STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Health & Rehab Center	9600 No 5 School Road Ash, NC 28420

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 0684 Level of Harm - 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, Nurse Practitioner (NP) and Medical Director interviews, the facility failed to complete and document comprehensive assessments and failed to identify or recognize the significance of severe pain and changes in mobility, transfers and ambulation after the resident reported an unwitnessed fall. The NP was notified of the resident's hip pain on 7/15/25 and evaluated the resident but was not informed of the unwitnessed fall on 7/14/25. The NP indicated had he known Resident #61 had fallen and was reporting pain, he would have ordered xˆrays immediately. The NP was notified again on 7/18/25 the resident was reporting hip pain and an x-ray of the resident's bilateral hips was ordered. The resident experienced pain and decreased ability to ambulate and transfer from 7/14/25 (the day of an unwitnessed fall) through 7/19/25 when the facility acted on a mobile x-ray report that identified an acute left femoral neck fracture with displacement (a serious type of hip fracture where the broken bone ends separate causing severe pain, inability to walk and often shortening or external rotation of the leg). She was sent to the Emergency Department for evaluation and treatment. The resident underwent a hemiarthroplasty of the left femur (a procedure in which the fractured ball or head of the hip is replaced) with no complications as a result of the surgery. This failure to comprehensively assess a resident was for 1 of 3 residents reviewed for accidents (Resident #61). Findings included: Resident #61 was admitted on [DATE] with diagnosis which included a femur fracture, osteoporosis, and dementia. A review of Resident #61's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had severe cognitive impairment, was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #61 did not have pain assessed and had one fall with no injury. Resident #61 required limited assistance with transfers, bed mobility and toileting.A review of Resident #61's electronic health record revealed that there was no nursing progress note documented on 7/14/25. There was no documentation indicating that Resident #61 experienced an unwitnessed fall, reported pain, or received an assessment of the lower extremity or of the resident's ability to transfer, ambulate, or move.An interview was conducted with Nurse #5 on 4/9/26 at 9:58 AM. Nurse #5 was assigned to care for Resident #61 on 7/14/25 during the 11:00 AM to 11:00 PM shifts. During the interview, Nurse #5 stated that he did not recall Resident #61's condition in July 2025 and could not remember whether he assessed the resident for pain or range of motion. He further reported that he did not recall Resident #61 reporting an unwitnessed fall on 7/14/25 or reporting pain on that date. Nurse #5 stated that Resident #61 would have been able to get up off the floor if she fell. A review of Resident #61's electronic Medication Administration Record revealed that on 7/14/25 on the day shift (7:00 AM to 7:00 PM) Nurse #5 documented the resident's pain level was 0 on a 10-point scale with 0 being no pain and 10 being the worst pain ever. A nursing progress note dated 7/15/25 at 5:57 AM written by Nurse #11 revealed that Resident #61 stated she was having a lot of pain in her hip and a note was placed in the doctor's book. The note did not indicate that Nurse #11 called the on-call provider or administered medication for pain. A review of Resident #61's Medication Administration Record (MAR) revealed Nurse #11 did not document administration of pain medication from 7/14/25 at 7:00 PM through 7:00 AM on 7/15/25. A review of the pain monitoring documentation on Resident #61's July (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2025 electronic MAR revealed that on 7/14/25 on the night shift (7:00 PM to 7:00 AM) Nurse #5 documented the resident's pain level was 0. An interview with Nurse #11 on 4/8/26 at 5:15 PM via phone revealed that she had been assigned to Resident #61 on 7/14/25 from 7:00 PM to 7:00 AM on 7/15/25. Nurse #11 stated that when she received report from the off^going nurse on 7/14/25, she was not informed that Resident #61 had experienced a fall. She reported that during the night, the resident was having significant hip pain, which was not typical for her. Nurse #11 stated that she assessed Resident #61 but did not recall whether she assessed the resident's left leg for a leg^length discrepancy or deformity. Nurse #11 stated that she asked the Nurse Aide assigned to Resident #61 whether the resident had any changes and was informed that the resident was unable to ambulate, which was a change from her baseline. She reported that she documented the change in condition in the facility's internal communication log (doctor's book) for the provider. Nurse #11 stated that she believed she had administered something for pain but could not recall specifically, adding that if it was not documented, she must not have given it. She was informed that the electronic Medication Administration Record did not contain documentation of an as^needed dose of acetaminophen administered by her on 7/15/25. Nurse #11 stated that she asked Resident #61 whether she had fallen, and the resident replied that she did not remember. She stated that she reported the resident's increased pain to another nurse on 7/15/25 at the end of her shift, though she did not recall which nurse it was.An interview was conducted with NA #10 on 4/9/26 at 2:00 PM. NA #10 was assigned to Resident #61 on 7/14/25 from 7:00 PM to 7:00 AM on 7/15/25. NA #10 did not recall if Resident #61 had any changes in condition, changes to her left leg or complaint of pain. NA stated that if Resident #61 had pain during care she reported it to the nurse on duty. A review of a nursing progress note written by Nurse #12 dated 7/15/25 at 11:30 AM indicated that the note was a late entry that was recorded on 7/19/25 at 12:30 PM. The note indicated that Nurse #12 was assigned to Resident #61 on 7/15/25 when the resident reported that she had pain in her hips and knees. The note indicated that Resident #61 stated that she fell yesterday (7/14/25), was able to pull herself up and did not tell anyone. Nurse #12 documented that she spoke to the Nurse Practitioner regarding Resident #61's pain and that the resident was screaming in pain when she was moved. The progress note stated that the NP's response to Nurse #12's report of Resident #61's pain was that the resident complained of pain all the time. Nurse #12 informed the NP that the pain Resident #61 was demonstrating was not her normal behavior. The NP instructed staff to administer acetaminophen as needed and stated that he would evaluate the resident the following day. The progress note did not document a pain level or an assessment of Resident #61's lower extremities, nor did it indicate that the unwitnessed fall reported by Resident #61 had been communicated to the NP. Nurse #12 was assigned to Resident #61 on 7/15/25 from 7:00 AM to 7:00 PM. Attempted to interview Nurse #12 via phone with voicemail messages left and texts sent on 4/8/26 at 5:02 PM and 4/9/26 at 2:36 PM with no return call received. A review of Resident #61's electronic Medication Administration Record revealed acetaminophen 650 milligrams as needed was administered by Nurse #12 on 7/15/25 at 11:50 AM for pain and was documented as slightly effective. The MAR did not have numerical pain monitoring documented with the administration of the as needed medication for pain. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/15/25 on the day shift Nurse #12 documented the resident's pain level was 0. Review of a progress note written by the Nurse Practitioner (NP) dated 7/15/25 at 12:38 PM indicated that Resident #61's chief complaint was hip pain. The history of present illness documented that nursing staff reported the resident was having pain. The NP educated Resident #61 to request pain medication as needed. The note indicated that Resident #61 appeared sleepy and groggy, and that her pain was non^specific. The assessment did not include documentation of an assessment of Resident #61's lower extremities. The assessment and plan indicated Resident #61 had neuropathic or nerve and hip pain with staff directed to administer acetaminophen as needed. The resident was again educated to ask for pain medication. An interview was conducted with the former Nurse Practitioner (NP) on 4/9/26 at 10:15 AM via (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	phone. The NP stated that although he was no longer employed at the facility, he had been assigned to Resident #61 during July 2025. He explained that Resident #61 experienced intermittent pain, which he believed to be her baseline, and he assumed it was just her complaining when he was informed that she was having pain on 7/15/25. The NP reported that he was unaware the resident had experienced a fall when he was asked to evaluate her on 7/15/25. He stated that had he known Resident #61 had fallen and was reporting pain, he would have ordered xˆrays immediately. The NP acknowledged that he did not recall speaking with staff, including Nurse #12, on 7/15/25 to inquire about the resident's pain or any changes in her condition including pain with movement and ambulation. He stated that if a resident exhibited newˆonset of severe pain, with or without a fall, an xˆray should have been ordered. The NP stated that he did not assess Resident #61's legs or hips and that the resident was unable to specifically tell where the pain was due to her dementia. The NP indicated that if he had examined Resident #61's hips and legs, he may have determined where the pain was and would have ordered x-rays. The NP did not recall whether he communicated with the Medical Director regarding Resident #61. He reported that any communication they had was informal and consisted mainly of occasional updates and reviewing each other's progress notes. The NP indicated that there was potential for complications when a fracture remained undiagnosed for several days while the resident continued to be moved, transferred, and assisted with ambulation. He stated that this could have allowed the fracture to worsen. A nursing progress note written by Nursing Supervisor #4 dated 7/15/25 at 4:13 PM indicated a Stop and Watch internal communication tool was received regarding Resident #61's complaint of hip pain. The nurse assigned to Resident #61 requested that the Nurse Practitioner evaluate the resident. The Nurse Practitioner evaluated Resident #61. A physician order for acetaminophen as needed was already in place in Resident #61's list of ordered medications and the Nurse Practitioner recommended to encourage the resident to ask for the medication. Nurse #13 was assigned to Resident #61 on 7/15/25 from 7:00 PM to 7:00 AM on 7/16/25. Attempted to interview Nurse #13 via phone on 4/9/26 at 1:55 PM. A voicemail was left with no return call received. A review of Resident #61's electronic health record revealed no documentation by Nurse #13 on 7/15/25 with no assessment completed. A review of Resident #61's electronic Medication Administration Record revealed that acetaminophen 650 milligrams was documented as administered by Nurse #13 on 7/16/25 at 6:06 AM for pain and was documented as effective. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/15/25 on the night shift Nurse #13 documented the resident's pain level was 0. Nurse #12 was assigned to Resident #61 on 7/16/25 from 7:00 AM to 7:00 PM. Attempted to interview Nurse #12 via phone with voicemail messages left and texts sent on 4/8/26 at 5:02 PM and 4/9/26 at 2:36 PM with no return call received. A review of the electronic MAR for Resident #61 for July 2025 indicated that acetaminophen 650 mg was administered for pain by Nurse #12 on 7/16/25 at 2:33 PM and was documented as effective. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/16/25 on the day shift Nurse #12 documented the resident's pain level was 5. An interview with Nurse #11 on 4/8/26 at 5:15 PM via phone revealed she was also assigned to Resident #61 on 7/16/25 from 7:00 PM to 7:00 AM on 7/17/25 and on 7/17/25 from 7:00 PM to 7:00 AM on 7/18/25 but did not recall the resident's condition or pain level on those dates. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/16/25 on the night shift Nurse #11 documented the resident's pain level was 0. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/17/25 on the night shift Nurse #11 documented the resident's pain level was 0. An interview was conducted via phone with Nurse #7 on 4/8/25 at 4:18 PM. Nurse #7 was assigned to Resident #61 on 7/17/25 from 7:00 AM to 11:00 AM. Nurse #7 stated that she did not recall anything about Resident #61 or her condition in July 2025. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/17/25 on the day shift Nurse #7 documented the resident's pain level was 4. A review of Resident #61's electronic MAR for July 2025 revealed that the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	resident did not receive acetaminophen on 7/17/25 or 7/18/25. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/17/25 on the night shift Nurse #5 documented the resident's pain level was 0. A review of Resident #61's electronic health record revealed there were no nursing progress notes dated 7/16/25 or 7/17/25 with documentation of an assessment of the resident's lower extremity or ability to transfer, ambulate or move.An interview conducted with NA #4 on 4/8/26 at 6:00 PM revealed that she had been assigned to Resident #61 on 7/15/25, 7/16/25 and 7/19/25 from 7:00 AM to 7:00 PM. NA #4 stated that on 7/15/25, Resident #61 experienced significant pain when she attempted to transfer the resident from the bed to the wheelchair to go to the bathroom. She reported that she informed the nurse on duty on 7/15/25 when the pain started, although she did not recall which nurse she spoke to and did not know what actions were taken. NA #4 stated that she kept Resident #61 in bed for the remainder of the shift and on the other days also due to the resident's pain with movement and provided all care in bed. She did not recall whether Resident #61's leg showed any abnormalities. NA #4 also reported that Resident #61 slept intermittently throughout the day, which was a change from the resident's usual baseline. NA #4 indicated that on 7/16/25 and 7/19/25 Resident #61 continued to demonstrate pain with movement, transfers and ambulation. An interview with NA #5 via phone on 4/9/26 at 8:26 AM revealed that she was assigned to Resident #61 on 7/16/25 from 7:00 PM to 11:00 PM and on 7/18/25 from 7:00 PM to 7:00 AM on 7/19/25. NA #5 stated that she assisted Resident #61 to the bathroom on 7/16/25 when the resident complained that her leg was hurting during the transfer. Because she was unfamiliar with Resident #61's baseline, NA #5 reported that she asked another Nurse Aide how the resident had been doing. According to the other Nurse Aides, the resident had been fine until a day or two earlier but had recently developed hip pain and required increased assistance. NA #5 did not report Resident #61's pain when transferring to the assigned nurse as she assumed the nurse was already aware. Attempted to interview NA #6 who was assigned to work with Resident #61 on 7/15/25 from 7:00 PM to 7:00 AM on 7/16/25 and on 7/16/25 from 11:00 PM to 7:00 AM on 7/17/25. Attempts made via phone on 4/9/26 at 8:05 AM and at 11:15 AM with voice mail and text sent with no return call. A nursing progress note written by Nursing Supervisor #4 dated 7/18/25 at 8:02 AM indicated that Resident #61 appeared to be in discomfort. Resident #61 verbalized hip pain but was unable to provide details due to resident's dementia. The NP was contacted and x-rays were ordered. The progress note did not reference a pain level or an assessment of Resident #61's lower extremity. An interview was conducted with Nursing Supervisor #4 via phone on 4/8/26 at 3:53 PM. Nursing Supervisor #4 stated that although she was no longer employed at the facility, she had served as a supervisor during July 2025. She reported that she became aware of Resident #61's pain after reviewing some information as part of her supervisory duties, though she could not recall the specific source of that information. After reviewing the information, she obtained an order from the Nurse Practitioner for an xˆray, but she did not remember the exact date this occurred. Nursing Supervisor #4 stated that she was not aware of any fall involving Resident #61, and she did not assess the resident even after receiving information indicating the resident was experiencing hip pain. The Nursing Supervisor was unable to state why she did not complete a comprehensive assessment of Resident #61's pain but stated that she probably should have. She reported that she received a Stop and Watch communication tool from a staff member, but she did not recall which one and explained that this tool served as an internal communication method to report changes in condition. As a Nursing Supervisor, she was responsible for following up on these reports, and a copy was also provided to the Director of Nursing for tracking purposes. The Nursing Supervisor stated that copies of the Stop and Watch communication tools were only kept for a short period of time and then they were shredded. A review of Resident #61's electronic health record revealed a physician order was entered by Nursing Supervisor #4 on 7/18/25 at 9:11 AM for x-rays of bilateral hips to rule out displacement or fracture. A nursing progress note in Resident #61's electronic health record dated 7/18/25 at 3:01 PM written by Unit Manager #1 indicated that x-rays of bilateral hips were completed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/18/25 on the day shift Unit Manager #1 documented the resident's pain level was 0. An interview was conducted with NA #7 via phone at 9:50 AM on 4/9/26. NA #7 was assigned to Resident #61 on 7/18/25 from 7:00 AM to 7:00 PM. NA #7 stated that Resident #61 was getting up in the weeks prior to 7/14/25 and was able to transfer and ambulate without difficulty. NA #7 recalled Resident #61 suddenly began experiencing difficulty transferring and ambulating and she could tell that the resident was having a lot of pain. NA #7 stated that Resident #61 was not able to express her pain level, but she demonstrated increased pain and was having trouble getting around and therefore required increased assistance. NA #7 stated that she assisted the x ray technician to obtain Resident #61's x rays and it was difficult to reposition the resident in bed due to pain. NA #7 stated that she observed Resident #61 grimacing and wincing in pain. NA #7 stated that Resident #61 demonstrated increased pain when ambulating and transferring in the days prior to her transfer to the hospital for evaluation of the left hip fracture. NA #7 indicated that she was assigned to Resident #61 on 7/18/25 but she and the other NAs worked together, and she had helped one of the other NAs with Resident #61's care on one of the prior days. NA #7 stated that Resident #61 had dementia and had trouble expressing herself. NA #7 did not recall a nurse assessing Resident #61 and she did not report the resident's increased pain with ambulation and transfers on 7/18/25 as she assumed that the nurse was aware. An interview was conducted with the Unit Manager #1 on 4/9/26 at 11:00 AM. Unit Manager #1 stated that in July 2025 she was the facility wound care nurse but was assigned to Resident #61 on 7/18/25 from 11:00 AM to 3:00 PM. Unit Manager #1 stated that Resident #61 was not scheduled for medications while she was assigned to her, so she did not go into Resident #61's room and did not assess the resident. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/18/25 on the night shift Nurse #11 documented the resident's pain level was 0. A review of an x-ray report of the left hip dated 7/18/25 at 11:31 PM indicated Resident #61 had an acute left femoral neck fracture with displacement. A nursing progress note dated 7/19/25 at 11:52 AM written by Nurse #5 stated that results of the x-ray completed on 7/18/25 indicated an acute left femoral neck fracture with displacement. The note did not contain an assessment of the resident. A nursing progress note dated 7/19/25 at 12:45 PM written by Nurse #5 stated that Resident #61 was transferred to the emergency department for evaluation. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/19/25 on the day shift Nurse #5 documented the resident's pain level was 0. An interview was conducted with Nurse #5 on 4/9/26 at 9:58 AM. Nurse #5 was assigned to care for Resident #61 on 7/17/25 and 7/19/25 during the 11:00 AM to 11:00 PM shifts. During the interview, Nurse #5 stated that he did not recall Resident #61's condition in July 2025 and could not remember whether he assessed the resident for pain or range of motion.A follow up interview with Nurse #5 on 4/9/26 at 4:15 PM revealed that he was assigned to Resident #61 on 7/19/25 from 11:00 AM to 11:00 PM. Nurse #5 stated when he came on for his shift, he found the x-ray results for Resident #61 dated 7/18/25 on the fax machine. Upon noting that the x -ray report indicated a fracture, he reported the results to the on-call provider and received an order to send Resident #61 to the hospital for evaluation. A review of the hospital history and physical report dated 7/19/25 indicated that Resident #61 was sent to the emergency department for evaluation of a femoral neck fracture. The report indicated that Resident #61 endorsed hip pain on arrival to the emergency department and orders were written on presentation for hydromorphone (a potent narcotic medication use to treat moderate to severe pain) 0.2 milligrams intravenous every 3 hours as needed and cyclobenzaprine (a muscle relaxant) 5 milligrams every 8 hours as needed for pain. A review of the hospital medication administration record revealed that Resident #61 received acetaminophen 650 milligrams every 6 hours as needed for pain on 7/19/25 at 8:28 PM. Resident #61 received hydromorphone 0.2 milligrams intravenous on 7/20/25 at 9:37 AM. A review of the hospital Discharge summary dated [DATE] indicated that Resident #61 underwent a left hip hemiarthroplasty on 7/20/25 without complications and was stable to return to (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Nurse Practitioner (NP) and Physician, the facility failed to ensure pain management was provided to Resident #61, who had severe cognitive impairment and was unable to verbalize the need for pain medication, following an unwitnessed fall on 7/14/25 that resulted in changes in the level of transfer assistance she needed for toileting and moving from chair to bed. Communication from the nursing staff to the Nurse Practitioner on 7/15/25 failed to include Resident #61 had an unwitnessed fall. The NP did not assess the lower extremities for pain and concluded that the source of the hip pain was nerve pain. The NP's plan was for staff to administer acetaminophen 650 milligrams for pain as previously ordered and educate the severely cognitively impaired resident to request pain medication. Resident #61 continued to have pain after the NP visit. Resident #61 was transferred to the emergency department on 7/19/25 for evaluation of a left femoral neck fracture. Resident #61 was prescribed hydromorphone (a potent narcotic medication used to treat moderate to severe pain) intravenous and cyclobenzaprine (a muscle relaxant) for pain. Resident #61 underwent a left hip hemiarthroplasty (a procedure in which the fractured ball or head of the hip is replaced) on 7/20/25 and returned to the facility. This deficiency affected 1 of 1 resident reviewed for pain management (Resident #61). Findings included: Resident #61 was admitted on [DATE] with diagnoses which included a history of a right femur fracture, osteoporosis, and dementia. Resident #61's physician orders revealed an order dated 2/2/25 for acetaminophen 650 milligrams (mg) every 6 hours as needed for pain unspecified site. Resident #61's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had a severe cognitive impairment, was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #61 did not have pain assessed and had one fall with no injury. Resident #61 required limited assistance with transfers, bed mobility and toileting and used a wheelchair for mobility. Resident #61 was usually able to make herself understood and understand others. During the assessment lookback period, Resident #61 occasionally had pain and pain rarely or never interfered with activities.A review of Resident #61's electronic Medication Administration Record revealed that on 7/14/25 on the day shift (7:00 AM to 7:00 PM) Nurse #5 documented the resident's pain level was 0 on a 10-point scale with 0 being no pain and 10 being the worst pain ever. Resident #61's electronic health record revealed that there was no nursing progress note documented on 7/14/25. There was no documentation that indicated Resident #61 experienced an unwitnessed fall, reported pain, or received an assessment of the left lower extremity or of the resident's ability to transfer, ambulate, or move.An interview was conducted with Nurse #5 on 4/9/26 at 9:58 AM. Nurse #5 was assigned to care for Resident #61 on 7/14/25, 7/17/25, and 7/19/25 during the 11:00 AM to 11:00 PM shifts. During the interview, Nurse #5 stated that he did not assess Resident #61 for pain or range of motion. He further reported that he did not recall Resident #61 reporting an unwitnessed fall on 7/14/25 or reporting pain on that date but he indicated that if Resident #61 fell, she could have gotten herself up without assistance. Nurse #5 indicated that Resident #61 was cognitively impaired and had an impaired ability to request pain medication.An interview was conducted with NA #10 on 4/9/26 at 2:00 PM. NA #10 was assigned to Resident #61 on 7/14/25 from 7:00 PM to 7:00 AM on 7/15/25. NA #10 did not recall if Resident #61 had any changes in condition, changes to her left leg or complaint of pain. NA #10 stated that if Resident #61 had pain during care she reported it to the nurse on duty. A nursing progress note dated 7/15/25 at 5:57 AM written by Nurse #11 revealed that Resident #61 stated she was having a lot of pain in her hip and a note was placed in the doctor's book (a facility internal communication logbook for non-urgent communication). The progress note did not indicate that a pain assessment or head to toe assessment was completed. A review of Resident #61's Medication Administration Record (MAR) revealed Nurse #11 did not document administration of pain medication from 7/14/25 at 7:00 PM through 7:00 AM on 7/15/25. A review of the pain monitoring documentation on Resident #61's July (continued on next page)

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	345575	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Health & Rehab Center	9600 No 5 School Road Ash, NC 28420

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2025 electronic MAR revealed that on 7/14/25 on the night shift (7:00 PM to 7:00 AM) Nurse #5 documented the resident's pain level was 0. An interview with Nurse #11 on 4/8/26 at 5:15 PM via phone revealed that she was assigned to Resident #61 on 7/14/25 from 7:00 PM to 7:00 AM on 7/15/25. Nurse #11 stated that when she received report from the off˜going nurse on 7/14/25, she was not informed that Resident #61 had experienced a fall. She reported that during the night, the resident was having significant pain and was screaming and crying, which was not typical for her. Nurse #11 stated that she asked the Nurse Aide (NA) assigned to Resident #61 whether the resident had any changes and was informed that the resident was unable to ambulate, which was a change from her baseline. She reported that she documented the change in condition in the facility's internal communication log (doctor's book) for the provider. Nurse #11 stated that she believed she had administered something for pain but could not recall specifically, adding that if it was not documented, she must not have given it. She was informed that the electronic Medication Administration Record did not contain documentation of an as needed dose of acetaminophen administered by her on 7/15/25. Nurse #11 stated that Resident #61 demonstrated pain by screaming, crying and grimacing but was unable to request pain medication. She stated that on the morning of 7/15/25, she reported the resident's increased pain to another nurse, though she did not recall which one. Nurse #11 stated that Resident #61 was unable to rate her pain or request pain medication. Nurse #11 was unable to state why she recorded Resident #61's pain as a 0 on a scale of 0 to 10 when the resident had demonstrated pain during her shift. An interview conducted with NA #4 on 4/8/26 at 6:00 PM revealed that she had been assigned to Resident #61 on 7/15/25, 7/16/25 and 7/19/25 from 7:00 AM to 7:00 PM. NA #4 stated that on 7/15/25, Resident #61 experienced significant pain and was yelling out when she attempted to transfer the resident from the bed to the wheelchair to go to the bathroom. NA #4 stated that she was familiar with Resident #61, and the resident did not usually demonstrate pain with transfers or moving. NA #4 stated that she informed the nurse on duty, although she did not recall which nurse she spoke to and did not know what actions were taken. NA #4 stated that she kept Resident #61 in bed for the remainder of the shift on 7/15/25 due to the resident's pain with movement and provided all care to the resident in bed on the subsequent days. NA #4 stated that Resident #61 was unable to rate her pain on a scale of 0 to 10 and was unable to request pain medication.A nursing progress note written by Nurse #12 dated 7/15/25 at 11:30 AM indicated that the note was a late entry that was recorded on 7/19/25 at 12:30 PM. The note indicated that Nurse #12 was assigned to Resident #61 on 7/15/25 when the resident reported that she had pain in her hips and knees. The note indicated that Resident #61 stated that she fell yesterday (7/14/25), was able to pull herself up and did not tell anyone. The note stated that Nurse #12 spoke to the Nurse Practitioner regarding Resident #61's pain and that the resident was screaming in pain when she was moved. The progress note stated that the NP informed Nurse #12 that Resident #61 complained of pain all the time. Nurse #12 informed the NP that the pain Resident #61 was demonstrating was not her normal behavior. The NP instructed staff to administer the previously ordered acetaminophen as needed and stated that he would evaluate the resident the following day. The progress note did not document a pain level or an assessment of Resident #61's lower extremities, nor did it indicate that the unwitnessed fall reported by Resident #61 had been communicated to the NP. A review of Resident #61's electronic Medication Administration Record revealed that acetaminophen 650 milligrams as needed was administered by Nurse #12 on 7/15/25 at 11:50 AM for pain and was documented as slightly effective. The MAR did not have numerical pain monitoring documented with the administration of the as needed medication for pain. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/15/25 on the day shift (7:00 AM to 7:00 PM) Nurse #12 documented the resident's pain level was 0. The surveyor attempted to interview Nurse #12 via phone, leaving voicemail messages and sending text messages on 4/8/26 at 5:02 PM and 4/9/26 at 2:36 PM, but no return call was received. Nurse #12 was assigned to Resident #61 on 7/15/25 from 7:00 AM to 7:00 PM and on 7/16/25 from 7:00 AM to (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	7:00 PM. A progress note written by the Nurse Practitioner (NP) dated 7/15/25 at 12:38 PM indicated that Resident #61's chief complaint was hip pain and indicated that the nursing staff reported the resident was having pain. The note stated that Resident #61 was oriented to person only, had forgetfulness with diagnosis of dementia and received medication for dementia. Resident #61 had anxiety and received the antianxiety medication lorazepam scheduled every 8 hours. The NP educated Resident #61 to request pain medication as needed. The note indicated that Resident #61 appeared sleepy and groggy, and that her pain was nonˆspecific. The assessment did not include documentation of an assessment of Resident #61's lower extremities. The assessment and plan indicated Resident #61 had nerve and hip pain with staff directed to administer acetaminophen as needed. The progress note indicated that the NP educated Resident #61 to ask for pain medication. An interview was conducted with the former Nurse Practitioner (NP) on 4/9/26 at 10:15 AM via phone. The NP stated that although he was no longer employed at the facility, he had been assigned to Resident #61 during July 2025. He explained that Resident #61 experienced intermittent pain, which he believed to be her baseline, and he assumed it was just her complaining when he was informed that she was having pain on 7/15/25. The NP reported that he was unaware the resident had experienced a fall when he was asked to evaluate her on 7/15/25. He stated that had he known Resident #61 had fallen and was reporting pain, he would have ordered xˆrays immediately. The NP acknowledged that he did not speak with staff on 7/15/25 to inquire about the resident's pain or any changes in her condition including pain with movement and ambulation. He stated that if a resident exhibited new onset of severe pain, with or without a fall, an xˆray should have been ordered. The NP indicated that there was potential for complications when a fracture remained undiagnosed for several days while the resident continued to be moved, transferred, and assisted with ambulation. He stated that this could have caused the fracture to worsen with further displacement and that would result in increased pain. The NP stated that Resident #61 was not specific regarding her pain and was unable to rate her pain on a scale of 0 to 10. The NP stated that he did not know if the resident was able to request pain medication but stated that he instructed the staff to encourage the resident to ask for pain medication. A nursing progress note written by Nursing Supervisor #4 dated 7/15/25 at 4:13 PM indicated a Stop and Watch internal communication tool was received (it did not state who had provided the communication tool) regarding Resident #61's complaint of hip pain. The nurse assigned to Resident #61 (Nurse #12) requested that the Nurse Practitioner evaluate the resident. The Nurse Practitioner evaluated Resident #61. A physician order for acetaminophen as needed was already in place in Resident #61's list of ordered medications and the Nurse Practitioner recommended to encourage the resident to ask for the medication. An interview was conducted with Nursing Supervisor #4 via phone on 4/8/26 at 3:53 PM. Nursing Supervisor #4 stated that although she was no longer employed at the facility, she had served as a supervisor during July 2025. She reported that she became aware of Resident #61's pain after reviewing some information as part of her supervisory duties, though she could not recall the specific source of that information. Nurse Supervisor #4 stated that she did not assess Resident #61 even after receiving information indicating the resident was experiencing hip pain. Nursing Supervisor #4 was unable to state why she didn't assess Resident #61 and indicated that she probably should have. Nursing Supervisor #4 stated that she did not know if the assigned nurse assessed Resident #61 for the source of her pain, the intensity or any changes in mobility or range of motion. Nursing Supervisor #4 stated that it was the nurse assigned to Resident #61 that was responsible for administering pain medication and assessing the resident. Nursing Supervisor #4 stated that Resident #61 was unable to rate her pain on a scale of 0 to 10 and was not able to request pain medicationA review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/15/25 on the night shift (7:00 PM to 7:00 AM) Nurse #13 documented the resident's pain level was 0. Resident #61's electronic Medication Administration Record (MAR) for 7/16/25 revealed that acetaminophen 650 milligrams was administered by Nurse #13 for pain at 6:06 AM and was documented as effective. The MAR did not (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	have numerical pain monitoring documented with the administration of the as needed medication for pain. Nurse #13 was assigned to Resident #61 on 7/15/25 from 7:00 PM to 7:00 AM on 7/16/25. The surveyor attempted to interview Nurse #13 via phone on 4/9/26 at 1:55 PM with a voicemail left with no return call received. An interview with NA #5 via phone on 4/9/26 at 8:26 AM revealed that she was assigned to Resident #61 on 7/16/25 from 7:00 PM to 11:00 PM and on 7/18/25 from 7:00 PM to 7:00 AM on 7/19/25. NA #5 stated that she assisted Resident #61 to the bathroom on 7/16/25 when the resident complained that her leg was hurting during the transfer. Because she was unfamiliar with Resident #61's baseline, NA #5 reported that she asked another NA, she did not recall which NA, how the resident had been doing. According to the other NA, the resident had been fine until a day or two earlier but had recently developed hip pain and required increased assistance. NA #5 stated that she did not report Resident #61's pain in her leg during the transfer as she assumed that the nurse was already aware since the other NA stated the resident was having pain for a day or two. NA #5 stated that she did not request that the nurse assess the resident to determine if the resident required pain medication and that the resident seemed a little better after she repositioned her. NA #5 stated that Resident #61 was unable to rate her pain or request pain medication.An interview conducted with NA #4 on 4/8/26 at 6:00 PM revealed that she had been assigned to Resident #61 on 7/15/25, 7/16/25 and 7/19/25 from 7:00 AM to 7:00 PM. NA #4 indicated that on 7/16/25 and 7/19/25 Resident #61 continued to demonstrate pain with movement, transfers and ambulation but she did not report this to the nurse assigned to the resident as she assumed the nurse was already aware.Resident #61's electronic health record revealed there were no nursing progress notes dated 7/16/25 or 7/17/25 with no documentation of an assessment of the resident's pain.Resident #61's electronic Medication Administration Record (MAR) for 7/16/25 revealed that acetaminophen was administered by Nurse #12 at 2:33 PM for pain and was documented as effective. Resident #61's electronic MAR indicated a pain level of 5 was documented by Nurse #12 for day shift on 7/16/25. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/16/25 on the night shift Nurse #11 documented the resident's pain level was 0 and no acetaminophen was administered.Resident #61's electronic MAR indicated a pain level of 4 was documented by Nurse #7 for the day shift on 7/17/25 and as needed acetaminophen was not administered.An interview with Nurse #7 on 4/8/26 at 4:18 PM via phone revealed that she was assigned to Resident #61 on 7/17/25 from 7:00 AM to 11:00 AM. Nurse #7 stated that she worked at the facility infrequently on an as needed basis and she did not recall Resident #61's condition, pain level, ability to express her pain level or request pain medication in July 2025. A review of the pain monitoring documentation on Resident #61's July 2025 electronic MAR revealed that on 7/17/25 on the night shift Nurse #11 documented the resident's pain level was 0 and no acetaminophen was administered.An interview with Nurse #11 on 4/8/26 at 5:15 PM via phone revealed that she was assigned to Resident #61 on 7/16/25 from 7:00 PM to 7:00 AM on 7/17/25 and 7/17/25 from 7:00 PM to 7:00 AM on 7/18/25 but did not recall the resident's condition or pain level on those dates.An interview was conducted with NA #7 via phone at 9:50 AM on 4/9/26. NA #7 was assigned to Resident #61 on 7/18/25 from 7:00 AM to 7:00 PM but had also assisted other NAs with the resident's care and was familiar with the resident. NA #7 stated that Resident #61 was getting up, ambulating and transferring without difficulty in the weeks prior to 7/14/25. NA #7 recalled Resident #61 suddenly began having trouble transferring and ambulating and she could tell that the resident was having a lot of pain. NA #7 stated that Resident #61 was unable to express her pain level on a 0 to 10 pain scale due to dementia, but she demonstrated increased pain by wincing, grimacing and holding her hip. NA #7 stated that Resident #61 was unable to request pain medication. NA #7 stated that she assisted the X-ray technician on 7/18/25 to obtain Resident #61's x- rays and it was difficult to reposition the resident in bed due to pain. NA #7 did not recall a nurse assessing Resident #61 and she did not report the resident's increased pain with ambulation, transfers, and repositioning as she assumed that the nurse was aware. A nursing progress note written by Nursing Supervisor #4 dated 7/18/25 at 8:02 AM (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	indicated that Resident #61 appeared to be in discomfort. The note indicated that Resident #61 verbalized hip pain but was unable to provide details due to resident's dementia. Mobile x-rays were ordered. The progress note did not reference a pain level or an assessment of Resident #61's left lower extremity. An interview was conducted with the Unit Manager #1 on 4/9/26 at 11:00 AM. Unit Manager #1 stated that in July 2025 she was the facility wound care nurse but was assigned to Resident #61 on 7/18/25 from 11:00 AM to 3:00 PM. Unit Manager #1 stated that Resident #61 was not scheduled for any medication during the time she was assigned to her, so she did not go into Resident #61's room and did not assess the resident. Unit Manager #1 stated that she did not recall if she was informed of Resident #61 having pain or any changes in mobility. Unit Manager #1 stated that she had not assessed Resident #61's pain but she did not think that Resident #61 was able to rate her pain on a 0 to 10 scale or request pain medication due to her dementia with impaired cognition. Resident #61's x-ray report of the mobile X-ray of the left hip dated 7/18/25 at 11:31 PM indicated an acute left femoral neck fracture with displacement. Resident #61's electronic MAR indicated that acetaminophen was administered by Nurse #5 on 7/19/25 at 10:36 AM and was documented as effective. The MAR did not have numerical pain monitoring documented with the administration of the as needed medication for pain. A nursing progress note in Resident #61's electronic health record dated 7/19/25 at 11:52 AM written by Nurse #5 stated that results of the x-ray completed on 7/18/25 indicated an acute left femoral neck fracture with displacement. A nursing progress note dated 7/19/25 at 12:45 PM written by Nurse #5 stated that Resident #61 was transferred to the emergency department for evaluation. A follow up interview with Nurse #5 on 4/9/26 at 4:15 PM revealed that he was assigned to Resident #61 on 7/19/25 from 11:00 AM to 11:00 PM. Nurse #5 stated that he came in early for his 11:00 AM to 11:00 PM shift on 7/19/25 and when he came on for his shift, he found the x-ray results for Resident #61 dated 7/18/25 on the fax machine. Nurse #5 did not recall if Resident #61 was able to indicate a pain level or request pain medication or if he administered the acetaminophen on 7/19/25 after seeing the x-ray result that indicated a fracture. Upon noting that the x-ray report indicated a fracture, he reported the results to the on-call provider and received an order to send Resident #61 to the hospital for evaluation. The hospital history and physical report dated 7/19/25 indicated that Resident #61 was sent to the emergency department for evaluation of a left femoral neck fracture. The report indicated that Resident #61 stated upon arrival to the emergency department that she had hip pain and orders were written on presentation for hydromorphone (a potent narcotic medication use to treat moderate to severe pain) 0.2 milligrams intravenous every 3 hours as needed and cyclobenzaprine (a muscle relaxant) 5 milligrams every 8 hours as needed for pain. The hospital medication administration record revealed that Resident #61 received acetaminophen 650 milligrams every 6 hours as needed for pain on 7/19/25 at 8:28 PM. Resident #61 received hydromorphone 0.2 milligrams intravenous on 7/20/25 at 9:37 AM. The hospital Discharge summary dated [DATE] indicated that Resident #61 underwent a left hip hemiarthroplasty on 7/20/25 without complications and was stable to return to the facility. An interview with the Director of Nursing (DON) on 4/9/26 at 1:25 PM revealed that she expected residents with pain would be thoroughly assessed regardless of the residents' cognitive status. The DON further stated that her expectation was for the nursing staff to monitor residents for pain, assess the resident, and report increased pain or any changes in condition to the physician for further evaluation. The DON stated that Resident #61 was unable to rate her pain on a scale of 0 to 10 and was unable to request pain medication but that the resident should have been assessed for pain using non-verbal indicators and provided with pain medication as needed.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and resident and staff interviews, the facility failed to determine whether self-administration of medications was clinically appropriate for 1 of 1 resident reviewed for self-administration of medications (Resident #7).Findings included: Resident #7 was admitted [DATE] with the diagnosis of renal dialysis, end stage renal disease, gastrointestinal hemorrhage and anemia. A review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact and had no behaviors. Review of Resident #7 ' s current care plan revealed that the resident was not care planned for self-administration of his medications. A review of Resident #7 ' s electronic medical record revealed no assessments were completed for the self-administration of his medications. A review of Resident #7's current physician's orders revealed no order for naproxen sodium (nonsteroidal anti-inflammatory drug) as needed for a headache and no order for lidocaine-prilocaine cream (prescription only topical anesthetic) to be applied to the fistula site prior to dialysis. The physician orders did not include an order for the resident to self-administer any of his medications.An observation was conducted on 4/7/26 at 9:10 AM as Resident #7 was sitting on the side of his bed in his room. An observation and interview conducted on 4/7/26 at 9:10 AM revealed an opened bottle of naproxen sodium 500 milligrams and 4 opened tubes of lidocaine-prilocaine cream on his overbed tray table. An interview was conducted on 4/7/26 at 9:15 AM with Medication Aide #1. At that time, Medication Aide #1 was outside of the Resident #7's room standing at the medication cart (not within view of the resident). Medication Aide #1 was assigned to Resident #7 on 4/7/26 from 7:00 AM to 11:00 AM. Medication Aide #1 stated that she was unaware that Resident #7 had medications in his room including the tubes of lidocaine cream and a bottle of naproxen observed on the overbed tray table. An interview conducted on 4/7/26 at 9:20 AM with Resident #7 revealed that he had naproxen in his room in case he had a headache and that he took the medication on occasion. Resident #7 indicated that he applied the lidocaine cream to his fistula prior to dialysis. Resident #7 stated that the medications were obtained from an outside pharmacy and his responsible party brought them into the facility. An interview was conducted with the Physician on 4/8/26 at 12:40 PM. The Physician explained that naproxen is a nonˆsteroidal antiˆinflammatory drug (NSAID) that Resident #7 should not selfˆadminister and that unsupervised use could lead to complications. The Physician indicated that the prescription lidocaine cream was an anesthetic and that unsupervised use of the lidocaine cream could cause complications. The Physician further stated that residents were to be assessed for the ability to safely self-administer medications. An interview with Unit Manager #1 on 4/8/26 at 12:00 PM confirmed that medications should not be kept at the bedside, as there were confused residents on the unit who sometimes entered other residents' rooms. Unit Manager #1 explained that residents must be assessed for their ability to self-administer medications, the medications must be secured, a physician's order must be obtained, and the care plan must be updated accordingly. Unit Manager #1 stated that she was unaware that Resident #7 was self-administering naproxen and lidocaine cream and that the medications were kept unsecured in his room.An interview was conducted on 4/9/26 at 4:43 PM with the Director of Nursing (DON). During the interview, concerns identified regarding a resident's self-administration of medications and the safe and secure storage of the medications were discussed. The DON stated that she was not aware that Resident #7 had medications in his room that he was self-administering. The DON stated that for a resident to self-administer medications, the resident had to be assessed for safety and if determined to be appropriate, a physician order was required specifying which medications were to be self-administered, the medications were to be stored properly, and the care plan was to be updated to reflect this.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with staff, residents, and Nurse Practitioner, the facility failed to transfer Resident #72 with a slide board according to the care plan, placing the resident at risk for avoidable injury. On 5/25/25, Nurse Aide #9 transferred Resident #72 from the wheelchair to the bed without using the slide board. This deficient practice was identified for 1 of 2 residents reviewed for accidents (Resident #72). Findings included. Resident #72 was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (CVA), hemiplegia (total loss of motor function on one side of the body), hemiparesis (weakness on one side), and expressive aphasia (loss of the ability to produce spoken or written language). A care plan dated 4/29/25 revealed Resident #72 was at risk of falls and had an activities of daily living (ADL) functional deficit due to limited ability to transfer herself related to a recent CVA with right side hemiplegia. Interventions included to use the slide board for transfers from the wheelchair to bed. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #72 had moderately impaired cognition. She required substantial assistance to transfer to and from a bed to a wheelchair. She had no falls. A progress note dated 5/25/25 at 1:45 PM documented by Nurse #44 revealed Resident #72's roommate (Resident #12) approached this writer at the start of shift with concerns about Resident #72's current mood. Resident #72 stated that she was upset and crying over ADL care she had received overnight. This writer spoke with Resident #72, and she stated that she was upset because she felt that the Nurse Aide (#9) who worked with her did not properly transfer her into bed. Resident #72 stated that the Nurse Aide (Nurse Aide #9) had used her pants pulling her up out of her chair to put her into bed. During the transfer Nurse Aide #9 ripped her pants. Resident #72 was immediately assessed for any pain or injury with no complaints. Following the determination that Resident #72 was unharmed and feeling safe, the Director of Nursing was notified and an investigation was conducted. A progress note dated 5/26/25 documented by the Nurse Practitioner revealed Resident #72 was evaluated. Resident #72 stated the Nurse Aide (#9) was rough with her, but she was not injured. The exam revealed no physical injuries. The facility's 5 day investigation report dated 5/29/25 revealed on Sunday, 5/25/25 around 7:30 AM during shift change Resident #72's roommate (Resident #12) approached the nurses' station and reported to the oncoming Nurse Supervisor (Nurse #44) that Nurse Aide (Nurse Aide #9) transferred Resident #72 inappropriately and Resident #72 was upset about it. Resident #72's roommate (Resident #12) stated she offered the Nurse Aide (Nurse Aide #9) to use her gait belt, but the Nurse Aide (#9) stated she transferred Resident #72 the best she could since they were short staffed. The Nurse Supervisor (Nurse #44) interviewed Resident #72, and she was able to communicate that the Nurse Aide (Nurse Aide #9) did not transfer her correctly the night before. Nurse Aide #9 transferred Resident #72 from her wheelchair to the bed using the back of her pants causing the pants to be ripped. Resident #72 required two person assistance with a sliding board for transfers. Nurse Aide #9 was suspended pending the investigation and the police were notified. The Social Worker visited Resident #72 on 5/27/25 and reported she was in good spirits. It was determined that the Nurse Aide (Nurse Aide #9) did not follow Resident #72's correct transfer method causing unwanted stress to her and damage to her clothing. A written statement provided by Nurse Aide #9 dated 5/25/25 revealed in part; On 5/24/25 round 8:00 PM she went in Resident #72's room to assist her back to bed. Nurse Aide #9 informed Resident #72 that she had to place the sliding board under her and Resident #72 agreed. Once the sliding board was under Resident #72 the Nurse Aide locked the wheels and instructed Resident #72 to grab the bed rail. While Resident #72 was pulling the rail the Nurse Aide told Resident #72 she would be behind her holding the back of her pants to assist her to slide down the board. Resident #72 agreed. After the transfer was over Resident #72's roommate (Resident #12) asked if she would like to use her gait belt. Nurse Aide #9 replied no thanks she had (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Health & Rehab Center	9600 No 5 School Road Ash, NC 28420

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	already completed the transfer. After the transfer Resident #72 stated her arm was in pain and she was holding her arm. The Nurse Aide asked Resident #72 if it had occurred during the transfer and Resident #72 stated no. Nurse Aide #9 asked Resident #72 if she needed to notify the nurse to assess her arm or give her pain medication and Resident #72 stated no. Around 7:07 AM Nurse Aide #9 overheard Resident #72's roommate (Resident #12) talking with the oncoming Nurse Supervisor (Nurse #44) about how she transferred Resident #72. Nurse Aide #9 then went up and asked Resident #72's roommate (Resident #12) if everything was okay. The roommate explained that she did not agree with how she transferred Resident #72 and she should have had help. Resident #72's roommate claimed she was rough with her. Nurse Aide #9 agreed with her and told her she did the best she could but could have done better with help. Nurse Aide #9 explained that she was not rough; she was as gentle as she could be due to Resident #72 being very heavy. Nurse Aide #9 then proceeded down the hall to apologize to Resident #72 if she had hurt her during the transfer. Resident #72 told her she did not hurt her, and Nurse Aide #9 apologized to Resident #72. She clocked out at 7:15 AM on 5/25/25. During a phone interview on 4/9/26 at 12:00 PM Nurse Aide #9 stated she had already given her written statement and hung up the call. A written statement provided by the oncoming Nurse Supervisor (Nurse #44) revealed in part: On 5/25/25 she arrived for her shift at 6:45 AM. When she arrived on the unit Resident #72's roommate (Resident #12) informed Nurse #44 that she was concerned about the way Nurse Aide #9 had taken care of her roommate throughout the night. The roommate (Resident #12) stated that Nurse Aide #9 needed assistance and should have used the gait belt and told the Nurse Aide she had a gait belt she could use. Nurse Aide #9 approached the conversation and interrupted the conversation argumentatively stating that she didn't do anything wrong. Nurse Aide #9 stated that she took care of Resident #72 the best she could and worked alone because they were short staffed. Nurse #44 ended the conversation and told Resident #72's roommate (Resident #12) and Nurse Aide #9 that she would speak to them separately. Approximately 5 minutes later Nurse #44 walked toward Resident #72's room and witnessed Nurse Aide #9 walking out of Resident #72's room. Nurse #44 stopped Nurse Aide #9 and told her she needed to speak with her after she spoke with Resident #72. Upon entering Resident #72's room both Resident #72 and her roommate (Resident #12) appeared to be upset. Resident #72's roommate (Resident #12) stated that Nurse Aide #9 had returned to the room and told her that if she had a problem with her that she needed to come to her and not go to anyone else. Nurse #44 ensured that both residents were safe and assessed both residents for injury. She told the residents that Nurse Aide #9 would not be coming back into their room. Resident #72 stated that she was put into bed by Nurse Aide #9 during the night and she did not do it properly. Resident #72 stated that she needed to use a slide board and two people to help her. Resident #72 stated that Nurse Aide #9 lifted her from the chair by her pants ripping them. She stated that she made her upset and that she had cried. Resident #72 then stated that she was okay and felt safe. Nurse #44 then spoke with Nurse Aide #9 about the incident and informed her that she would not be working with the residents again. Nurse Aide #9 then left the unit for the end of her shift. Nurse #44 spoke with a second Nurse Aide (Nurse Aide #11) who worked that night (11:00 PM through 7:00 AM) and Nurse Aide #11 stated Nurse Aide #9 did not ask her for assistance during the night. Attempts were made to contact Nurse #44 on 4/9/26. There was no response. The Director of Nursing stated Nurse #44 no longer worked at the facility. During an observation and interview on 4/8/26 at 2:00 PM Resident #72 was observed lying in bed. Resident #72 had difficulty speaking due to her diagnosis of expressive aphasia. She was in no distress. Resident #72 stated the Nurse Aide (Nurse Aide #9) pulled her up out of the wheelchair by her pants and ripped her pants and they had to throw the pants away. Resident #72 stated it upset her, and she indicated she didn't feel safe during the transfer because she could not use her right arm or right leg. The most recent Minimum Data Set (MDS) quarterly assessment dated [DATE] for Resident #72's roommate (Resident #12) revealed she was cognitively intact. During an interview on 4/8/26 at 2:10 PM Resident #72's roommate (Resident #12) who was alert and oriented to person, place, and time (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she witnessed the transfer and the Nurse Aide (Nurse Aide #9) hoisted Resident #72 up out of the wheelchair by her pants and put her in bed. Her pants were ripped and the Nurse Aide (Nurse Aide #9) transferred her without any assistance and did not have a second person to help her. During an interview on 4/9/26 at 11:20 AM the Assistant Director of Nursing (ADON) stated she worked 7:00 PM until 11:00 PM on 5/24/25 and came in for medication pass only. The ADON stated Resident #72, or her roommate (Resident #12) did not report anything to her regarding this incident. The ADON stated Nurse Aide #9 did not ask her for help to transfer Resident #72 during that time. During a phone interview on 4/9/26 at 12:46 PM the Nurse Practitioner stated he evaluated Resident #72 the day after the incident and Resident #72 was upset about the incident. He stated Resident #72 required assistance with transfers due to immobility, and she was non-ambulatory, increased weight, hemiplegia, and she was not progressing with therapy. He stated Resident #72 had no physical injuries from the incident. During an interview on 4/9/26 at 3:00 PM the Director of Nursing (DON) stated the unsafe transfer incident was reported to her on 5/25/25 and Nurse Aide #9 was suspended pending an investigation. The DON stated Nurse Aide #9 should have used a slide board and two person assistance when transferring Resident #72 from her wheelchair to the bed. The DON stated through staff interviews, Resident #72 and her roommate (Resident #12) interviews, and after a conversation with Nurse Aide #9 she determined that Nurse Aide #9 did not use the slide board, gait belt, or two person assistance with the transfer on the night of 5/24/25. They terminated Nurse Aide #9. The DON stated on 5/25/25 that she and the Administrator made the decision to implement a plan of correction and monitor the plan and the audits in the Quality Assurance Performance Improvement Committee. The facility provided the following corrective action plan with a compliance date of 5/27/25 which included the following: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/25/25 the roommate for Resident #72 reported that a nursing assistant (Nurse Aide #9) was pulling on Resident #72 and did not use the slide board to perform her transfer. The weekend supervisor (Nurse #44) assessed the resident (Resident #72) and noted she was tearful but without physical harm. The resident (Resident #72) reported she felt safe at this time after talking with the Supervisor. Resident #72 was assessed by the Nurse Practitioner on 5/26/25 and reported she was uninjured but was upset about the incident. Nursing Aide #9 was sent home on 5/25/25 and terminated on 5/27/25. Nursing Aide (#9) reported that she did the best she could do due to staffing issues. An initial investigation report was sent to DHHS on 5/25/25, the police and APS were notified by the Director of Nursing. It was determined by the Interdisciplinary team that the root cause was Nurse Aide #9 made a poor choice and chose to transfer the Resident (Resident #72) alone instead of seeking additional assistance. Staffing sheets were reviewed by the Director of Nursing on 5/26/25 to ensure all scheduled staff on the night of 5/24/25 were present and that there was enough staff to perform care. No staffing issues were identified. On 5/25/25 the Director of Nursing and the Administrator made the decision to implement a plan of correction and monitor the plan and the audits in the Quality Assurance Performance Improvement Committee. On 5/26/25 an ADHOC Quality Assurance meeting was held. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/25/25 the Director of Nursing performed skin observations on cognitively impaired residents on the Rehabilitation Unit where Nurse Aide #9 was assigned to ensure there were no injuries of unknown origin or signs that a resident had been transferred incorrectly. All cognitively impaired residents in the facility were assessed by the DON and the Unit Managers to ensure they were transferred appropriately by conducting observations of resident transfers on various shifts and reviewing the resident's profile to ensure the transfer status was correct. All alert and oriented residents were interviewed by the DON and Unit Managers regarding safe transfers. There were no concerns identified. On 5/25/25 the Director of Nursing and the administrative nursing team interviewed cognitively intact residents residing on the Rehabilitation Unit to ensure they felt safe in the facility. No issues were identified. 3. Address what measures will be put into place or systemic (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes made to ensure that the deficient practice will not recur. On 5/25/25 the Director of Nursing educated all staff on how to review the resident profile to determine the transfer status, ensuring gait belts and slide boards were used when appropriate, customer service expectations, and the Abuse policy was reviewed. Any staff member that was unable to be educated was educated by the Director of Nursing prior to their next scheduled shift. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Director of Nursing or designee will observe transfers 3 times a week for 4 weeks on all halls on various shifts to ensure residents are being transferred according to their plan of care. In addition, the Director of Nursing will assess 3 cognitively impaired residents weekly for 4 weeks to ensure there are no signs of mistreatment or psychosocial distress and interview 3 cognitively intact residents weekly for 4 weeks to ensure the residents feel safe in the facility. The audits will be reviewed by the QA committee at the end of the monitoring period to ensure the plan is effective. The QAPI committee will determine the need for further intervention and auditing beyond 4 weeks to assure compliance is sustained. The facility alleged compliance of the corrective action plan on 5/27/25. Validation of the corrective action plan was completed on 4/9/26. This included staff interviews regarding the incident and in-service training that was received to ensure understanding and knowledge of the training provided. Inservice training records were verified and included staff signatures. The initial audits including the weekly audits were reviewed to verify all residents on all halls across various shifts were included. Staff providing a safe transfer of a resident was observed during the validation. There were no concerns identified. The plan of correction with a completion date of 5/27/25 was validated.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and resident, staff and Registered Dietitian (RD) interviews, the facility failed to maintain the ordered fluid restrictions, renal diet restrictions and provide double portions of protein per the physician order for 1 of 1 sampled resident receiving hemodialysis (Resident #7). Findings included:The National Kidney Foundation recommends specific dietary adjustments for individuals receiving hemodialysis, including strict restrictions on fluids, potassium, and phosphorus. High potassium levels can be dangerous for the heart, requiring limits on foods such as bananas, potatoes, tomatoes, and oranges. Fluid restrictions help prevent excessive weight gain and fluid buildup in the body. Processed foods should be avoided to reduce sodium and phosphorus intake. A highˆprotein diet that includes lean meats, poultry, fish, and egg whites is recommended. Resident #7 was admitted on [DATE] with diagnosis which included renal dialysis, end stage renal disease, hyperkalemia (an elevated potassium level in the blood which can cause muscle weakness, heart palpitations and shortness of breath), and heart failure. A review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact with no behaviors, had a diagnosis of renal failure/end stage renal disease and received a therapeutic diet. A review of Resident #7's electronic health record revealed a physician order dated 3/30/26 for a renal diet with double protein portions and a 1000 milliliter (mL) fluid restriction per 24 hours. The special instructions specified that Dietary was to provide 600 mL per day, distributed as 240 mL at breakfast, 240 mL at lunch, and 120 mL at dinner. The order also directed nursing to provide the remaining 400 mL per 24 hours, with first shift (7:00 AM to 7:00 PM) providing 200 mL and second shift (7:00 PM to 7:00 AM) providing 200 mL each day.A Registered Dietitian (RD) progress note dated 3/30/26 indicated that Resident #7 remained on a renal diet with double protein portions every meal and 1000 mL per 24 hours fluid restriction. RD to continue monitoring weight trends, intakes, nutrition-related lab values, skin status, and medications per protocol. A review of Resident #7's care plan initiated on 8/19/25 and last revised on 3/30/26 indicated a nutritional status problem for increased nutrition and hydration risk related to end stage renal disease, hemodialysis, therapeutic diet, and fluid restriction. Interventions included: maintain fluid restriction as ordered and encourage compliance with the prescribed diet. A lunch tray observation was conducted with Resident # 7 on 4/7/26 at 12:30 PM. Resident's meal tray ticket stated renal diet, allergy to tea, fluid restriction of 1000 mL per day with 240 mL fluid limit at lunch and double portions of protein. The meal tray ticket indicated that the resident received beef ravioli, Italian blend vegetables, sherbet 4 ounces, water 8 ounces and beverage of choice 8 ounces. Observation of the meal tray revealed that the resident received a small serving of beef ravioli with tomato sauce, a small dish of potatoes and carrots, a dinner roll, 4 ounces strawberry ice cream, 8 ounces water and 8 ounces ginger ale. The total number of ounces on the resident's meal tray for the water, ginger ale and ice cream was 600 mL. Double portions of protein were not observed. The Medical Records Manager, who served Resident #7 his lunch meal on 4/7/26 at 12:30 PM, was observed asking the resident what he wanted to eat instead after he informed her that he could not eat the ravioli due to his tomato allergy and his renal diet restrictions. Resident #7 responded that he would like whatever he was permitted to have under his renal diet restrictions. The Medical Records Manager then asked Resident #7 if he wanted a deli ham sandwich, a turkey sandwich, or an egg salad sandwich. The resident stated that he was not supposed to eat processed deli meats, so he requested an egg salad sandwich instead. An interview with Resident #7 on 4/7/26 at 12:35 PM revealed that the facility did not follow his renal diet and that he was often served foods that were not appropriate for his dietary needs, including the potatoes that he received on his lunch tray and the processed lunch meat sandwich he was offered as an alternate meal instead of the ravioli with tomato sauce. Resident #7 stated that staff were not aware of his fluid restriction. An observation of his bedside table revealed a large 12ˆounce Styrofoam cup containing orange juice. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident stated that he was provided the orange juice with breakfast, but he was restricted from consuming large servings of fluid and could not have a large cup of orange juice. An interview with the Medical Records Manager on 4/7/25 at 12:40 PM revealed that she was a Nurse Aide and assisted with delivering meal trays and feeding residents as needed. She stated that when she delivered meal trays, she checked the meal tray ticket for allergies and the diet. The Medical Records Manager indicated that she did not notice that Resident #7 received more fluid on his meal tray than permitted under his ordered fluid restriction and that he did not receive a double portion of protein. The Medical Records Manager stated that she was not sure what a renal diet consisted of.An interview with the Dietary Manager was conducted on 4/7/26 at 3:15 PM. The Dietary Manager stated that a renal diet included restrictions such as no tomatoes, tomato sauce or bananas and avoidance of other things that are high in potassium. She reported that she maintained a posted list in the kitchen identifying foods to avoid on a renal diet and expected her staff to refer to the list when preparing Resident #7's meal trays. The Dietary Manager stated that the small serving of ravioli provided to Resident #7 at lunch did not meet the requirement for a double protein portion and was served in error. She also reported that the potatoes and carrots substituted for the Italian blend vegetables should not have been served due to the resident's renal diet restriction, which specifies avoiding potatoes. The Dietary Manager added that she believed Resident #7 could have the roll, as he frequently received sandwiches in his bag lunch when going to dialysis. Additionally, she confirmed that the meal tray ticket listing 8 ounces of water, 8 ounces of a beverage of choice, and 4 ounces of sherbet exceeded the resident's 240 mL fluid restriction and acknowledged this was an error for which she could not provide an explanation. The Dietary Manager stated that there was no system in place to ensure that residents consistently received the correct diet or appropriate items on their meal trays. An interview with [NAME] #1 was conducted on 4/7/26 at 3:30 PM. [NAME] #1 stated that a renal diet meant the resident was not to receive tomatoes, potatoes and a few other certain things. The [NAME] stated that there was a list posted in the kitchen that identified foods to avoid on a renal diet. [NAME] #1 stated that she did not check the list when she prepared Resident #7's lunch meal tray on 4/7/26. [NAME] #1 indicated she read the tray card when preparing the meals. An observation of Resident #7's breakfast tray on 4/8/26 at 8:30 AM revealed that the resident received 1 fried egg, 1 slice of toast and a 4-ounce (120 mL) cup of coffee. The meal tray ticket indicated Resident #7 was to receive a renal diet with double portion of protein with an allergy listed as tea and a fluid restriction of 1000 mL per day with 240 mL provided at breakfast and lunch and 120 mL at dinner. The ticket indicated that Resident #7 was to receive 4 ounces (120mL) coffee and did not list the food items that the resident received. An interview with the consultant Registered Dietitian (RD) on 4/8/26 at 1:40 PM revealed that Resident #7 was ordered a renal diet with double protein and a 1000 mL fluid restriction. The RD stated that increased fluids can cause risks of poor volume management. The RD indicated that increased protein was important for a resident receiving dialysis to counteract the protein losses during treatment, to prevent muscle wasting and combat chronic inflammation. The RD stated that a small serving of ravioli was not a double portion of protein and further 1 fried egg was not a double portion of protein. The RD indicated that 2 large fried eggs constituted a standard serving so a double serving was 3-4 eggs. An interview with the Director of Nursing on 4/9/26 at 4:43 PM revealed that she expected that fluid restrictions and diet restrictions would be followed as ordered by the physician. The Director of Nursing stated that the dietary department was responsible for preparing meal trays according to the physician's orders, while the nursing staff was responsible for reviewing the meal tray ticket to ensure the diet was correct. She further indicated that nursing staff should be knowledgeable about special diets, such as a renal diet, and any associated restrictions. If a resident received an item on their tray and the nursing staff were uncertain whether it was permitted, they were expected to consult the dietary department for clarification.

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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 observation, record review and staff, resident and Physician interviews, the facility failed to ensure the medications were administered to the resident which had the potential for an adverse outcome for 1 of 1 resident observed with medication left at the bedside (Resident #7). Findings included:Resident #7 was admitted [DATE] with the diagnosis of renal dialysis, end stage renal disease, gastrointestinal hemorrhage and anemia.A review of Resident #7's electronic health record revealed a physician order dated 1/29/26 for velphoro (a phosphate binder which is used to lower phosphate in the blood of a resident with kidney disease), 500 milligrams take one tablet three times per day for hypokalemia (low blood potassium levels) at 7:00 AM, 11:00 AM and 4:00 PM. A review of Resident #7's electronic health record revealed a physician order dated 1/30/26 for sucralfate (a medication used to treat and prevent stomach ulcers) 1 gram tablet take 1/2 hour prior to meals and at bedtime at 8:00 AM, 11:00 AM, 5:00 PM and 8:00 PM.Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact and had no behaviors.A review of Resident #7's electronic health record revealed a physician order dated 4/3/26 for midodrine (a medication used to treat orthostatic hypotension, a sudden drop in blood pressure upon standing, which constricts the blood vessels to raise the blood pressure) 10 milligrams tablet once per day and 5 milligrams twice per day. Hold for systolic blood pressure greater than 130 millimeters of mercury. An observation and interview on 4/7/26 at 9:10 AM revealed Resident #7 sitting on the edge of his bed in his room. Medication Aide #1 was outside the room at the medication cart and Resident #7's room was not visible from where she was standing. Four plastic medication cups containing medications were noted on Resident #7's bedside table. Two of the plastic medication cups contained one large round brown tablet, one cup contained one white oblong tablet and one small white pill, and the fourth medication cup contained a white oblong tablet. Upon noticing the medication cups in Resident #7's room Medication Aide #1 was called into the room. She observed the medication cups and confirmed that the medications present were those ordered for Resident #7. She identified the brown tablet as velphoro, the white oblong tablet was sucralfate, and the small white pill was midodrine. Medication Aide #1 stated that the medications must have been left in the room from a prior shift's medication pass. She confirmed that she was running late that morning, had not yet administered Resident #7's medications, and had not been in his room. Medication Aide #1 indicated that she was assigned to Resident #7 on 4/6/26 from 7:00 AM to 3:00 PM and stated that she did not recall leaving medications at the bedside at 8:00 AM or 11:00 AM when the resident had medications scheduled. She further stated that medications should never be left at the bedside and that residents should be observed swallowing their medications before staff leave the room. Medication Aide #1 disposed of the medications in the medication cups by placing the tablets in a bottle of destroyer solution located in the medication cart.An interview with Nurse #5 on 4/9/26 at 4:15 PM revealed that he was assigned to Resident #7 on 4/6/26 from 3:00 PM to 11:00 PM. Nurse #5 did not recall leaving medications at Resident #7's bedside on 4/6/26 when he administered the resident's medications. Nurse #5 stated that it was not appropriate to leave medications unattended and unsecured at the bedside. Nurse #5 stated that he was not aware that Resident #7 was self-administering medications and had not noticed medications left on Resident #7's bedside table. An interview conducted on 4/7/26 at 9:20 AM with Resident #7 revealed that the medication cups had been left on his bedside table, though he did not recall when they were placed there. Resident #7 stated that the nurses often left medications at his bedside for him to take, but they did not always inform him that the medications were there or that he was expected to take them.An interview with the Physician on 4/8/26 at 12:40 PM revealed that Resident #7 not receiving Velphoro, Sucralfate, and Midodrine as prescribed had the potential to result in significant adverse effects. The Physician further stated that failure to receive Velphoro, a phosphorusˆbinding medication, as ordered could (continued on next page)

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	345575	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Health & Rehab Center	9600 No 5 School Road Ash, NC 28420

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	negatively impact Resident #7's electrolyte balance and result in adverse outcomes. An interview with Unit Manager #1 conducted on 4/8/26 at 12:00 PM revealed that medications were not to be left for a resident to take at a later time and that proper medication administration required remaining with the resident to ensure the medications were taken and swallowed. She further reported that she had not observed any medications left in Resident #7's room.An interview with the Director of Nursing (DON) on 4/9/26 at 4:43 PM revealed that she expected medications would not be left unattended and unsecured in a resident's room. The DON stated that staff were expected to remain with the resident and observe the resident taking and swallowing the medications before leaving the room. The DON further stated that medications were not to be left on the bedside table for the resident to take later and that residents were to be assessed for self-administration before they were allowed to have medications kept at the bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and resident, staff and Registered Dietitian (RD) interviews, the facility failed to provide food that accommodated a documented allergy to tomatoes for 1 of 5 residents reviewed for nutrition (Resident #7).Findings included: Resident #7 was admitted on [DATE]. A review of Resident #7's care plan initiated on 8/19/25 indicated the top of the document listed the resident's food allergies as tea and tomatoes. Resident #7 was discharged to the hospital on 1/26/26 and was readmitted on [DATE]. A review of a hospital Discharge summary dated [DATE] indicated that Resident #7 had documented food allergies, including anaphylaxis to tea and mouth and throat swelling in response to tomatoes. Review of Resident #7's electronic health record revealed an area on the clinical dashboard that listed food allergies as tea and tomatoes. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact with no behaviors, had diagnoses of renal failure and end stage renal disease and received a therapeutic diet. A review of a cardiology progress note dated 3/17/26 indicated that Resident #7 had documented food allergies, including anaphylaxis to tea and mouth and throat swelling in response to tomatoes.Review of Resident #7's electronic health record revealed a physician order dated 3/30/26 for a renal diet with double protein portions and a 1000ˆmilliliter fluid restriction per 24 hours. A nutritional status problem dated 3/30/26 indicated that Resident #7 was at risk for increased nutrition and hydration problems related to end stage renal disease, hemodialysis, therapeutic diet, and fluid restriction with tea allergy noted. The interventions included ensuring allergen avoidance. The resident's allergy to tomatoes was not included in the care plan.A lunch tray observation was conducted with Resident # 7 on 4/7/26 at 12:30 PM. Resident#7 was sitting on the edge of his bed when the Medical Records Director served Resident #7 his meal. Resident's meal tray ticket stated renal diet, allergy to tea, fluid restriction of 1000 milliliters per day and double portions of protein. The meal tray ticket indicated that the resident received beef ravioli with tomato sauce, Italian blend vegetables, sherbet 4 ounces, water 8 ounces and beverage of choice 8 ounces. Observation of the meal tray revealed that the resident received a small serving of beef ravioli with tomato sauce, a small dish of potatoes and carrots, a dinner roll, strawberry ice cream 4 ounces, 8 ounces water and 8 ounces ginger ale. Resident # 7 informed the Medical Records Director that he was allergic to tomatoes, and he requested an alternate meal. The Medical Records Director offered Resident #7 a deli ham or turkey sandwich or an egg salad sandwich. Resident #7 responded that he was not supposed to eat processed deli meat so he would have an egg salad sandwich instead. An interview with Resident #7 on 4/7/26 at 12:35 PM revealed that he was served tomato sauce today and he was unable to eat this due to his allergy and his renal restriction. Resident #7 stated that he was allergic to tomatoes and that they caused swelling of his face and mouth. Resident #7 stated that he had not talked to anyone from the kitchen regarding his diet, allergies, likes or dislikes since he was admitted to the facility. Resident #7 stated that he was served tomatoes and tomato sauce before and had told the staff that delivered the meal trays that he was not able to eat tomatoes. An interview with the Medical Records Manager on 4/7/25 at 12:40 PM revealed that she was a Nurse Aide and assisted with delivering meal trays and feeding residents as needed. She stated that when she delivered meal trays, she checked the meal tray ticket for allergies and the diet. The Medical Records Manager indicated that she was unaware that Resident #7 was allergic to tomatoes as it was not listed on the meal tray ticket. An interview conducted with Nurse Aide (NA) #1 on 4/9/26 at 5:00 PM indicated that she was familiar with Resident #7. However, NA #1 stated she was not aware that Resident #7 had an allergy to tomatoes. She reported that she typically checked the meal tray ticket for allergy information when she served resident meals. An interview was conducted with the Dietary Manager on 4/7/26 at 3:15 PM. The Dietary Manager stated that she was unaware that Resident #7 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had an allergy to tomatoes. The Dietary Manager indicated that when a resident was admitted , she received the diet order from the nursing department, that nursing entered the allergies in the clinical record, but she was responsible for ensuring that food allergies were listed in her meal tray ticket system. The Dietary Manager indicated that usually if nursing entered an allergy it showed up in her system for the meal tray ticket. The Dietary Manager stated that she did not know why she did not have Resident #7's allergy to tomatoes on his meal tray ticket and that she would need to contact someone at the corporate office to investigate this. The Dietary Manager stated that she talked to residents regarding their likes and dislikes as needed but she did not have a form for this and did not document this information. The Dietary Manager indicated that she did not have any documentation of the last time she spoke with Resident #7, did not recall the last time she talked to him about his diet, allergies, likes or dislikes and did not recall reviewing Resident #7's clinical record for allergies. The Dietary Manager pulled up her meal tray ticket system and observed that tea was listed in the system as an allergy, but tomatoes were not and she again stated there was an error that it did not pull into the system from the clinical record. An interview with the Director of Nursing (DON) on 4/9/26 at 4:43 PM revealed that she expected that food allergies would be communicated from the nursing department to the dietary department and would be honored. The DON stated that allergies were supposed to transfer from the clinical dashboard to the Dietary Manager's system but should also be included on the diet order slip that was provided to the dietary department.