication room with Unit Manager (UM) #1 on 8/19/25 at 1:50 PM revealed five unopened vials and two opened vials of influenza vaccine labeled with an expiration date of 6/30/25. These influenza vaccine vials were available for use in the medication room refrigerator.An interview with UM #1 on 8/19/25 at 1:58 PM revealed the Infection Preventionist or the third shift nurses were responsible for checking the medication room for expired medications. UM #1 stated she knew they had just ordered some influenza vaccine from the pharmacy for the upcoming flu season. During the interview, further observation of the pharmacy label on the bag which contained the expired influenza vaccine vials indicated the vials were delivered to the facility from the pharmacy on 11/7/24. UM #1 stated the expired vials should have been sent back to the pharmacy after they expired.An interview with the Infection Preventionist (IP) on 8/20/25 at 10:20 AM revealed she had just checked the medication rooms on 8/17/25 and she did not observe the expired influenza vials inside the [NAME] medication room refrigerator. The IP stated she checked the medication rooms for expired medications at least once a week or as needed whenever a resident was discharged . She stated that she would have gotten rid of the expired influenza vials if she had observed them during her weekly audits.An interview with the Director of Nursing (DON) on 8/20/25 at 10:30 AM revealed the IP cleaned out the medication rooms weekly and whenever there were discharges. The DON stated the IP normally looked for any expired medications and she would return them to the pharmacy or destroy them if they could not be returned. The DON further stated that she was surprised about hearing about the expired flu vials because the IP told her that she had just checked the [NAME] medication room, and they had not given a flu shot since May 2025 because it was not flu season. 2.An observation of the Dogwood medication cart with Nurse #1 on 8/19/25 at 1:59 PM revealed an undated opened Insulin lispro pen available for use in the top drawer.Review of the manufacturer's instruction for Insulin lispro indicated it expired 28 days after opening, whether it was in a vial, cartridge, or pen, as long as it was stored at room temperature. After 28 days, any remaining insulin should be discarded, even if it still looks and feels normal. Further observation of the Dogwood medication cart revealed a plastic cup with a handwritten resident name containing 18 loose pills stored inside the narcotic drawer.An interview with Nurse #1 on 8/19/25 at 2:00 PM revealed she didn't notice the undated open pen of Insulin lispro, but that it should have been dated when it was opened because it expired 28 days after opening. Nurse #1 stated she was not aware of the loose pills in the narcotic drawer and did not notice them whenever she counted the narcotics with the outgoing nurse. Nurse #1 stated the loose pills looked like morning medications for Resident #124 but denied that she placed the loose pills in the narcotic drawer and that she gave Resident #124 his morning medications.An interview with the Director of Nursing (DON) on 8/20/25 at 10:30 AM revealed the insulin pen should have been dated when it was opened because it was only good for 28 days after opening. The DON stated that the nurses were not supposed to keep loose pills in the medication carts, and that the nurses were supposed to be checking the medication carts daily.