STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Rehabilitation and Healthcare Center	1070 Old Ocean Highway Bolivia, NC 28422

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and staff interviews, the facility failed to implement a facility-wide system to monitor the use of antibiotics. This was evident for 8 of 9 months (July 2025, August 2025, September 2025, October 2025, November 2025, December 2025, February 2026, March 2026) that surveillance data was reviewed. This practice had the potential to affect all residents in the facility. Findings included: The facility's Antibiotic Stewardship Program policy last revised on December 2016, indicated that all clinical infections treated with antibiotics will undergo review by the Infection Preventionist or designee. The Infection Preventionist will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. The antibiotic stewardship program will review essential data including antibiotic orders, clinical documentation, infection surveillance logs, microbiology testing, other tests to confirm infections, and trends in data including a listing of antibiotic orders, clinical documentation confirming the infection, surveillance logs and trending of infections. The facility was unable to provide any infection control data including no listing of antibiotic orders, clinical documentation confirming the infection, surveillance logs or trending of infections for July 2025, August 2025, September 2025, October 2025, November 2025, and December 2025.A review was conducted of resident infections reported in January 2026. The list included residents who exhibited symptoms and were treated with antibiotics during the month. The facility did not utilize a structured tool to track infection rates, antibiotic use, or to monitor, conduct surveillance, or identify trends related to infections or possible infections among residents during this period.The facility was unable to provide any infection control data including no listing of antibiotic orders, clinical documentation confirming the infection, surveillance logs or trending of infections for February 2026 and March 2026. An interview with the Director of Nursing (DON) on 4/22/26 at 11:50 AM revealed that she assumed the position on 4/13/26, following a period in which several interim Directors of Nursing had served. The current DON stated that she was unable to locate Infection Control reports, surveillance records, or infection tracking data for the period of July 2025 through April 2026 except for the January list of residents that received antibiotics. The DON acknowledged that she was expected to function as the Infection Preventionist in addition to fulfilling her responsibilities as the DON. She explained that she had just begun reviewing the infection control information for April 2026 and stated that moving forward, she would implement a system to ensure infection surveillance data was compiled and reviewed monthly.An interview with the Administrator on 4/22/26 at 4:30 PM revealed that the facility had multiple interim Directors of Nursing since she started in her position at the facility in July 2025. The Administrator stated that the tracking of infection control data, including infection trends and antibiotic use, had not been completed. The Administrator explained that the Infection Control Program was intended to be a comprehensive system that included surveillance, tracking, and trend analysis. She stated that she had been in her role only a short time and had not had a consistent Infection Preventionist in place. The Administrator further noted that her expectation was for the Infection Preventionist to follow facility protocols and complete all tasks related to the antibiotic stewardship program, including surveillance and tracking of infection and antibiotic use trends.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with facility staff, the Nurse Practitioner, Pharmacy Consultant and the Pharmacy Director, the facility failed to 1) have effective safeguards and systems in place to prevent drug diversion of discontinued Oxycodone (narcotic pain medication), Hydrocodone/Acetaminophen (narcotic pain medicine with Tylenol) and Lorazepam (an antianxiety medication); and 2) failed to have an effective tracking system to monitor declining count sheets and remove discontinued controlled substances from the medication cart for 5 of 6 residents reviewed for drug diversion (Residents #9, #41, #69, #94, and #95). These failures resulted in inaccurate narcotic counts and had the potential for residents being administered incorrect medications, and receiving narcotics that were not physician ordered. Findings included: 1a. A physician's order was written on 07/18/25 to discontinue Lorazepam 0.5mg every 8 hours as needed for anxiety for Resident #9. The declining count sheet (an inventory log used to record a running total for each controlled medication) for 90 Lorazepam 0.5mg tablets with prescription #979977 for Resident #9 revealed the Lorazepam 0.5 mg was documented having a total of 83 tablets remaining on the count sheet. An undated note written on the count sheet revealed 82 tablets were returned, one tablet was missing. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation that she, the previous DON and the Administrator initiated on 12/30/25 it was found that Resident #9 had one tablet missing from the declining count sheet. The documented number of tablets left should have been 83 but the total count was 82 tablets. The Regional Clinical Director stated a total of 82 tablets were returned to the pharmacy. Review of the Prescriptions Returned To Pharmacy Log revealed the prescription for Resident #18 with prescription #979977 for Lorazepam 0.5 mg had a quantity of 82 tablets recorded as returned on 01/17/26. A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that 82 tablets of Lorazepam were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received medications back from the facility, the medications were reviewed to verify contents and quantity returned. An interview with the current Director of Nursing (DON) on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance had been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated at the time of the investigation (12/30/25) it was the responsibility of all the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the system failure was that the controlled medication was discontinued on 07/18/25 and should have been returned back to the pharmacy when the order was discontinued. 1b.) A physician's order written on 04/23/25 which was discontinued on 07/24/25 for Resident #41 revealed Oxycodone 5 milligrams (mg) tablets, one tablet by mouth every 8 hours for pain as needed. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 04/28/25 a total of 90 Oxycodone 5 mg tablets for Resident #41 with prescription #991627 were delivered to the facility. The delivery receipt was signed off as received by night shift Nurse #12 on 04/28/25. The declining count sheet for 90 Oxycodone 5mg tablets with prescription #991627 that were delivered to the facility on [DATE] for Resident #41 revealed the first dose was signed off as removed on 09/14/25 at 12:00 PM leaving 89 pills remaining. The second dose was signed off as removed on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/21/25 at 4:00 PM leaving 88 pills remaining, the third dose was signed off as removed on an illegible date at 5:10 AM leaving a total of 87 tablets remaining. There was no signature recorded indicating which nurse removed the medication on each day that the medications were removed. On 12/30/25 at 1:13 PM the count was noted to be 90 tablets and a note on the declining sheet indicated the count was corrected by the Regional Clinical Director and the previous Director of Nursing for 90 tablets. An undated note on the declining count sheet also revealed 87 pills returned and 3 pills did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed on 12/30/25 there were multiple incidents where blister packs were perforated and taped back up. She stated an investigation began due to the tampering of the narcotic blister packs and it was discovered that the narcotics were being replaced with other medications such as blood pressure medications. The DON could not recall if the Oxycodone blister pack she identified as being taped up and tampered with on 12/30/25 belonged to Resident #41, but she knew it was Oxycodone and that the replacement tablets that were noted in the blister packs were Metoprolol (a blood pressure medication) which made the count remaining look as though there were 90 tablets. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25 it was found that Resident #41 had 3 pills that were removed from the blister pack of Oxycodone 5mg and were replaced with 3 Metoprolol tablets. She stated when she and the previous DON did the count there were 90 tablets left, but it was realized 3 of the tablets were Metoprolol and were removed leaving a remainder of 87 tablets of Oxycodone which were returned back to the pharmacy. Review of the Prescriptions Returned To Pharmacy Log revealed the prescription date of 04/28/25 for Resident #41 with prescription #991627 for Oxycodone 5 mg had a quantity of 87 tablets recorded as returned on 01/17/26. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #41 did not have a physician's order for Metoprolol. The Nurse Practitioner stated if Resident #41 had received the Metoprolol in error due to being replaced in the Oxycodone blister pack it may have lowered his blood pressure and heartrate and could have caused a syncopal event (a temporary loss of consciousness known as fainting or passing out caused by a sudden drop in blood pressure). A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that 87 Oxycodone tablets were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received medications back from the facility, the medications were reviewed to verify contents and quantity returned. The Pharmacy Director stated had Resident #41 received the Metoprolol in error it would have had the potential to lower his blood pressure and heartrate. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance had been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box on the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the secured controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the system failure was that the controlled medication for Resident #41 was discontinued on 07/24/25 and should have been returned back to the pharmacy when the order was discontinued. 1c.) A physician's order written on 06/18/25 and discontinued on 11/12/25 for Resident #69 revealed Hydrocodone/Acetaminophen (Tylenol) 10mg/325mg one tablet by mouth every six hours as needed for pain. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 09/10/25 a total of 60 Hydrocodone/Acetaminophen 10mg/325mg tablets for Resident (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#69 with prescription #1144328 were delivered to the facility. The delivery receipt was not signed off as received by a nurse. The declining count sheet for 60 Hydrocodone/Acetaminophen 10mg/325 mg tablets that were delivered to the facility on [DATE] for Resident #69 with prescription #1144328 revealed the remaining count was recorded at 43 tablets. The declining count sheet had 17 doses signed out as being removed. An undated note on the declining count sheet indicated 42 pills were returned and 1 pill did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed she could not recall if the Hydrocodone/Acetaminophen 10mg/325mg blister pack she identified as being taped up and tampered with on 12/30/25 belonged to Resident #69, but she knew it was Hydrocodone/Acetaminophen and the replacement tablet was replaced with a lower dose of Hydrocodone/Acetaminophen 5mg/325mg. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25 it was found that Resident #69 had a blister pack of Hydrocodone/Acetaminophen 10mg/325mg but that there was one tablet removed and was replaced with Hydrocodone/Acetaminophen 5mg/325mg. She stated the remaining 42 tablets were returned back to the pharmacy. Review of the Prescriptions Returned To Pharmacy Log revealed the prescription date of 09/10/25 for Resident #69 with prescription #1144328 Hydrocodone/Acetaminophen 10mg/325mg had a quantity of 42 tablets recorded as returned on 01/17/26. A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that a total of 42 tablets of Hydrocodone/Acetaminophen 10mg/325mg were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received medications back from the facility, the medications were reviewed to verify contents and quantity returned. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the secured controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Hydrocodone/Acetaminophen 10mg/325mg was discontinued on 11/12/25 and should not have still been in the controlled substance box on the medication cart. The DON stated the system failure was that the controlled medication was not returned back to the pharmacy when the medication was discontinued. 1d.) A physician's order written on 12/05/25 and discontinued on 12/08/25 for Resident #94 revealed Oxycodone 5 mg one tablet by mouth every 4 hours as needed for pain for up to 7 days, and a physician's order written on 12/05/25 for Hydroxyzine (anti-itch medication) 25 mg one tablet every 8 hours for itching for 15 days; which was discontinued on 12/19/25. Resident #94 did not have physician orders in place for Seroquel (a medication to treat psychiatric diagnoses) or Metoprolol (a medication to treat high blood pressure). A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 12/06/25 a total of 30 Oxycodone 5 mg tablets for Resident #94 with prescription #1268757 were delivered to the facility. The delivery receipt was received by Nurse #14 on 12/06/25. The declining count sheet for 30 Oxycodone 5 mg tablets that were delivered on 12/06/25 with prescription #1268757 for Resident #94 revealed the remaining count was recorded as 18 tablets remaining. A total of 12 doses were signed out as removed from the declining count sheet. An undated handwritten note on the declining count sheet indicated 12 pills were returned with 6 pills that did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed she could not recall if the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxycodone blister pack she identified as being taped up and tampered with on 12/30/25 belonged to Resident #94, but she knew it was Oxycodone and there were other medication pills that were replaced in the blister pack, but she could not recall how many or what the pills were. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25, Resident #94 had 3 pills that had been replaced with Seroquel, 2 pills were replaced with Metoprolol and one pill was replaced with Hydroxyzine. She stated that a total of 12 tablets of Oxycodone 5 mg were returned back to the pharmacy. Review of the Prescriptions Returned To Pharmacy log revealed the prescription date of 12/05/25 for Resident #94 with prescription #1268757 Oxycodone 5 mg had a quantity of 12 tablets returned on 01/17/26. A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that a total of 12 tablets of Oxycodone 5 mg were returned on 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received the medications back from the facility, they were reviewed to verify contents and quantity returned. The Pharmacy Director stated had Resident #94 received the Metoprolol in error it would have had the potential to lower his blood pressure and heartrate and had he received the Seroquel it could have caused Resident #94 to be lethargic (sleepy). An interview with the Nurse Practitioner on 04/24/26 at 1:30 PM confirmed that Resident #94 did not have a physician's order for Seroquel or Metoprolol, but he did have an order for Hydroxyzine which was discontinued on 12/15/25. The Nurse Practitioner stated had Resident #94 received the Metoprolol or Seroquel he could have had syncopal event and increased lethargy as result. The Nurse Practitioner stated there was no allergy listed for either medication for Resident #94. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the box located in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Oxycodone 5mg medication was discontinued on 12/08/25 and should not have still been in the controlled substance box on the medication cart. The DON added that the system failure was not returning the controlled medication back to the pharmacy when it was discontinued. 1e.) A physician's order written on 12/19/25 for Resident #95 revealed Oxycodone 5mg; give 5mg every 6 hours as needed for pain for 3 days. This order was discontinued on 12/22/25. Resident #95 did not have an order in place for Metoprolol. A packing slip and proof of delivery receipt from the dispensing pharmacy revealed on 12/19/25 a total of 12 Oxycodone 5mg tablets for Resident #95 with prescription #1294991 were delivered to the facility. The delivery receipt was signed off with an illegible name on 12/20/25. The declining count sheet for Oxycodone 5mg one tablet by mouth every 6 hours as needed for pain for Resident #95 with prescription #1294991 revealed the remaining count was 9 tablets. There were three doses signed out as removed by a nurse. An undated handwritten note on the declining count sheet indicated that 8 pills were returned and one pill did not match. A phone interview with the previous Director of Nursing on 04/24/26 at 12:37 PM revealed she could not recall if the Oxycodone blister pack identified as being taped up and tampered with on 12/30/25 belonged to Resident #95, but she knew it was Oxycodone and there were other medication pills that were replaced in the blister pack. An interview with the Regional Clinical Director on 04/24/26 at 10:17 AM revealed according to the investigation she, the previous DON and the Administrator initiated on 12/30/25, Resident #95 had one pill that had been replaced with Metoprolol. Review of the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prescriptions Returned To Pharmacy log revealed the prescription date of 12/19/25 for Resident #95 with prescription #1294991 Oxycodone 5mg had a quantity of 8 tablets recorded as returned on 01/17/26. A phone interview was conducted with the Pharmacy Director on 04/24/26 at 3:17 PM. The Pharmacy Director reviewed the Prescriptions Returned to Pharmacy Log that was sent back to the pharmacy. He confirmed that a total of 8 tablets of Oxycodone 5mg were returned 01/17/26. He stated there were no documented discrepancies and added when the pharmacy received the medications returned back from the facility, they were reviewed to verify contents and quantity returned. The Pharmacy Director stated had Resident #95 received the Metoprolol in error it would have had the potential to lower his blood pressure and heartrate. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #95 did not have a physician's order for Metoprolol. The Nurse Practitioner stated if Resident #95 had received the Metoprolol in error due to being replaced in the Oxycodone blister pack it may have lowered his blood pressure and heartrate and could have caused a syncopal event. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance had been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located in the medication cart. The DON stated at the time of this investigation (12/30/25) it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and verify the serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the Oxycodone 5mg medication was discontinued 12/22/25 and should not have still been in the controlled substance box on the medication cart. The DON added that the system failure was not returning the controlled medication back to the pharmacy when it was discontinued. A phone interview was conducted with Nurse #5 on 04/23/26 at 7:38 PM. Nurse #5 stated on the morning of 12/30/25 when she arrived for her shift, she noticed that Nurse #6 was doing the narcotic count with Nurse #7 and Nurse #6 stated she was not taking the keys to cart because there were some narcotic blister packs that were tampered with on the 300 hall medication cart. Nurse #5 stated she worked on the 400 hall medication cart and thought it best to look through her cart to see if there were any tampered narcotic blister packs on her cart. Nurse #5 stated she identified a few (could not recall how many or for which residents) and notified the Nurse Supervisor. Nurse #5 stated some of the blister packs were taped up and some had the tiniest little sliver break noted on the back of the blister pack. She stated the Administrator saw that there were different pills replaced in the blister packs and the previous Director of Nursing did a narcotic count on the 400 hall medication cart and there were no other discrepancies. Nurse #5 stated she had to complete a drug test and it was negative for opioids (narcotic pain medications). A phone interview was conducted with Nurse #7 on 04/24/26 at 11:27 AM. Nurse #7 reported when she arrived for her shift 7:00 PM to 7:00 AM on 12/29/25 she had begun to do her narcotic medication count for 300 hall medication cart with Nurse #1. Nurse #7 stated the narcotic count appeared to be accurate; however, it was noted there were two blister packs for Oxycodone that had tape on the back side of the packs. Nurse #7 stated she did not remember which resident the blister packs belonged to or the dose of the medication. Nurse #7 stated, at that time, she told Nurse #1 that they should waste the medications that were taped up in the blister pack and Nurse #1 stated no. Nurse #7 stated the tablets that were taped up were noted to be on the bottom right hand corner of the blister pack. Nurse #7 stated she should have reported this to the supervisor and not taken over the medication cart keys until it was investigated. Nurse #7 stated she did not see tape on any of the other narcotic cards but she knew that having tape on the blister packs was not right and the integrity of the blister pack had been tampered with. Nurse #7 stated when she did the shift change count off on 12/30/25 with Nurse #6 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and showed her the taped up Oxycodone blister packs, Nurse #6 stated they needed to call the Director of Nursing immediately and she would not accept the keys to the 300 hall medication cart. Nurse #7 stated she was asked to do a drug screening test and it was negative for opioids. A phone interview was conducted with Nurse #6 on 04/24/26 at 12:07 PM. Nurse #6 reported on the morning of 12/30/25 she arrived for her shift and had begun to do her narcotic medication count with Nurse #7 who worked the night shift. Nurse #6 stated while they were doing the count, Nurse #7 pointed out that there were two narcotic blister packs of Oxycodone that had tape covering the back of the blister pack. Nurse #6 stated when Nurse #7 showed her the blister packs, it looked as though the Oxycodone pills had been popped out of the blister pack but there were different pills in place in the blister packs that were taped up. Nurse #6 stated she did not remember which resident the blister packs belonged to or what the dose of the medication was. Nurse #7 stated to Nurse #6 that the pills that were in the blister pack did not match the description of an Oxycodone tablet and both Nurse #7 and Nurse #6 looked up the description of the tablets that were replaced on the internet to check and see what medications were put in place. She stated the medication was Metoprolol which was a blood pressure medication for one of the blister packs and the other blister pack had been replaced with a lower dose of Oxycodone. Nurse #7 stated she reported the concern to the Weekend Supervisor and she called the Administrator and the previous Director of Nursing. Nurse #6 stated she was not asked to do a drug screening test. A phone interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated she was nurse doing the shift change with Nurse #7 on the evening of 12/29/25. She stated she recalled Nurse #7 showing her the taped up narcotic blister packs and asked if they should waste the medications that were taped up. Nurse #1 stated she told Nurse #7 not to waste it. Nurse #1 stated sometimes medications would accidentally pop out and she would tape them back up if she saw them falling out. Nurse #1 stated she did not know that the narcotics were replaced with other medications. Nurse #1 stated the DON asked her to do a drug test and she refused to do a drug test that day because she was not feeling well and then was terminated for not doing the drug test. An interview was conducted with the current Director of Nursing on 04/24/26 at 5:10 PM. The DON stated the system failure was that controlled substances were not being returned to the pharmacy when they were discontinued and that resulted in the misappropriation of the narcotics. The DON stated education was initiated when this occurred to be sure when doing the controlled substance count at shift change, both nurses should be checking for accuracy of the right medication and checking the blister packs for any signs of being tampered with, but she would reinforce that education along with providing education for making sure all discontinued narcotics were returned to the pharmacy according to the procedure. 2a. A physician's order was written on 07/18/25 to discontinue Lorazepam 0.5mg every 8 hours as needed for anxiety for Resident #9. The declining count sheet for 90 Lorazepam 0.5mg tablets with prescription #979977 for Resident #9 revealed the Lorazepam 0.5mg was documented as removed on 09/10/25, 09/30/25, 10/03/25, 10/05/25, and 12/03/25 by Nurse #1. On 11/19/25, one (1) tablet was documented as removed by Nurse #20. There was no active physician order for this medication during these dates. Review of the Medication Administration Record for September 2025, October 2025, and December 2025 revealed there was no active order for Lorazepam 0.5mg recorded on the Medication Administration Records for Nurse #1 and Nurse #20 to sign off as administered. An interview was attempted with Nurse #20 via phone on 04/24/26 at 12:33 PM. A voice mail message was left but Nurse #20 but did not return the phone call. A phone interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated my system was not good and clarified that she knew which medications her residents' received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an order before she administered the medication. Nurse #1 stated whenever she removed the Lorazepam for Resident #9, she administered the medication to him. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #9's Lorazepam order for 0.5mg was discontinued on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Rehabilitation and Healthcare Center	1070 Old Ocean Highway Bolivia, NC 28422

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/18/25 and there was no active order to administer this medication after that date in 2025. The Nurse Practitioner stated the medication should not have been removed to be administered if there was no active order for it. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON stated in 2025, it was the responsibility of the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the secured controlled substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag with a serial number. She stated two nurses were required to verify the tote was sealed and serial numbers of the tags. She stated the declining count sheet and the proof of delivery receipt should be attached together and kept on file. The DON stated the system failure was that the controlled medication was discontinued on 07/18/25 and should have been returned back to the pharmacy when the order was discontinued. The DON added that Nurse #1 and Nurse #20 should not have documented the removal of the Lorazepam tablets since there was not an active order. She stated before nursing staff removed a medication from the blister pack, they should be confirming there was a physician's order, check the order against the controlled substance blister pack, sign and date the declining count sheet with the number of tablets remaining after removal, and then sign off the administration of the medication on the Medication Administration Record. 2b. A physician's order written on 04/23/25 for Resident #41 and discontinued on 07/24/25 for Oxycodone 5mg tablet, one tablet by mouth every 8 hours for pain as needed. There was no active physician order for Oxycodone 5mg to be given from 07/25/25 through 09/10/25. The declining count sheet for 90 Oxycodone 5mg tablets with prescription #909487 for Resident #41 revealed the Oxycodone 5mg was documented as removed on 08/08/25 and 09/06/25 by Nurse #1. There was no active physician order for this medication at this time. Review of the Medication Administration Record for August 2025, revealed there was no order for Oxycodone 5mg recorded on the Medication Administration Records for Nurse #1 to sign off as given on 08/08/25 and 09/06/25. An interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated my system was not good and clarified that she knew which medications her residents' received and she would administer them without looking at the order. Nurse #1 stated she should have reviewed the physician order on the electronic medication administration record (eMAR) to be sure there was an active order before she administered the medication. Nurse #1 stated whenever she removed the Oxycodone for Resident #41, she administered the medication to him. An interview was conducted with the Nurse Practitioner on 04/24/26 at 1:30 PM and confirmed Resident #41's Oxycodone 5mg order was discontinued on 07/24/25 and there was no active order to administer this medication on 08/08/25 and 09/06/25. The Nurse Practitioner stated the medication should not have been removed to be administered if there was no active order for it. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM revealed when a narcotic or controlled substance has been discontinued, the procedure was that the discontinued blister pack should be removed from the controlled substance box located on the medication cart. The DON in 2025, it was the responsibility of all the floor nurses who were on the medication cart to be sure any discontinued controlled substances were removed from the control substance box in the medication cart and sent back to the dispensing pharmacy utilizing the Prescriptions Returned to Pharmacy Log. The controlled substances were to be placed in a tote with a secured zip tie tag [TRUNCATED]

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	345549	A. Building B. Wing	05/05/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews the facility failed to treat a resident in a respectful and dignified manner when Resident #19 was seated in his geriatric wheelchair (a special medical recliner with a wheeled base designed for older adults and individuals with mobility issues) and Nurse Aide #1 pulled the wheelchair down the hall with the resident positioned behind her resulting in the resident being unable to see where he was going. A reasonable person would have had the expectation of being treated with dignity and would have wanted to be wheeled facing forward. In addition, the facility failed to promote dignity during meals when Nurse Aide #1 and Nurse Aide #4 were observed standing over the bedside feeding Resident #19 and Resident #33 who required total dependent care with eating. A reasonable person would have the expectation of being treated with dignity while dining. This occurred for 2 of 6 residents reviewed for dignity (Resident #19 and Resident #33). Findings included: 1. Resident #19 was admitted to the facility on [DATE] with diagnoses of dementia and anxiety. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #19 had severe cognitive impairment. An observation of Resident #19 on 04/20/26 at 1:30 PM revealed the resident was seated in a geriatric wheelchair, slumped over with his head hanging over the chair and with his eyes opened. Resident #19 was noted to be moaning as Nurse Aide #1 was pulling the geriatric wheelchair down the hall. Resident #19 was facing the opposite direction of travel and was not able to see where he was being taken by NA #1. An interview was conducted with Nurse Aide #1 on 04/20/26 at 1:30 PM. Nurse Aide #1 stated she had been educated and in-serviced on treating residents with dignity and respect and realized that she should not have been pulling the resident from behind her and instead should have pushed him in front of her. NA #1 stated the wheelchair was hard to push and that was why she was pulling it. Nurse Aide #1 stated she was not aware he was slumped over the chair or that he was moaning and if he had been in front of her, she would have visualized and heard Resident #19. At this time, Nurse Aide #1 turned Resident #19's geriatric wheelchair around so that he was being pushed in front of her and repositioned him. An interview with the Director of Nursing (DON) on 04/24/26 at 3:30 PM revealed that the Nurse Aide should have been pushing the resident in front her and not pulling him. The DON stated it was a dignity issue, and staff should be treating all residents with dignity and respect. The Director of Nursing added that had the nurse aide been pushing the resident in front of her she would have seen that he was slumped over and perhaps he was moaning due to his positioning. 2. Resident #33 was admitted to the facility on [DATE] with a diagnosis of traumatic brain injury. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #33 had severely impaired cognition. He was dependent on staff assistance with eating.During an observation of the lunch meal on 4/22/26 at 1:20 PM. Resident #33 was observed in bed in his room with the head of the bed elevated. Resident #33 was assisted with eating by Nurse Aide #4 who was standing at the bedside over Resident #33 and was not at eye level. A chair was observed in Resident #33's room. (continued on next page)

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	345549	A. Building B. Wing	05/05/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/26 at 1:20 PM Nurse Aide #4 stated she was an agency nurse aide and had been a nurse aide for 10 years and had never heard of having to sit down to feed a resident. She asked if she needed to pull up a chair to continue assisting Resident #33 with eating. Nurse Aide #4 then placed a chair that was in the room at the bedside and sat down at eye level and continued to assist Resident #33 with his meal. During an interview on 4/24/26 at 1:30 PM the Director of Nursing (DON) stated staff should be providing care to residents while promoting and maintaining dignity. She stated staff were to sit down with residents while assisting them with eating to promote dignity. The DON stated Nurse Aide #4 was an agency Nurse Aide and she was uncertain of what type of education on resident rights and promoting dignity that agency staff had received. 3. Resident #19 was admitted to the facility on [DATE]. Review of an annual Minimum Data Set assessment dated [DATE] revealed Resident #19 had severely impaired cognition and was dependent on staff for all activities of daily living. During the lunchtime meal on 04/24/26 at 1:01 PM Nurse Aide #1 was observed standing over Resident #19 while feeding him his meal in the dining room. Resident #19 was positioned in a geriatric chair, semi-reclined, with his eyes closed as he was fed. An empty chair was observed in the dining room that was available for Nurse Aide #1 to use. Nurse Aide #1 was interviewed at the completion of the observation on 04/24/26 and stated she did not have a chair to sit on during the meal but realized as she looked around the room that there was a chair available across the room for her to sit on as she fed the resident. She also stated that she needed to stand as she fed Resident #19 because she had to keep an eye on the other 3 residents seated at another table in the dining room who were feeding themselves. She reported she was the only staff member in the dining area. In an interview with the Director of Nursing on 04/24/26 at 2:20 PM she stated that she expected staff to sit when assisting a resident during a meal.

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	345549	A. Building B. Wing	05/05/2026

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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 record review, and staff and Nurse Practitioner interviews, the facility failed to follow a physician's order when nursing staff administered the wrong dose of a prescription opioid pain medication 5 times for 1 of 6 residents reviewed for medications (Resident #69). Findings included: Resident #69 was admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease (narrowed or blocked blood vessels, typically affecting legs and feet, that can cause pain and cramping in the leg muscles) and status post above the knee amputation of left leg. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #69 was moderately cognitively impaired. Resident #69 did not receive scheduled pain medication but did receive as needed pain medication for a pain rating of 6 out of 10. Resident #69 was coded as receiving opioids (narcotic pain medication) during this assessment. A physician's order written on 06/18/25 and discontinued on 11/12/25 for Resident #69 revealed Hydrocodone/Acetaminophen (Tylenol) 10mg/325mg one tablet by mouth every 6 hours as needed for pain. A physician's order written on 11/12/25 and discontinued on 11/19/25 for Resident #69 revealed Hydrocodone/Acetaminophen 5mg/325mg one tablet by mouth every 6 hours as needed for pain. Review of the November 2025 Medication Administration Record (MAR) revealed there were two orders on the MAR. One order was for documenting the administration of the Hydrocodone/Acetaminophen 10mg/325mg. This order was in effect until 11/12/25. There was no documentation to support that 10mg/325mg was given from 11/01/25 thru 11/12/25. On the same page of this November 2025 MAR, revealed an order for Hydrocodone/Acetaminophen 5mg/325mg starting on 11/12/25. The following days were noted that the discontinued order of Hydrocodone/Acetaminophen 10mg/325mg were removed from the declining count sheet: On 11/16/25 Nurse #17 documented on the MAR at 10:00 PM she administered Hydrocodone/Acetaminophen 5mg/325mg, but the declining count indicated Nurse #17 removed one tablet of Hydrocodone/Acetaminophen 10mg/325mg. On 11/17/25 Nurse #17 documented on the MAR at 10:00 PM she administered Hydrocodone/Acetaminophen 5mg/325mg, but the declining count indicated Nurse #17 removed one tablet of Hydrocodone/Acetaminophen 10mg/325mg. On 11/18/25 Nurse #17 documented on the declining count sheet at 5:00 AM she removed one tablet Hydrocodone/Acetaminophen 10mg/325mg. There was no documentation on the MAR that the narcotic pain medication was given at this time. On 11/18/25 Nurse #15 documented on the MAR at 2:08 PM she administered Hydrocodone/Acetaminophen 5mg/325mg, but the declining count indicated Nurse #15 removed one tablet of Hydrocodone/Acetaminophen 10mg/325mg. On 11/18/25 Nurse #20 documented on the declining count sheet at 9:00 PM she removed one tablet Hydrocodone/Acetaminophen 10mg/325mg. There was no documentation on the MAR that the narcotic pain medication was given at this time. An interview was attempted via phone with Nurse#20 on 04/24/26 at 12:30 PM. Nurse #20 did not return the call. An interview was attempted via phone with Nurse #17 on 05/04/26 at 4:22 PM. Nurse #17 did not return the call. An interview was attempted via phone with Nurse #15 on 05/04/26 at 4:23 PM. Nurse #7 did not return the call. An interview with the Nurse Practitioner on 04/24/26 at 1:30 PM confirmed that from 11/12/25 through 11/19/25 Resident #69 had an order for Hydrocodone/Acetaminophen 5mg/325mg. The Nurse Practitioner stated the nurses removed the 10mg/325mg tablet instead of 5mg/325mg resulting in Resident #69 receiving the wrong dose. The Nurse Practitioner reviewed her progress notes during this time frame and reported there was no negative outcome as a result of Resident #69 receiving the wrong dose. An interview was conducted with the Director of Nursing on 04/24/26 at 4:00 PM. The Director of Nursing stated that the order for the Hydrocodone/Acetaminophen 10mg/325mg was discontinued on 11/12/25 and the declining count sheet and the blister pack for that dose should have been removed from the controlled substance box on the medication cart when it was discontinued. The DON stated had the nurses removed the discontinued Hydrocodone/Acetaminophen 10mg/325mg it could have prevented Resident #69 from getting the wrong dose.

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	345549	A. Building B. Wing	05/05/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to assist a resident who was dependent on staff for feeding assistance with a meal. This resulted in Resident #2, who was cognitively impaired, waiting for assistance with eating after the meal tray was placed within view at the bedside. This occurred for 1 of 3 residents reviewed for assistance with activities of daily living (Resident #2). Findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury and diabetes. A care plan dated 2/28/26 revealed Resident #2 had activities of daily living (ADL) self-care deficit related in part to; failure to thrive, lack of coordination, and muscle weakness. Interventions included to assist with ADL's including eating. Resident #2 was totally dependent on staff with eating her meals. The Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #2 had moderately impaired cognition. She was dependent on staff for feeding assistance. Resident #2 received Hospice services. During an observation on 4/22/26 at 9:20 AM Resident #2 was observed in her room seated upright in bed. The breakfast tray was on the bedside table in view of Resident #2. During an interview on 4/22/26 at 9:20 AM Nurse Aide #5 stated she was an agency nurse aide and today was her third day in the facility. She stated she had 16 residents on her assignment, and she had two residents that needed assistance with eating. She stated the assignment was busy since she was not familiar with the residents, but she was getting ready to start assisting the residents that needed assistance with eating. Nurse Aide #5 stated she was assisting other residents and had not had time to sit and assist Resident #2 with eating yet. Nurse Aide #5 stated the cart with the breakfast trays came out on the hallway around 9:00 AM. During an interview on 4/22/26 at 9:25 AM Nurse #8 stated she was the assigned nurse for the 200 hall. She stated there were two residents including Resident #2 on the 200 hall that needed assistance with eating. She stated Resident #2 was dependent on staff with eating. A continuous observation conducted on 4/22/26 from 9:20 AM until 9:45 AM revealed no staff member entered Resident #2's room to assist her with eating breakfast. During an observation on 4/22/26 at 9:45AM Nurse #8 was observed sitting at the nurses' station. When asked if she knew Resident #2 still had not been fed her breakfast meal, she stated that Nurse Aide (#5) had not asked her for help. Nurse #8 stated she was not aware Resident #2 had not been fed her breakfast yet. Nurse #8 stated she would go assist Resident #2. During an observation on 4/22/26 at 9:50 AM Nurse #8 was observed in Resident #2's room assisting her with eating her breakfast meal. During an interview on 4/22/26 at 9:50 AM Resident #2 was asked by the Surveyor if her food was warm enough to eat. Resident #2 stated yes. During an interview on 4/22/26 at 10:30 AM the Unit Manager stated Resident #2 was dependent on staff assistance with ADL care including eating. She stated Resident #2's appetite varied, she has had weight loss and was currently on Hospice services. During an interview on 4/22/26 at 11:00 AM the Director of Nursing (DON) stated she was new to the facility and had been the DON for three weeks. She stated Resident #2 should not have waited 45 minutes to be assisted with eating her breakfast meal. The DON stated the Nurse on the hallway should assist the Nurse Aides during meals to ensure that the residents that needed assistance with eating didn't have to wait for that length of time to be assisted by staff.

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	345549	A. Building B. Wing	05/05/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Nurse Practitioner interviews, the facility failed to obtain weights as ordered by the physician and failed to verify the accuracy of weights after significant weight changes for 1 of 3 residents reviewed for weight monitoring (Resident #32).Findings included: Resident #32 was admitted to the facility on [DATE] with diagnoses including end stage renal disease with dependence on hemodialysis, and congestive heart failure (CHF). A physician's order dated 1/29/26 for Resident #32 revealed to obtain daily weights for CHF. Record review revealed the following documented weights for Resident #32 for February 2026: 02/01/26 - 190.6 lbs. (pounds) 02/03/26 - 193.6 lbs.02/09/26 - 194.0 lbs.02/10/26 - 194.4 lbs.02/11/26 - 194.6 lbs.02/16/26 - 194.1 lbs.02/17/26 - 194.8 lbs.02/18/26 - 194.0 lbs.02/19/26 - 195.4 lbs.02/20/26 - 195.4 lbs.02/21/26 - 203.2 lbs. Review of Resident #32's progress notes from 2/1/26 through 2/21/26 revealed no documentation explaining why weights were not obtained on days when no weight was recorded. There was no notation of Resident #32's refusal. Record review revealed Resident #32 was hospitalized from late February through 03/04/2026. A care plan dated 3/9/26 revealed Resident #32 was at risk for nutritional compromise due to end stage renal disease and dependence on hemodialysis, chronic obstructive pulmonary disease (COPD) and chronic respiratory failure. Resident #32 was at risk for weight fluctuations secondary to hemodialysis. The care plan included an intervention to obtain weights per the physician's order. Record review revealed the following documented weights for Resident #32 for March 2026: The weight was scheduled to be obtained daily at 6:00 AM: 03/05/26 - Refused03/07/26 - Refused03/08/26 - 197 lbs. 03/09/26 - 222 lbs., documented by Nurse #2403/10/26 - 221 lbs.03/13/26 - 223.4 lbs.03/14/26 - 222 lbs.03/19/26 - Refused03/22/26 - 218.8 lbs.03/23/26 - 220.2 lbs.03/24/26 - 245 lbs., documented by Nurse #2503/24/26 - 187.2 lbs., documented by Nurse #16 Review of Resident #32's progress notes from 3/5/26 through 3/24/26 revealed no documentation explaining why weights were not obtained on days when no weight was recorded. There was no documentation indicating a reweigh was completed on 3/9/26 that showed a 25 pound weight gain. There was no documentation on 3/24/26 that the Unit Manager or Director of Nursing were notified of the weight difference. Record review revealed Resident #32 was hospitalized [DATE] through 4/2/26 for evaluation of shortness of breath with coughing and wheezing. A physician's order dated 4/2/26 for Resident #32 revealed to obtain weekly weights for CHF. Record review revealed the following documented weights for Resident #32 for April 2026: 04/06/26 - 193.0 lbs.04/10/26 - 189.9 lbs.04/17/26 - 185.6 lbs.04/20/26 - 183.3 lbs.04/21/26 - 193.2 lbs., documented by Nurse #26 Review of Resident #32's progress note dated 4/21/26 revealed no documentation indicating a reweigh was completed or any follow up to verify accuracy for the 10 lb. weight increase in 24 hours. There were no further weights recorded after 4/21/26. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #32 had moderately impaired cognition. Resident #32 received diuretics, oxygen, and dialysis. She had no rejection of care. During an interview on 4/24/26 at 10:00 AM the Administrator indicated that nursing staff should obtain weights according to the physician's order and document accurate weights. She stated Nurse #24 (who documented the 3/9/26 weight of 222 lbs.) was no longer employed at the facility. Attempts were made on 4/24/26 to contact Nurse #25 who documented the 3/24/26 weight of 245 lbs. which was a 25 lb. weight gain. There was no response. During a phone interview on 4/24/26 at 5:10 PM Nurse #16 who documented the 3/24/26 weight of 187.2 lbs., a 57.8 lb. weight difference stated she was most likely told by another Nurse or the Unit Manager to get a reweigh on Resident #32 and entered the weight without reviewing the previous weight. Nurse #16 had no further comment. Attempts were made on 4/24/26 to contact Nurse #26 who documented the 4/21/26 weight of 193.2 lbs. which was a 10-pound weight gain in a 24-hour period. There was no response. During an interview on 04/23/26 at 10:53 AM Nurse Aide #6 stated nurse aides obtained weights and recorded (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them on a weight list posted at the nurses' station. She stated the Unit Manager, or nurse would notify them if a reweigh was needed. During an interview on 4/24/26 at 10:00 AM the Unit Manager indicated Resident #32 had orders for daily weights that was changed to weekly weights. She stated the assigned nurse aide obtained the weights and she or the assigned nurse would enter the weights into the resident's record. The Unit Manager stated weights should be obtained as ordered and residents should be reweighed the same day if there was a significant change. She stated she was not aware that daily weights were missed or that significant weight discrepancies occurred for Resident #32. During an interview on 4/24/26 at 1:00 PM, the Nurse Practitioner (NP) stated Resident #32 had multiple comorbidities, including endˆstage renal failure and endˆstage congestive heart failure, and required accurate weights. She stated a 20 to 25 lb. weight gain in 24 hours was unlikely and may indicate failure to subtract wheelchair weight or scale variance, and the 57 lb. weight loss was inaccurate. The NP indicated nursing staff should also compare facility weights with dialysis center weights. She stated she should be notified only after a significant weight change was verified. During an interview on 4/24/26 at 2:00 PM the Director of Nursing (DON) stated she expected weights to be obtained according to the physician's order, and residents reweighed the same day if significantly different from the previous weight and reported to her or the Unit Manager so accuracy could be verified and communicated to the Physician.

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	345549	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Rehabilitation and Healthcare Center	1070 Old Ocean Highway Bolivia, NC 28422

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff, and the Nurse Practitioner's interviews the facility failed to administer an as needed antihypertensive medication (Clonidine 0.2 milligrams) according to the physician's order and withhold the medication Isosorbide Mononitrate (a vasodilator that relaxes and dilates blood vessels and can lower blood pressure) according to the physicians order when blood pressure parameters were met. This occurred for 1 of 6 residents reviewed for medication administration (Resident #60). Findings included: Resident #60 was admitted to the facility on [DATE] with diagnoses including hypertension, congestive heart failure, and coronary artery disease. a. A physician's order dated 12/13/25 for Resident #60 revealed to administer Clonidine 0.2 milligrams (mgs) every 12 hours as needed for systolic blood pressure greater than 180 or diastolic blood pressure greater than 90. Review of Resident #60's Medication Administration Record (MAR) dated December 2025 revealed the following blood pressure recorded: 12/21/25 at 9:00 AM blood pressure 248/100 documented by Nurse #15 Review of Resident #60's Medication Administration Record (MAR) dated 12/21/25 revealed no documentation that Clonidine 0.2 mgs was administered to Resident #60. Review of Resident #60's nursing progress notes on 12/21/25 revealed no documentation that Clonidine 0.2 mgs was administered, and no documented clinical rationale for withholding the medication. Review of Resident #60's Medication Administration Record dated January 2026 revealed the following blood pressures recorded: 1/07/26 at 9:00 AM blood pressure 210/87 documented by Nurse #16 1/08/26 at 9:00 AM blood pressure 235/101 documented by Nurse #15 1/13/26 at 9:00 AM blood pressure 231/90 documented by Nurse #15 1/17/26 at 9:00 AM blood pressure 187/88 documented by Nurse #15 1/21/26 at 9:00 AM blood pressure 212/87 documented by Nurse #15 Review of Resident #60's Medication Administration Record dated January 2026 revealed no documentation that Clonidine 0.2 mgs was administered to Resident #60 from 1/7/26 through 1/21/26. Review of Resident #60's nursing progress notes from 1/7/26 through 1/21/26 revealed no documentation that Clonidine 0.2 mgs was administered, and no documented clinical rationale for withholding the medication. During a phone interview on 4/24/26 at 9:30 AM Nurse #15 stated that she had not been assigned to Resident #60 for a while prior to the times she recorded the elevated blood pressures. Nurse #16 stated she was not aware during that time that Resident #60 had an order for Clonidine as needed if her blood pressure was elevated. During a phone interview on 4/24/26 at 5:10 PM Nurse #16 stated she could not speak on a medication issue that occurred in January. She had no further comment. b. A physician's order dated 4/6/26 for Resident #60 revealed Isosorbide Mononitrate extended release 60 milligrams (mg). Give 1 tablet by mouth once a day for angina (chest pain or discomfort that occurred when the heart muscle does not receive enough oxygenˆrich blood). Hold for systolic blood pressure less than 120. Review of Resident #60's Medication Administration Record (MAR) dated April 2026 revealed Isosorbide Mononitrate extended release 60 mg tablets were administered on the following dates and time as evidence by the nurses signature with the following blood pressures recorded: 4/09/26 at 8:30 AM Nurse #8 signed as administered with blood pressure 112/76. 4/22/26 at 8:30 AM Nurse #8 signed as administered with blood pressure 118/70. 4/23/26 at 8:30 AM Nurse #8 signed as administered with blood pressure 118/75. Review of Resident #60's nursing progress notes on 4/9/26, 4/22/26, and 4/23/26 revealed no documentation or clinical justification for administering the medication. During an interview on 4/23/26 at 3:30 PM Nurse #8 stated she has not had to hold Resident #60's Isosorbide Mononitrate any time including today. She stated she didn't realize the medication had hold parameters. Nurse #8 stated when she viewed the electronic Medication Administration Record (eMAR) the hold parameters weren't noticeable which was why it was overlooked. Nurse #8 stated she would go check Resident #60's blood pressure to ensure her blood pressure was not too low. Nurse #8 stated Resident #60 had been resting quietly this afternoon with no complaints. The Minimum Data Set (MDS) quarterly assessment dated [DATE] (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #60 had moderately impaired cognition. During an interview on 4/24/26 at 9:00 AM Resident #60 who was alert and oriented to person, and place stated she was on blood pressure medications, but she did not know what medications or when they were to be given. She stated she would get headaches and felt dizzy at times but otherwise felt okay at this time. During an interview on 4/24/26 at 1:00 PM the Nurse Practitioner stated Resident #60 had elevated blood pressures and received scheduled antihypertensive medications and had the Clonidine order in place for increased blood pressure. She stated Resident #60's blood pressure continued to run high at times and then would run low at times, and she has had to adjust her medications. The Nurse Practitioner indicated that the as needed Clonidine was ordered for a reason and the blood pressure parameters should be followed and as needed medications administered when indicated. She stated nitrates dilated blood vessels, and can lower blood pressure, which is why the hold parameters were ordered for the Isosorbide Mononitrate. She stated the ordered parameters should be followed and the medication held if the systolic blood pressure was less than 120. The Nurse Practitioner stated she would only need to be notified of Resident #60's blood pressure if the Clonidine had been administered and the blood pressure had remained significantly elevated. The Nurse Practitioner indicated Resident #60 has had no significant outcome related to the medication errors. During an interview on 4/24/26 at 2:30 PM the Director of Nursing (DON) stated the nurses were expected to read the medication orders and follow the ordered parameters and administer or withhold medications when it was indicated when the parameters were met.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Nurse Practitioner and staff, the facility failed to accurately document the administration of controlled substances for 4 of 6 residents reviewed for accurate medical records (Residents #41, #69, #94 and #95).Findings included: a.) Resident #41 was admitted to the facility 03/23/23. A physician's order written on 09/11/25 for Resident #41 and discontinued on 11/19/25 for Oxycodone (opioid pain medication) 5 milligrams (mg) tablet, one tablet by mouth every 8 hours as needed for pain. Review of Resident #41's declining count sheet (an inventory log used to record a running total for each controlled medication) revealed Nurse #1 documented the removal of Oxycodone 5 mg on 09/11/25 at 4:00 PM, 09/12/25 at 2:00 PM and 6:00 PM, 09/19/25 at 9:00 AM and 4:00 PM, 09/20/25 at 9:00 AM and 4:00 PM, and 09/21/25 at 1:00 PM. The Medication Administration Record (MAR) for September 2025 for Resident #41 revealed on 09/11/25 at 4:00 PM, 09/12/25 at 2:00 PM and 6:00 PM, 09/19/25 at 9:00 AM and 4:00 PM, 09/20/25 at 9:00 and 4:00 PM, and 09/21/25 at 1:00 PM, Nurse #1 did not document that she administered the Oxycodone 5 mg on the MAR. b.) Resident #69 was admitted to the facility on [DATE]. A physician's order written on 11/12/25 and discontinued on 11/19/25 for Resident #69 revealed Hydrocodone/Acetaminophen (opioid pain medication) 5 mg / 325 mg one tablet by mouth every 6 hours as needed for pain. Review of Resident #69's declining count sheet revealed on 11/14/25 at 9:00 AM and 11/15/25 at 4:00 PM, Nurse #1 documented the removal of Hydrocodone/Acetaminophen 5 mg/325 mg. The MAR for November 2025 for Resident #69 revealed on 11/14/25 at 9:00 AM and 11/15/25 at 4:00 PM, Nurse #1 did not document that she administered Hydrocodone/Acetaminophen 5 mg / 325 mg on the MAR. c.) Resident #94 was admitted to the facility on [DATE]. A physician's order written on 12/05/25 and discontinued on 12/08/25 for Resident #94 revealed Oxycodone 5 mg one tablet by mouth every 4 hours as needed for pain for up to 7 days. A physician's order written on 12/14/25 for Resident #94 revealed Oxycodone 5 mg one tablet by mouth every 6 hours as needed for pain until 12/16/25. Review of Resident #94's declining count sheet for Oxycodone 5 mg revealed on 12/08/25 at 8:00 AM and 12:00 PM, and 12/14/25 at 8:00 AM and 12:00 PM, Nurse #1 documented the removal of Oxycodone 5 mg. The MAR for December 2025 for Resident #94 revealed on 12/08/25 and 12/14/25 at 8:00 AM and 12:00 PM, Nurse #1 did not document that she administered Oxycodone 5 mg on the MAR. d.) Resident #95 was admitted to the facility on [DATE]. A physician's order written on 12/19/25 for Resident #95 revealed Oxycodone 5 mg; give 5 mg every 6 hours as needed for pain for 3 days. Review of Resident #95's declining count sheet for Oxycodone 5 mg revealed on 12/22/25 at 8:00 AM, Nurse #1 documented the removal of Oxycodone 5 mg. The MAR for December 2025 for Resident #94 revealed on 12/22/25 Nurse #1 did not document that she administered Oxycodone 5 mg on the MAR. A phone interview was conducted with Nurse #1 on 04/24/26 at 7:30 PM. Nurse #1 stated my system was not good and clarified that she knew which medications her residents' received and she would administer them without looking at the order. Nurse #1 added that she did not sign off the medication as given on the MAR because she was too busy at the time and she forgot to go back and sign the MAR. A phone interview with the previous Director of Nursing (DON) on 04/24/26 at 12:37 PM revealed that she would expect the nursing staff to sign off on the MAR whenever administering pain medications and added it was important to document on the MAR to determine if the pain was being managed for the resident. An interview with the Nurse Practitioner on 04/24/26 at 1:30 PM revealed she utilized the MAR to determine how residents were responding to their as needed pain medication, so it was important for the nursing staff to accurately document the administration of the medication. An interview with the current Director of Nursing on 04/24/26 at 4:00 PM stated she expected her nursing staff to be accurately documenting the administration of pain medications on the MAR. She stated the system failure was that this nurse did not follow the process of medication administration which included the documentation of administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews, the facility failed to implement their infection control policy and procedures for Contact Precautions when cleaning a resident's room (Resident #37) who was on Contact Precautions for suspicion of Norovirus (a highly contagious group of viruses that cause inflammation of the stomach and intestines and can survive on surfaces for weeks) and Rotavirus (a highly contagious virus that causes gastrointestinal symptoms). This occurred with 2 of 5 staff members who were observed for infection control practices (Housekeeping Aide #1 and Housekeeping Aide #2). Findings included: The Infection Control Policy dated January 2026 revealed Contact Precautions were implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the residents environment. Staff and visitors are to wear gloves and a gown when entering the room and remove before leaving the room when a resident is on Contact Precautions. During an observation on 4/22/26 at 9:35 AM Resident #37 was observed lying in bed. A Contact Precautions sign was observed on the door of Resident #37's room. A PPE (personal protective equipment) supply bag with supplies including gloves and gowns were hanging on the door of Resident #37's room. Housekeeping Aide #1 was observed in Resident #37's room, cleaning the room including wiping down the bedside table and handling trash. Housekeeping Aide #1 was wearing gloves but no gown. She removed her gloves and performed hand hygiene before leaving the room.During an interview on 4/22/26 at 9:35 AM Housekeeping Aide #1 stated she did not see the sign on Resident #37's door because the door was open. She stated she saw the gloves and gowns hanging on Resident #37's door but did not see the Contact Precautions sign. Housekeeping Aide #1 then read the sign and stated she should have put on a gown and gloves before going into Resident #37's room. She stated she had received infection control training on Contact Precautions.During an observation on 4/23/26 at 11:05 AM Resident #37 was observed lying in bed. A Contact Precautions sign was observed on the door of Resident #37's room. A PPE supply bag with supplies including gloves and gowns were hanging on the door of Resident #37's room. Housekeeping Aide #2 was observed in Resident #37's room cleaning the room including the bathroom, and handling trash. Housekeeping Aide #2 was wearing gloves but no gown. He removed his gloves and performed hand hygiene before leaving the room.During interview on 4/23/26 at 11:05 AM Housekeeping Aide #2 stated he wasn't sure what it meant to be on Contact Precautions. Housekeeping Aide #2 stated he had received infection control training.During an interview on 4/23/26 at 11:20 AM the Housekeeping Manager stated Housekeeping Aide #1 and Housekeeping Aide #2 had received infection control training. She stated housekeeping staff had been instructed to read the precaution signs on the door of the residents' room before entering and wear the appropriate PPE.During an interview on 4/24/26 at 3:50 PM the Assistant Director of Nursing (ADON) stated she was also the Infection Preventionist, but she was new to the facility and had only worked here for three weeks. She indicated that all staff should have received infection control training and should wear the appropriate PPE when going into resident rooms that are on transmission-based precautions.During an interview on 4/24/26 at 4:00 PM the Director of Nursing (DON) stated she was new to the facility and had worked here for three weeks. She stated staff were to follow the guidelines and wear the appropriate PPE when entering resident rooms that were on any type of precautions. She stated Resident #37 was on Contact Precautions and the Housekeeping Aides (#1 and #2) should have had on gloves and a gown before entering Resident #37's room.