STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: O'Berry Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 Old Smithfield Road, Goldsboro, NC 27533	

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review, and staff and physician interviews, the facility failed to consult with the physician immediately when Resident #2, who had a tracheostomy, experienced a medical emergency. On 1/16/25, Resident #2 exhibited signs of pain, and her oxygen saturation levels were at 69% on room air (normal range is 95%-100%). Nurse #1 was able to stabilize the resident's oxygen saturation through administration of oxygen and she medicated the resident for pain. Later in the shift, Nurse #1 was notified by Nurse Aide (NA) #1 Resident #2's oxygen saturation levels had dropped to 55% (a life threatening level), the resident was crying, and her tongue was blue. Emergency Medical Services (EMS) and the physician were not notified immediately. After notifying the physician and calling EMS Resident #2 was transferred to the hospital and was diagnosed with acute hypoxia (lack of oxygen in the body) respiratory failure (occurs when the body is unable to maintain adequate oxygen levels in the blood due to a sudden impairment of lung function) and a heart attack related to a lack of oxygen. This deficient practice affected 1 of 6 residents reviewed for notification of physician. Immediate jeopardy began on 1/16/25 when the facility failed to immediately notify the physician when the resident experienced a medical emergency in condition when the Resident #2's oxygen saturation level dropped to 55%. The immediate jeopardy was removed on 2/7/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D to ensure education is completed and monitoring systems put in place are effective. The findings included: Resident #2 was admitted to the facility 10/30/14. Resident #2's cumulative diagnoses included respiratory failure with hypoxia (low oxygen level) and a tracheostomy. Resident #2's Minimum Data Set (MDS) dated [DATE] indicated she had severe cognitive impairment. Resident #2 was not documented for use of supplemental oxygen. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2's nursing progress note dated 1/16/25 at 3:30 AM written by Nurse #1 noted while performing personal care by staff, Resident #2 started crying and her oxygen saturation levels fell to 69% on room air. Nurse #1 noted she changed the tracheostomy inner cannula, suctioned her (tracheostomy canula) three times, raised the head of her bed, and supplemental oxygen was started and increased to 10 liters per minute (lpm) via trach collar. Resident #2's oxygen saturation rose to 99% and the oxygen was titrated (monitored and adjusted) down to 4 lpm. Resident #2's oxygen saturation was 93% when retested and her vital signs were normal. Physician #1 was notified that Resident #2 had been given a dose of tramadol 50 milligrams (mg) at 12 midnight but the resident was still in pain. Physician #1 gave a new order for one dose of morphine 2 mg subcutaneously (SQ) to be given immediately, a urinalysis was to be completed in the morning, and to titrate (adjust) the supplemental oxygen to keep Resident #2's oxygen saturation above 92%. Nurse #1 noted she gave Resident #2 morphine, and the resident tolerated the medication well. Resident #2's Resident Monitoring Check Sheet (a routine monitoring sheet completed for all residents in the facility to demonstrate staff were monitoring residents at set time periods) for 1/15/25 11:00 PM to 1/16/25 7:00 AM noted residents were to be checked by staff every 30 minutes. The last time NA #1 initialed checking on Resident #2 was 4:15-4:30 AM on 1/16/25. Further review of the Resident Monitoring Check Sheet revealed documentation from a nurse Resident #2 was checked at 11:00-11:15 PM and 1:45-2:00 AM. A nursing note dated 1/16/25 at 4:40 AM completed by Nurse #1 indicated at 4:40 AM, Nurse #1 was called to Resident #2's room by Nurse Aide (NA) #1. When Nurse #1 entered the room, Resident #2's oxygen saturation levels were 55%. Resident #2 was documented as crying and her tongue appeared blue. Nurse #1 raised the supplemental oxygen from 4 lpm to 8 lpm and notified Physician #1. Physician #1 ordered for Resident #2 to be sent out to the Emergency Department (ED). Nurse #1 noted she called Emergency Medical Services (EMS) and Resident #2 left the facility with EMS at 5:00 AM. Resident #2's physician orders dated 1/16/25 at 4:40 AM revealed an order to send Resident #2 to the ED. In a written statement dated 1/17/25, Nurse #1 said when she called Physician #1 on 1/16/25 at approximately 3:30 AM, he ordered morphine 2mg SQ and to monitor her. She administered the morphine and Resident #2 stabilized. At around 4:40 AM, NA #1 notified her that Resident #2's oxygen levels were dropping again. She said she asked Nurse #2 to come to Resident #2's room to stay with her (the resident) while Nurse #1 called Physician #1 to send her out to the ED. Nurse #1 then called EMS and Resident #2 left the facility at 5:00 AM. In a phone interview on 1/30/25 at 2:14 AM, Nurse #1 said she was notified by NA #1 on 1/16/25 at 4:40 AM that Resident #2's oxygen saturation levels were dropping as reported by NA #1. She went to Resident #2's room, took Resident #2's oxygen saturation level, which was 55%, turned the supplemental oxygen level up from 4 lpm to 8 lpm, and then went to get Nurse #2. After turning the oxygen concentration level up, Resident #2's oxygen saturation level increased to 70%. She asked Nurse #2 to stay in the room so she could call Physician #1. Nurse #2 was unable to recall specific information about times about what happened after NA #1 notified her at 4:40 AM while she was helping Resident #2 and said the situation seemed to happen very quickly. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a statement written by Nurse #2 on 1/17/25, she indicated on 1/16/25, Nurse #1 requested assistance with Resident #2. She wrote she saw Nurse #1 called Physician #1 and obtained an order for morphine. Nurse #1 administered the morphine and Nurse #2 went back to her office. A little while later Nurse #1 called Nurse #2 back for help due to Resident #2's oxygen saturation levels dropping and Nurse #1 needed to call Physician #1 to send Resident #2 to the hospital. She noted she stayed with Resident #2 while Nurse #1 got the transfer paperwork ready. When EMS arrived, Nurse #1 stayed with the resident and Nurse #2 went to help direct EMS to Resident #2's room when they arrived at the facility. Nurse #2 did not note how long it took to call the physician. In a phone interview on 1/30/25 at 2:30 AM, Nurse #2 indicated she heard Nurse #1 ask for help with Resident #2 on 1/16/25 at approximately 4:30-4:45 AM though she could not remember the exact time. She stated Resident #2's oxygen levels had dropped again, and Nurse #1 asked her to stay with Resident #2 while she called the physician. Nurse #2 stayed in the room assisting Resident #2 until Nurse #1 returned to the room. Nurse #2 could not say how much time had passed. Review of a phone record provided by the facility revealed the resident's physician was called at 3:30 AM and 4:57 AM. Resident #2's EMS record dated 1/16/25 indicated they received the call from the facility at 4:58 AM requesting assistance due to a sick person. Resident #2's oxygen saturation levels were 70% and she was experiencing respiratory distress with hypoxia. She continued on 8 lpm of supplemental oxygen via tracheostomy. EMS noted her pulse was 70 (normal range 60-100), her respirations were 16 (normal range 12-20), her breath sounds in her lungs were normal, and she did not show signs of pain. Resident #2's hospital documentation indicated the resident presented to the ED on 1/16/25 with shortness of breath and her oxygen saturation level was 50%. Resident #2 required up to 15 lpm of supplemental oxygen upon arrival to the ED and her oxygen saturation rose to 90%. She was also initially suspected to have demand ischemia (a type of heart attack due to the heart not getting enough oxygen) in the setting of her degree of hypoxia. The ED physician assessed her with diagnoses of acute hypoxia respiratory failure requiring 15 lpm of supplemental oxygen and a heart attack related to a lack of oxygen. The hospital record indicated Resident #2 discharged from the hospital back to the facility on [DATE]. In an interview on 1/30/25 at 4:45 PM, the Director of Nursing (DON) said Nurse #2 stayed with Resident #2 the whole-time interventions were being put into place while Resident #2's oxygen saturation levels were low and provided care for the resident in the emergency situation but did not say Nurse #1 did not notify the physician immediately. In an interview on 1/31/25 at 11:42 AM, Physician #1 said he was notified of Resident #2's first change of condition at approximately 3:15-3:30 AM, though he was unsure of the time. He said he wasn't too concerned about the resident because she had just had surgery on 1/10/25 for a kidney stone and they were going to do a urinary analysis (UA) but wanted to give her something for the pain. He stated he received another phone call at 5:00 AM from Nurse #1. He explained he was concerned and said she needed to be sent out to the hospital because she couldn't be cared for at the facility with oxygen levels that low and he ordered for Resident #2 to be sent to the hospital. He further explained due to the potential for Resident #2's condition, including her tongue turning blue, she could change within minutes, he would have expected to be notified quickly. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was notified of Immediate Jeopardy on 1/31/25 at 12:54 PM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #2 experienced an emergency change of condition at 4:40 AM and the physician was not notified until 5:00 AM. Once the physician was notified, he ordered to send Resident #2 to the emergency department. The delay in notifying the physician delayed the transfer of Resident #2 to the hospital. Resident #2 was non-verbal, vulnerable, and had a tracheotomy. On 1/16/25 at 4:40 AM, Nurse #1 was notified by NA #1 that Resident #2's oxygen saturation levels dropped to 55%, she was crying, and her tongue was blue. Nurse #2 was then called to the room. The physician and Emergency Medical Services were not called immediately. Emergency Medical Services was notified at 4:58 AM and the physician was not notified at 5:00 AM. Resident #2 was sent to the hospital on 1/16/25 at 5:00 AM. The hospital documented Resident #2 oxygen saturation levels were 50% on room air with no supplemental oxygen. She was diagnosed with acute on chronic hypoxic respiratory failure due to accidental overdose and a Non-ST-segment elevation myocardial infarction (NSTEMI, a type of heart attack that occurs when there's a partial blockage in a coronary artery) likely due to demand ischemia due to overdose. She was put on 15 liters of oxygen and admitted to the hospital. There is a potential for 119 residents to be impacted by the deficient practice of failing to contact the doctor in a timely manner during an emergency. On 1/16/25 there were no other residents identified who had an acute change of condition based on the 24-hour nursing report, and verified during management rounds, attended by the Unit Nurse Managers, Facility Director, The Assistant Director of Nursing, Business Officer and Standards Manager, when the Unit Nurse Managers discussed all events, significant changes, and concerns for the residents, residential units and staffing. The doctor who was on call on 1/16/25 shared that he had not received any notifications of any other significant change and there were none discussed by other doctors during their daily rounds the morning of 1/16/25. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 1/31/25 the Director of Nursing educated the Unit Nurse Managers, and Nurse Educators in his office, that immediately upon being notified of a significant change of status for a resident, the doctor is to be notified. They were provided with the emergency number (Code Blue number) for the doctor to ensure expedient responses by the doctor. In addition, the doctor's telephone numbers will be programmed into the residential unit cellphone, kept by the unit nurse, to contact doctors during non-emergent times and to call 911 immediately in case of an emergency followed by with a call to the doctor. Nurses not present will be in-serviced upon return to work by the Unit Nurse Manager, Floor Shift Nurse Supervisor Nurse Educator or any lead nurse who has been previously in-serviced. New Hires will be educated on this during their orientation period by the Nurse Educator. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All nursing department staff will be in-serviced by the Unit Nurse Manager, Nurse Educators, Floor shift Nurse Supervisor or the Director of Nursing on the Code Blue Policy to ensure activation for life threatening emergencies to include notification of EMS and the doctor. This was completed on 2/6/25 or prior to start of next assigned shift. On 1/31/25 the Unit Nurse Manager sent an all nursing department staff notification through CareTracker Electronic Data collection and messaging system in addition to in person in-servicing to increase the number of times the message is seen, heard, and received, to all direct staff, and nursing staff to report all changes in condition to nurse immediately or activate the Code Blue Policy by calling #4545 (This will call 911 and notify the doctor). Message was verified by the Unit Nurse Manager having staff members check CareTracker. Staff must read and acknowledge the message in CareTracker prior to being able to complete any documentation in the CareTracker system. This will be an addition to the in-person training. A read receipt will be sent to the Unit Nurse Manager once the message has been read. Direct Care and nursing staff not receiving message by 2/6/25 will be in-serviced in person upon return to duty by the Director of Nursing, immediate supervisors, or designee. The Unit Nurse Managers, Floor Shift Nurse Supervisors and the Facility Support Specialist are responsible for tracking the receipt of message and/or inservices and ensure that no nursing staff work after 2/6/25 until completed. The Floor Shift Nurse Supervisor, Unit Nurse Manager or the Facility Support Specialist and the Home Life Support Assistant (Charge CNA), once in-serviced, will in-service the Home Life Support Assistants and all CNAs on the importance of reporting all change in conditions, behaviors or appearance immediately to the nurse assigned to the resident's living area. This information will be discussed during their shift exchange daily and added to 24-hour shift report. In addition, a CareTracker message was sent out read receipt on 1/31/25 inclusive of this information for repetitive learning. Any staff not trained by 2/6/25 will be in-serviced prior to resident contact by the nurse manager or designee. The Unit Nurse Managers, Floor Shift Nurse Supervisors and the Facility Support Specialists are responsible for tracking the inservices and ensuring no nursing staff work after 2/6/25 until completed. IJ Removal Date 2/7/25 An onsite validation was conducted on 02/06/25 of the facility's implementation of their credible allegation for immediate jeopardy removal. The initial audit was verified. A review of in-service records revealed all nurses were in-service that the physician is to be notified immediately upon being notified of a significant change of status for a resident. The protocol for notification was included in the education. Nurses were instructed to call 911 immediately in case of an emergency followed by with a call to the physician. All nursing staff were educated on the following: the facility's Code Blue Policy and protocol to ensure activation for life threatening emergencies to include notification of EMS and the physician; and the importance of reporting any change in conditions immediately or to activate the Code Blue Policy. All NAs and Home Life Support Assistants were educated on the importance of reporting all changes in condition, behaviors, or appearance immediately to the nurse assigned to the resident's living area. Interviews conducted with nursing staff during the onsite validation were completed and the staff were able to verbalize knowledge of the policy and procedures for notification. The DON verified that no staff would work after 2/6/25 until education was received as noted in the removal plan. The immediate jeopardy removal date was validated as 2/7/25.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 50234 Based on record review and interviews with staff and physician, the facility failed to provide nursing assessments and monitoring for Resident #2 following an acute change of condition. On 1/16/25 at approximately 3:30 AM, Resident #2 exhibited signs of pain and her oxygen saturation levels were at 69% (normal range is 95%-100%). Supplemental oxygen was applied, the physician ordered morphine 2 milligrams (mg) subcutaneously (under the skin), and instructed Nurse #1 to monitor the resident closely. Nurse #1 inadvertently administered 20 mg of morphine to Resident #2 at approximately 3:45 AM rather than the 2mg ordered by the physician. Nurse #1 nor any other nurse monitored or assessed on Resident #2 until approximately 4:40 AM when Nurse #1 was notified by Nurse Aide (NA) #1 that Resident #2's oxygen saturation levels dropped to 55%, she was crying, and her tongue was blue. Emergency Medical Services were not contacted until 4:58 AM. Resident #2 was transferred to the hospital and was diagnosed with acute hypoxia respiratory failure (occurs when the body is unable to maintain adequate oxygen levels in the blood due to a sudden impairment of lung function) and a heart attack related to a lack of oxygen. This deficient practice affected 1 of 3 residents reviewed for change of condition. Immediate jeopardy began on 1/16/25 when the facility failed to ensure nursing assessments and monitoring was provided for Resident #2 following an acute change of condition. The immediate jeopardy was removed on 2/7/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D to ensure education is completed and monitoring systems put in place are effective. The findings included: Resident #2 was admitted to the facility 1/15/13 with diagnoses including respiratory failure with hypoxia (low oxygen level). Resident #2's Minimum Data Set (MDS) dated [DATE] indicated she had severe cognitive impairment, had no indications of pain, and did not take any scheduled or as needed pain relieving medications or opioids. Resident #2 did not use supplemental oxygen. Resident #2's comprehensive care plan dated 11/14/24 indicated she had a tracheotomy to maintain effective breathing patterns with a goal for her oxygen levels to remain above 90%. Interventions included to provide tracheotomy care per facility protocol, to report any changes in breathing patterns, congestion, or cough, and to report adverse symptoms to Medical Doctor (MD) or nurse immediately. Resident #2's physician orders dated 1/14/25 noted an order for Tramadol (narcotic pain medication) 50 mg per feeding tube every 8 hours for 3 days for pain after surgery. Resident #2's physician progress notes dated 1/15/25 noted the resident returned to the facility the previous day (1/14/25) after surgery to remove kidney stones and to place an indwelling ureteral stent (a tube inserted to help urine drain from the kidney to the bladder). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2's nursing progress note dated 1/16/25 at 3:30 AM written by Nurse #1 noted while performing personal care by staff, Resident #2 started crying and her oxygen saturation levels fell to 69% on room air (no supplemental oxygen used). Nurse #1 noted she changed the tracheostomy inner cannula, suctioned her three times, raised the head of her bed, supplemental oxygen was started and increased to 10 liters per minute (lpm). Resident #2's oxygen saturation rose to 99% and the oxygen was titrated down to 4 lpm. Resident #2's oxygen saturation was 93% when retested and her vital signs were normal. Physician #1 was notified that Resident #2 had been given a dose of Tramadol at 12 midnight but was still in pain, so Physician #1 gave a new order for one dose of morphine 2 mg subcutaneously (SQ) to be given immediately, for laboratory tests to be done in the morning, and to titrate the supplemental oxygen to keep Resident #2's oxygen saturation above 92%. Nurse #1 noted she gave Resident #2 morphine and the resident tolerated the medication well. In a phone interview on 1/30/25 at 2:14 AM, Nurse #1 said she was notified by NA #1 on 1/16/25 at 3:30 AM that Resident #2 was crying, grimacing, and appeared to be in pain. Her oxygen saturation levels were 69-70% on room air. She said she called for Nurse #2 to stay with Resident #2 while she got an oxygen concentrator. Resident #2 was placed on 10 lpm of oxygen. She said she called Physician #1, who told her to give morphine 2 mg SQ and to keep monitoring her (the resident). She said she (Nurse #1) administered the dose of morphine at approximately 3:45 AM and Resident #2 appeared to be stable. She said she then went back to the nurses' station. She said there was no specified time ordered to monitor Resident #2 and that NA #1 was sitting outside Resident #2's room and could monitor her. In a phone interview on 1/30/25 at 2:30 AM, Nurse #2 indicated she heard Nurse #1 ask for help with Resident #2 on 1/16/25 at approximately 3:30 AM. She (Nurse #2) went to Resident #2's room, helped apply oxygen and stayed with Resident #2 while Nurse #1 called Physician #1. She went to the nurses' station once Resident #2 stabilized and heard Nurse #1 acknowledge the order for morphine and to monitor the resident. Nurse #1 administered the morphine to Resident #2. Nurse #2 said Resident #2's oxygen levels stabilized at 95-96% and she went back to work in her office. Resident #2's Resident Monitoring Check Sheet (a monitoring sheet completed for all residents in the facility to demonstrate staff were monitoring residents at set time periods) for 1/15/25-1/16/25 noted residents were to be checked by staff every 30 minutes during bed time. There was documentation for NAs and nurses to initial when they checked on the resident. NA #1 initialed that she checked on Resident #2 during the time periods of 3:15-3:30 AM, 3:45-4:00 AM, and 4:15-4:30 AM on 1/16/25. Nurse #1 and Nurse #2 did not initial that either checked on Resident #2 during that time period. In an interview on 1/31/25 at 3:10 PM, the Director of Nursing (DON) said all residents have a regular monitoring sheet to document when the residents were last checked. A nursing note dated 1/16/25 completed by Nurse #1 indicated at 4:40 AM, Nurse #1 was called to Resident #2's room by Nurse Aide (NA) #1. When Nurse #1 entered the room, Resident #2's oxygen saturation levels were 55%. Resident #2 was documented as crying and her tongue appeared blue. Nurse #1 raised the supplemental oxygen from 4 lpm to 8 lpm and notified Physician #1. Physician #1 ordered for Resident #2 to be sent out to the Emergency Department (ED). Nurse #1 noted she called Emergency Medical Services (EMS) and Resident #2 left the facility with EMS at 5:00 AM. Resident #2's physician orders dated 1/16/25 at 4:40 AM revealed an order to send Resident #2 to the ED. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2's EMS report dated 1/16/25 indicated they received the call from the facility at 4:58 AM requesting assistance due to low oxygen saturation levels. They were enroute at 5:05 AM and onsite with the resident at 5:15 AM. Staff reported a few hours prior [the resident] began exhibiting poor [oxygen saturation levels] so she should be sent out for evaluation. Resident #2's oxygen saturation levels were 70% and she was experiencing respiratory distress with hypoxia. She continued on 8 lpm of supplemental oxygen. EMS noted her pulse was 70 (normal range 60-100), her respirations were 16 (normal range 12-20), her breath sounds in her lungs were normal, and she did not show signs of pain. EMS left the facility with Resident #2 at 5:25 AM. In a phone interview on 1/30/25 at 2:14 AM, Nurse #1 revealed she did not check on Resident #2 after the morphine administration on 1/16/25 until she was notified by NA #1 that Resident #2's oxygen levels were dropping approximately an hour later. She said NA #1 sat outside of Resident #2's room in the hallway throughout that time period to monitor her and take Resident #2's vital signs. She said she wasn't aware of how much time it took to stabilize Resident #2 and to call the Physician and EMS, saying everything happened so fast Attempts to interview NA #1 were unsuccessful. In a phone interview on 1/30/25 at 2:30 AM, Nurse #2 she said she did not check on Resident #2 on 1/16/25 after the morphine was administered until Nurse #1 requested help again approximately an hour or two later. She explained that Nurse #1 called her to Resident #2's room for a second incident of low oxygen saturation levels. She was unable to recall the exact time. She indicated she went to the room to assist. Nurse #2 said she attempted to suction Resident #2 and her oxygen saturation level went up to 70%. She said she stayed with Resident #2 until EMS came to the facility. Resident #2's hospital documentation indicated the resident presented to the ED on 1/16/25 with shortness of breath and her oxygen saturation level was 50%. Resident #2 required up to 15 lpm of supplemental oxygen upon arrival to the ED and her oxygen saturation rose to 90%. She was also initially suspected to have demand ischemia (a type of heart attack due to the heart not getting enough oxygen, also referred to as an NSTEMI) in the setting of her degree of hypoxia. The ED physician assessed her with diagnoses of acute hypoxia respiratory failure requiring 15 lpm of supplemental oxygen and an NSTEMI. The hospital record indicated Resident #2 discharged from the hospital back to the facility on [DATE]. Resident #2's nursing progress notes dated 1/16/25 at 7:02 PM by Unit Manager #2 notified Resident #2's resident representative that Resident #2 receiving 20 mg of morphine that morning prior to transferring to the hospital. In an interview on 1/30/25 at 2:28 PM, Unit Manager #2 said she received a text message from Nurse #1 on 1/16/25 at 12:37 PM saying that she had used 2 vials of morphine because she had mixed up the amount of medicine in the vial and the dose per milliliter (ml). There was 1 ml of 10 mg of morphine in each vial, and Nurse #1 told her that she drew 2 ml thinking it was 2 mg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER O'Berry Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Old Smithfield Road Goldsboro, NC 27533	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/30/25 at 4:45 PM, the Director of Nursing (DON) said Nurse #2 stayed with Resident #2 continuously during both incidents at 3:30 AM and 4:40 AM and assisted with interventions that were being put into place while Resident #2's oxygen saturation levels were low. He was not aware a licensed nurse had not checked on Resident #2 between 3:45 AM when the morphine was administered and Resident #2 oxygen levels stabilized and 4:40 AM when Resident #2 went into respiratory distress. He acknowledged the notification of the Physician and EMS were approximately 20 minutes after Nurse #1 became aware of Resident #2's condition, but said Nurse #2 was with the resident the entire time to stabilize her. In an interview on 1/31/25 at 11:42 AM, Physician #1 said he was notified of Resident #2's first change of condition on 1/16/25 at approximately 3:15-3:30 AM, though he was unsure of the time. He ordered the dose of morphine and for the nurse to closely monitor Resident #2. He said he did not have a specific monitoring time ordered, but expected a nurse to check on Resident #2 every few minutes, not an NA. He said he received another phone call at 5:00 AM from Nurse #1. He was sure it was 5:00 AM and he ordered for Resident #2 to be sent to the hospital immediately with emergency medical services. He said the resident's oxygen levels were in the 50s, the facility could not manage the level of care she needed, and that she needed to go to the hospital. Resident #2 suffered an NSTEMI heart attack which the hospital physician attributed to the overdose of morphine. He said he was not sure if Resident #2 had a heart attack due to the morphine overdose causing a lack of oxygen to the heart or if she had a heart attack before the morphine was administered which was why she was showing signs of pain. Physician #1 indicated that the morphine slowed her breathing which may have helped her survive the heart attack. The Administrator was notified of Immediate Jeopardy on 1/31/24 at 10:38 AM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #2 was non-verbal, vulnerable, and had a tracheotomy. She showed signs of pain by crying and grimacing on 1/16/25 at 3:30 AM and her oxygen saturation levels declined to 69-70%. Nurse #1 obtained an order for a one-time dose of morphine 2 mg subcutaneously and to closely monitor Resident #2. Oxygen was applied but there was a lack of ongoing nursing assessment/monitoring. At approximately 3:45 AM, Nurse #1 administered 2 milliliters instead of milligrams of morphine to Resident #2, which was equal to 20 mg of morphine. At 4:40 AM, Nurse #1 was notified by NA #1 that Resident #2's oxygen saturation levels dropped to 55%, she was crying, and her tongue was blue. Nurse #2 was then called to the room. Neither nurse had checked on Resident #2 since 3:45 AM. Emergency Medical Services was notified at 4:58 AM and the physician was notified at 5:00 AM The physician and EMS were not called immediately. Resident #2 was sent to the hospital on 1/16/25 at 5:00 AM. The hospital documented Resident #2 oxygen saturation levels were 50% on room air with no supplemental oxygen. She was diagnosed with acute on chronic hypoxic respiratory failure due to accidental overdose and a Non-ST-segment elevation myocardial infarction (NSTEMI, a type of heart attack that occurs when there is a partial blockage in a coronary artery) likely due to demand ischemia due to overdose. She was put on 15 liters of oxygen and admitted to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: O'Berry Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 Old Smithfield Road Goldsboro, NC 27533	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	119 residents could be impacted by this deficient practice if experiencing an acute change of condition and are not provided necessary care, medical evaluations and or treatment. There were no other residents identified who had an acute change of condition based on the 24-hour nursing report, and verified during management rounds, attended by the Unit Nurse Managers, Facility Director, The Assistant Director of Nursing, Business Officer and Standards Manager, when the Unit Nurse Managers discussed all events, significant changes, and concerns for the residents, resident units, and staffing on 1/16/25. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Director of Nursing in-service the Unit Nurse Managers and Nurse Educator on 1/31/25 to ensure that when medication or treatment is given for an acute condition the nurse will monitor every 15 minutes for 2 hours and document all findings to include vital signs and reactions to treatment/medication in a progress note. If a decision is made to transport resident to emergency department, a nurse will remain with the resident until care is transferred to EMS. All nurses present today, 1/31/25, will be in-serviced. All other nurses will be in-serviced upon return to duty by the Unit Nurse Manager, Nurse Educator, or the Director of Nursing. This will become an established procedure for the nursing department. Effective 2/6/25 all nursing department staff will be in-serviced prior to start of shift by the Unit Nurse Manager, Nurse Educators, Floor shift Nurse Supervisor or the Director of Nursing on the Code Blue Policy to ensure activation for life threatening emergencies to include notification of EMS and the doctor. All nursing department staff not present will receive in-service upon return to duty prior to start of shift by the Unit Nurse Manager, Floor Shift Nurse Supervisor, Nurse Educator, Facility Support Specialists, or a Manager who have been trained. The Unit Nurse Managers, Floor Shift Nurse Supervisors and the Facility Support Specialist will be responsible for tracking the inservices and ensuring they are completed prior to the start of their shift. On 1/31/25 the Unit Nurse Manager sent an all nursing department staff notification through CareTracker Electronic Data collection and messaging system in addition to in person in-servicing to increase the number of times the message is seen, heard, and received, to all direct staff, and nursing staff to report all changes in condition to nurse immediately or activate the Code Blue Policy by calling #4545 (This will call 911 and notify the doctor). Message was verified by the Unit Nurse Manager having staff members check CareTracker. Staff must read and acknowledge the message in CareTracker prior to being able to complete any documentation in the CareTracker system. This will be an addition to the in-person training. A read receipt will be sent to the Unit Nurse Manager once the message has been read. Direct Care and nursing staff not receiving message by 2/6/25 will be in-serviced in person upon return to duty by the Director of Nursing, immediate supervisors, or designee. The Unit Nurse Managers are responsible for tracking the receipt of message and/or inservices and ensuring no nursing staff work after 2/6/25 until completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34A002	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Berry Neuro-Medical Treatment Center	400 Old Smithfield Road Goldsboro, NC 27533

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Floor Shift Nurse Supervisor, Unit Nurse Manager or the Facility Support Specialist and the Home Life Support Assistant (Charge CNA), once in-serviced, will in-service the Home Life Support Assistants and all CNAs on the importance of reporting all change in conditions, behaviors or appearance immediately to the nurse assigned to the resident's living area. This information will be discussed during their shift exchange daily and added to 24-hour shift report. In addition, a CareTracker message was sent out read receipt on 1/31/25 inclusive of this information for repetitive learning. Any staff not trained by 2/6/25 will be in-serviced prior to resident contact by the nurse manager or designee. The Unit Nurse Managers, Facility Support Specialist and the Floor Shift Nurse Supervisors are responsible for tracking the receipt of message and/or inservices and ensuring no nursing staff work after 2/6/25 until completed. The Floor Shift Nurse Supervisor, Unit Nurse Manager or the Facility Support Specialist and the Home Life Support Assistant (Charge CNA), once in-serviced, will in-service the Home Life Support Assistants and all CNAs on the understanding of oxygen saturation levels and their impact to sustaining life. This information will be discussed during their shift exchange daily and added to 24-hour shift report. Any staff not trained by 2/6/25 due to absence will be in-serviced prior to resident contact by the nurse manager or designee. The Unit Nurse Manager, Floor Shift Nurse Supervisor, and the Facility Support Specialists are responsible for tracking the inservices and ensuring no nursing staff work after 2/6/25 until completed. This competency check will become part of the new employee competency checks conducted by the nurse educators effective immediately. Just Culture Review was conducted on 1/17/25 by the Unit Nurse Manager for both nurses involved in this deficient practice regarding their failure to respond appropriately to get the resident needed care with appropriate actions to be taken. IJ Removal Date 2/7/25 Onsite validation was conducted on 02/06/25. The initial audit was verified. A review of the in-service records revealed that education was provided to all Licensed Nurses on when a medication or treatment is given for an acute condition, the nurse will monitor the resident every 15 minutes for 2 hours and document all findings to include vital signs and reactions to treatment/medication in a progress note, and if the resident needed to be transported to the hospital, a nurse must remain with the resident until care is transferred to EMS. All nursing staff were educated on the facility's Code Blue Policy and protocol to ensure activation for life threatening emergencies to include notification of EMS and the doctor. All NAs and Home Life Support Assistants were educated on the following: the importance of reporting all change in conditions, behaviors, or appearance immediately to the nurse assigned to the resident's living area; and on understanding oxygen saturation levels, their impact on a resident's condition, and to report any value below 90% immediately. Interviews conducted with nursing staff verified their knowledge of this training. The DON verified that no staff would work after 2/6/25 until education was received as noted in the removal plan. The immediate jeopardy removal date was validated as 2/7/25.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review and interviews with staff and the physician, the facility failed to prevent a significant medication error when Nurse #1 administered ten times the ordered amount of morphine (narcotic pain medication) to Resident #2. On 1/16/25, Resident #2 exhibited signs of pain and her oxygen saturation levels were at 69% (normal range is 95%-100%). Supplemental oxygen was applied and the physician ordered morphine 2 milligrams (mg) subcutaneously (under the skin). Nurse #1 obtained two vials of morphine and administered them to Resident #2. She believed each vial contained 1 mg of morphine rather than the actual content of 10 mg per vial resulting in the resident receiving 20 mg instead of the physician ordered 2 mg. Approximately one hour later the resident's tongue appeared blue and her oxygen saturation level dropped to 55% on 4 liters per minute of supplemental oxygen. She was transferred to the hospital and was diagnosed with acute hypoxia respiratory failure (occurs when the body is unable to maintain adequate oxygen levels in the blood due to a sudden impairment of lung function) and a heart attack related to a lack of oxygen This deficient practice affected 1 of 5 residents reviewed for medication errors. Immediate jeopardy began on 1/16/25 when the facility failed to ensure Resident #2 was administered the ordered dose of morphine. The immediate jeopardy was removed on 2/2/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D to ensure education is completed and monitoring systems put in place are effective. The findings included: Resident #2 was admitted to the facility 1/15/13 with diagnoses including respiratory failure with hypoxia (low oxygen level). Resident #2's Minimum Data Set (MDS) dated [DATE] indicated she had severe cognitive impairment, had no indications of pain, and did not take any scheduled or as needed pain relieving medications or opioids. Resident #2 did not use supplemental oxygen. Resident #2's physician orders dated 1/14/25 noted an order for Tramadol (narcotic pain medication) 50 mg per feeding tube every 8 hours for 3 days for pain after surgery. Resident #2's nursing progress note dated 1/16/25 at 3:30 AM written by Nurse #1 noted while performing personal care by staff, Resident #2 started crying and her oxygen saturation levels fell to 69% on room air. Nurse #1 noted she changed the tracheostomy inner cannula, suctioned her three times, raised the head of her bed, supplemental oxygen was started and increased to 10 liters per minute (lpm). Resident #2's oxygen saturation rose to 99% and the oxygen was titrated down to 4 lpm. Resident #2's oxygen saturation was 93% when retested and her vital signs were normal. Physician #1 was notified that Resident #2 had been given a dose of Tramadol at 12 midnight but was still in pain, so Physician #1 gave a new order for one dose of morphine 2 mg subcutaneously (SQ) to be given immediately and for laboratory tests to be done in the morning, and to titrate supplemental oxygen to keep Resident #2's oxygen saturation above 92%. Nurse #1 noted she gave Resident #2 morphine and the resident tolerated the medication well. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Night Cabinet Sign Out Log (a sign out sheet for a locked cabinet of backup medications) noted Nurse #1 took 2 vials of morphine, 2 ml. Nurse #2 also signed that 2 vials were taken. Resident #2's January 2025 Medication Administration Record (MAR) indicated Nurse #1 gave one dose of morphine 2 mg SQ on 1/16/25 at 3:30 AM. A nursing note dated 1/16/25 completed by Nurse #1 indicated at 4:40 AM, Nurse #1 was called to Resident #2's room by Nurse Aide (NA) #1. When Nurse #1 entered the room, Resident #2's oxygen saturation levels were 55%. Resident #2 was documented as crying and her tongue appeared blue. Nurse #1 raised the supplemental oxygen from 4 lpm to 8 lpm and notified Physician #1. Physician #1 ordered for Resident #2 to be sent out to the Emergency Department (ED). Nurse #1 noted she called Emergency Medical Services (EMS) and Resident #2 left the facility with EMS at 5:00 AM. In a phone interview on 1/30/25 at 2:14 AM, Nurse #1 said she was notified by NA #1 on 1/16/25 at 3:30 AM that Resident #2 was crying and appeared to be in pain. Her oxygen saturation levels were 69-70% on room air. She said she called for Nurse #2 to stay with Resident #2 while she got an oxygen concentrator. Resident #2 was placed on 10 lpm of oxygen. She said she called Physician #1, who told her to give morphine 2 mg SQ and to keep monitoring her (the resident). She said she (Nurse #1) went to the night cabinet, which held medications for when the pharmacy was not open, and prepared syringes from two vials of morphine. She said each vial contained 1 milliliter (ml) of morphine, so she believed she drew (the process of filling the syringe to prepare for administration) 2 mls to equal 2 mg. She said she had not written the physician's order down, but she verbally told the order to Nurse #2, who verified she drew 2 vials of the medication. She administered the morphine into Resident #2's legs, and she appeared to be stable. In a phone interview on 1/30/25 at 2:30 AM, Nurse #2 indicated she heard Nurse #1 ask for help with Resident #2 on 1/16/25 at approximately 3:30 AM. She (Nurse #2) went to Resident #2's room, helped apply oxygen and stayed with Resident #2 while Nurse #1 called Physician #1. Nurse #1 obtained an order for morphine and Nurse #2 went to the medication room night cabinet with her to verify the amount of morphine drawn. Nurse #2 said Nurse #1 verbally told her the order for the morphine was 2 ml, but Nurse #1 did not have the order written down so she (Nurse #2) did not know the actual dose prescribed. Nurse #2 said she verified the first vial was drawn because Nurse #1 showed her that 1 ml of medication was in a syringe, but she (Nurse #2) did not verify the amount of medication in the second syringe as Nurse #1 did not show the syringe or the vial to her while drawing it. She did not see the label on the vial. She saw Nurse #1 with two syringes of medication on the way to the room. Nurse #1 administered the morphine to Resident #2. Nurse #2 said Resident #2's oxygen levels stabilized at 95-96% and she went back to work in her office. She said she signed off on the Night Cabinet Sign Out Log at the end of her shift but did not read what Nurse #1 wrote on the sheet. Resident #2's EMS report dated 1/16/25 indicated Resident #2's oxygen saturation levels were 70% and she was experiencing respiratory distress with hypoxia. She continued on 8 lpm of supplemental oxygen. EMS noted her pulse was 70 (normal range 60-100), her respirations were 16 (normal range 12-20), her breath sounds in her lungs were normal, and she did not show signs of pain. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2's hospital documentation indicated the resident presented to the ED on 1/16/25 with shortness of breath and her oxygen saturation level was 50%. She was given 15 lpm of supplemental oxygen and preventative antibiotics to rule out a respiratory infection. Her physical exam approximately 2 hours after arrival to the ED indicated her pulse was 93, her respirations were 10, and her oxygen saturation levels were 81%. The ED physician noted that after further investigation, the hospital learned that Resident #2 had received 10 times the dose of morphine than what was ordered which likely lead to her episode of hypoxic respiratory failure. Resident #2 required up to 15 lpm of supplemental oxygen upon arrival to the ED and her oxygen saturation rose to 90%. She was also initially suspected to have demand ischemia (a type of heart attack due to the heart not getting enough oxygen, also referred to as an NSTEMI) in the setting of her degree of hypoxia. The ED physician assessed her with diagnoses of acute hypoxia respiratory failure requiring 15 lpm of supplemental oxygen and an NSTEMI. The hospital record indicated Resident #2 discharged from the hospital back to the facility on [DATE]. In an interview on 1/29/25 at 11:37 AM, Nurse #3 said on 1/16/25 at approximately 9:00 AM as pharmacist was doing the daily audit of the night cabinet of medication used the previous evening, the pharmacist asked her (Nurse #3) if there was a document showing how much morphine was taken and how much was discarded. The Night Cabinet Sign Out Log indicated 2 vials were removed from the cabinet. Nurse #3 text messaged Nurse #1, who told her there was none discarded. In a written statement dated 1/17/25, Nurse #1 said when she called Physician #1 on 1/16/25 he ordered morphine 2mg SQ. She (Nurse #1) went to the night cabinet in the medication room, took out morphine, and drew the amount from the vial and then another vial. Nurse #2 was in the medication room as well sitting in a chair at the desk. Nurse #1 indicated she wasn't sure if the morphine dose was verified. She (Nurse #1) had not written the order for the morphine but had her notes with her that she took to the medication room to verify the amount. She (Nurse #1) was not sure if the morphine dose was right but thought Nurse #2 would catch any mistakes and would have said something. The next morning (no time specified), Nurse #3 text messaged her (Nurse #1) about signing a sheet about the amount of morphine that was not given. Nurse #1 text messaged Nurse #3 back that there was no discarded amount, that she gave 2 vials. She then text messaged Unit Manager #2 that she thought she made a mistake with the morphine. During a phone interview on 1/30/25 at 2:14 AM Nurse #1 revealed that on 1/16/25 at approximately 9:00 AM, after her shift, she received a call from Nurse #3, who asked her for documentation of what she (Nurse #1) had done with the doses of morphine not used. Nurse #1 indicated she informed Nurse #3 she did not have any morphine left over after administration. She explained that later that same day (1/16/25), she called Unit Manager #1 and told her she realized she had given Resident #2 more morphine than ordered, that each vial contained 10 mg, not 1 mg as she had thought, so she had given Resident #2 a total of 20 mg of morphine. Nurse #1 said she should have written down the order so the dose could be verified by both nurses. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a statement written by Nurse #2 on 1/17/25, she indicated on 1/16/25 she did not see or observe an order written by Nurse #1 from Physician #1 for Resident #2. Nurse #1 verbally told Nurse #2 to give one dose of 2 ml of morphine SQ. Nurse #1 gave the first syringe to Nurse #2 to verify that 1 ml had been drawn. Nurse #1 then drew morphine into the second syringe, but did not ask Nurse #2 to verify the amount drawn, so Nurse #2 could not verify the amount. Nurse #1 had put the Night Cabinet Sign Out Log on Nurse #2's desk, so she (Nurse #2) signed the book and asked the next shift to put it back into the night cabinet. When she left work after her shift, she did not know anything was wrong. During the investigation, she (Nurse #2) said to Unit Manager #2 that in her opinion, 2 ml was a lot of morphine to give in an SQ injection, but she (Nurse #2) figured the doctor knew what he was doing so she did not question it. Resident #2's nursing progress notes dated 1/16/25 at 7:02 PM by Unit Manager #2 notified Resident #2's resident representative that Resident #2 receiving 20 mg of morphine that morning prior to transferring to the hospital. In an interview on 1/30/25 at 2:28 PM, Unit Manager #2 said she received a text message from Nurse #1 on 1/16/25 at 12:37 PM saying that she had used 2 vials of morphine because she had mixed up the amount of medicine in the vial and the dose per ml. There was 1 ml of 10 mg of morphine in each vial, and Nurse #1 told her that she drew 2 ml thinking it was 2 mg. Nurse #1 wrote in her statement to Unit Manager #2 that she did not write down the order before drawing morphine and administering the medication, which she (Unit Manager #2) believed would have prevented the mistake. In an interview on 1/30/25 at 4:45 PM, the Director of Nursing (DON) said, based on the facility investigation into the medication error for Resident #2, that because Nurse #1 had not written down the order for the morphine before verifying the dosage drawn from the vial, Nurse #2 was unable to verify that the correct amount of medication was ready to give. Nurse #1 should have written the order, taken the order with her to the night cabinet, showed it to Nurse #2, and both verified the amount removed and the equivalent dosage. In an interview on 1/31/25 at 11:42 AM, Physician #1 said he prescribed a low dose of morphine, 2 mg, due to Resident #2's history of not needing pain relieving medications beyond Tylenol and her tracheostomy and respiratory status. Resident #2 suffered an NSTEMI heart attack which the hospital physician attributed to the overdose of morphine. He said he was not sure if Resident #2 had a heart attack due to the morphine overdose causing a lack of oxygen to the heart or if she had a heart attack before the morphine was administered which was why she was showing signs of pain. The Administrator was notified of Immediate Jeopardy on 1/30/24 at 4:28 PM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure Resident #2 was free from significant medication errors when Nurse #1 administered 20 mg of Morphine instead of 2 mg of Morphine as ordered by the doctor. Resident #2 was non-verbal, vulnerable, and had a tracheotomy. She showed signs of pain by crying and grimacing on 1/16/25 at 3:30 AM and her oxygen saturation levels declined to 69-70%. Nurse #1 obtained an order for a one-time dose of morphine 2 mg subcutaneously. Nurse #1 and Nurse #2 went to the night medication cabinet. Nurse #1 verbally received the doctor's order but did not write the order for Nurse #2 to verify the correct amount was obtained. Each vial of morphine had 1 milliliter (ml) of morphine, which was equivalent to 10 milligrams (mg) of morphine. Nurse #1 drew 2 vials of morphine. Nurse #2 validated the amount drawn for the first vial but not the second vial. Nurse #1 administered both syringes of morphine to Resident #2 equal to 20 mg of morphine. At 4:40 AM, Resident #2's oxygen saturation levels dropped to 55%, she was crying, and her tongue was blue. The physician was notified at 5:00 AM and ordered the nurse to send Resident #2 to the hospital. Resident #2 was sent to the hospital on 1/16/25 at 5:00 AM. The hospital documented Resident #2 oxygen saturation levels were 50% on room air with no supplemental oxygen. She was diagnosed with acute on chronic hypoxic respiratory failure due to accidental overdose and a Non-ST-segment elevation myocardial infarction (NSTEMI, a type of heart attack that occurs when there's a partial blockage in a coronary artery) likely due to demand ischemia due to overdose. She was put on 15 liters of oxygen and admitted to the hospital. One resident suffered because of this medication error with the potential for all 119 residents to be impacted if needing medication prescribed through a verbal doctor's order that must be transcribed by the nurse and verified. Immediately upon notification of this error, on 1/16/25, the 24-hour nursing report was reviewed by the unit nurse manager and the assistant director of nursing, and no other prn (as needed) medications had been given per verbal order. This was confirmed by the on-call doctor to the Director of Nursing on 1/31/25. In addition, there was no medication error reports submitted to the director of nursing 24-hours prior to and 24-hours afterwards. The medication night cabinet was checked by pharmacy on 1/16/25, and no other medication had been removed. Nurse #1 was reported to the NCBON on 1/16/25 by the Assistant Director of Nursing. Board on Nursing contacted Director of Nursing and Nurse #1's and #2's actions were discussed on 1/21/25. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 1/17/25 A Just Culture Algorithm was performed for staff involved to determine appropriate outcomes for each of them by the Unit Nurse Manager. Medication dose calculation test, created by the nurse educators and approved by the Director of Nursing, was implemented on 1/16/25 by the nurse educators. Nurse educators will be responsible for keeping track of who needs the test, and all new hires through staff development as agreed upon with the Director of Nursing. All nurses will be tested by 1/31/25 with those involved being tested immediately prior to return to duty on 1/16/25. The remaining nurses will be tested upon their return to duty. All new nurses will be tested upon hire with a state approved medication administration test. Competency of Nurse #1 was verified by a floor shift nurse supervisor utilizing the Medication Administration Evaluation tool on her next scheduled shift. completed 1/16/25. (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All Nurses were re-inserviced by the unit nurse managers on medication night cabinet policy and procedure to include obtaining a doctor's order, immediately transcribing it, and having the order verified by a second nurse prior to removing the medication. This was completed on 1/16/25. The Unit Nurse Managers and Nurse Educator were inserviced on 1/31/25 by the Director of Nursing to ensure that when a verbal order is given by a doctor it is transcribed by the nurse receiving the verbal order and a second nurse will verify the doctor's order by calling the doctor back to confirm it for all medications not filled by pharmacy or over-the-counter medications. All other nurses will be inserviced upon return to duty by the Unit Nurse Manager, the floor shift nurse supervisor or the Director of nursing. To be completed by 2/1/25. On 1/17/25 the Pharmacy Director and the Assisted Director of Nursing discussed the occurrence, and the Pharmacy Director decided to exchanged Morphine in the night cabinet from 10 mg vial to 5 mg vial. This was completed by the Pharmacy Director on 1/17/25. In October of 2024, The Director of Nursing and Unit Nurse Managers implemented nurses receiving annual training on medication administration best practices and competencies annually by the nurse educators. On 1/21/25 it was also decided by the Director of Nursing that all nurses will take the state approved medication administration written test during annual written competencies, The nurse educators were informed of this decision by the Director of Nursing. Effective immediately. Date of immediate jeopardy removal 2/2/25. An onsite validation was conducted on 02/06/25. The initial audit and reporting of Nurse #1 to the NCBON was verified. A review of the in-service records revealed that education was provided to all Licensed Nurses on medication dose calculations. All nurses completed and passed an exam that tested their knowledge and competency on medication dosage. Also, all nurses were educated on the facility's policy and procedures for the medication night cabinet, which included having a second nurse verify the order obtained from the physician and transcribed by the first nurse. Education was provided to the Unit Nurse Managers and Nurse Educator by the DON as indicated. Interviews conducted with nurses verified their knowledge of this education. The immediate jeopardy removal date of 02/02/25 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34A002	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Berry Neuro-Medical Treatment Center	400 Old Smithfield Road Goldsboro, NC 27533

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record reviews and staff interviews, the facility failed to have a complete and accurate medication administration record for 1 of 3 residents reviewed for medical record accuracy (Resident #2). The findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (low oxygen level). Resident #2's physician orders dated 1/14/25 noted an order for Tramadol (narcotic pain medication) 50 milligrams (mg) per feeding tube every 8 hours for 3 days for pain after surgery. Resident #2's physician progress notes dated 1/15/25 noted the resident returned to the facility the previous day (1/14/25) after surgery to remove kidney stones and to place an indwelling ureteral stent (a tube inserted to help urine drain from the kidney to the bladder). Resident #2's nursing progress note dated 1/16/25 at 3:30 AM written by Nurse #1 noted she had given Resident #2 a dose of Tramadol at 12 midnight. Resident #2's January 2025 Medication Administration Record (MAR) did not document that Tramadol had been administered to Resident #2 at midnight. The entry was blank. In an interview on 1/30/25 at 3:07 PM, Nurse #1 said she forgot to sign the MAR when she gave Resident #2 Tramadol and that she should have signed it when she gave the medicine. In an interview on 1/30/25 at 4:45 PM, the Director of Nursing (DON) said the nurses had been trained on completing the MAR accurately when medications and treatments were given.