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	10/09/2025

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.

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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 staff interviews, the facility failed to provide a safe transfer and failed to provide supervision to a resident, left unattended on the commode for 2 of 5 residents reviewed for accidents (Residents #114 and #85).The findings included: 1.Resident #114 was admitted to the facility on [DATE] with diagnoses that included dementia, profound intellectual disabilities, stroke and osteoporosis. Review of Minimum Data Set (MDS) dated [DATE] revealed the Resident was severely cognitively impaired, had impairment of upper extremities on one side and was dependent on staff for transfers. Resident #114's care plan initiated on 7/16/21 revealed a care plan was in place for assistance for safe transfers. Staff were to provide 2 people assisting with stand/pivot transfers and assistive devices / gait belt for all transfers. Review of HCT (Heath Care Technician) #2's a (contract staff) written statement provided to the facility on 4/24/25 revealed that on 4/24/25 she brought Resident #114 to the activity room between 10:44 AM and 10:45 AM. When she witnessed HCT #1 to stand and pivot Resident #114 into the chair by herself, made a comment and slammed him down in the recliner. HCT #2 stated that she did not want to get anyone in trouble but at the same time it was all about the patients' safety and any unusual conflict observed regarding the patients' health and safety. Review of HCT #1's (contract NA) written statement provided to the facility on 4/24/25 revealed that on 4/24/25 she was asked by the Standards Director to review a video of the incident and describe what she saw. HCT #1 stated she put Resident #114 (she did not shove him) in his recliner. When asked about his code status, HCT #1 stated he was a two-person transfer. The Standards Director asked me what she did wrong, and she admitted that she transferred the resident alone and it was wrong to not provide a safe transfer. Review of the facility Internal Investigation Report dated 4/24/25 revealed the Standards Director and Director of Nursing (DON) viewed the Video Review footage. The physical contact was shown at 10:30 am on 4/24/25. The video showed HCT #1 transfer Resident #114 into the recliner without assistance and let him fall into the chair instead of assisting him down. At 10:33 am the video showed HCT #2 entering the room as she witnessed NA #1 transferring the Resident. HCT #1 and HCT #2 did not respond to attempts to contact them via telephone for an interview. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 10/08/25 at 3:44 PM the prior Director of Nursing (DON) stated in the video Resident #114 had a gait belt on. HCT# 1 stood the Resident up, turned him towards the chair and instead of holding the gait belt, just let go and he set/fell hard into the recliner. The Nurse assessed the Resident, there were no noted injuries, and the Resident was not upset. In an interview on 10/09/25 at 2:45 PM the Administrator stated that not one person in the facility was a one person assist, and HCT #1 should have called another HCT to assist transfer Resident #114. On 10/08/25 at 3:25 PM the Standards Director stated that HCT #1 should have called another HCT to assist with transferring Resident #114 to his chair and used the gait belt. The facility provided the following corrective action plan with a completion date of 5/13/25. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Staff (HCT) # 1 used an improper stand/pivot transfer during a resident transfer on 4/24/25. On 4/24/25 Staff #1 transferred resident #114 without assistance. This was witnessed and reported by Staff #2. The resident was not injured in the transfer and did not change his expression or mood. He was assessed by nursing with no negative findings. Staff #1 was immediately removed from the area and placed on investigatory leave by the Director of Nursing. Resident #114 was assessed by nursing. Resident one showed no signs of discontentment. Advocacy and Management initiated an investigation involving Staff #1 and Resident #114. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility identified there is a possibility that any resident served at this facility could be affected by staff not following specified lifting and transferring procedures. Current population is 90% non-ambulatory, and all require staff assistance to meet their needs. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/24/25 Campus wide in-person in-service/education began to ensure understanding Code Status forms (these identifies the needs of residents to include how they should be transferred and/or lifted). The facilities nurse managers and floor shift nurse supervisors present were educated/in serviced the afternoon of 4/24/25 by the Director of Nursing. The nurse manager or a delegate provided educational in-services in their areas. Completed 4/29/25 for all staff members who worked. Those missed will be in-serviced upon return to work and before working with residents. (This includes those on extended leave). 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A monitoring tool was developed by the Quality Data Manager and put into place on 4/25/25. The unit nurse managers or designee completed monitoring daily of lifting and transfers on 10% of residents within their assigned clusters for 1 week with training provided on the spot for any deficient practice noted. The unit management team completed random monitoring of lifts and transfers for an additional week equaling 12 additional monitoring checks conducted. Completed 5/12/25. Incident was reviewed by an Ad Hoc Committee of executive leadership on 4/30/25 to include the director, director of nursing, medical director, and deputy director of standards. No additional concerns were noted. This information regarding lifting and transfers will be presented during the quarterly Quality Assurance Performance Improvement (QAPI) meeting by the Quality Data Manager on 5/13/25. It will be reviewed quarterly to monitor trends or deficiencies and to determine whether additional measures-such as root cause analysis, performance improvement projects, or other appropriated tools-should be implemented. Any member of the QAPI Committee may also call for an ad hoc meeting to address urgent trends or specific cases as deemed appropriate. Onsite validation was completed on 10/09/2025 through staff interviews and record reviews. Inservice education was confirmed to be provided on the code status to include the needs of residents and how they should be transferred and/or lifted. Staff were interviewed to validate the in-service education was completed. Staff were observed providing resident transfers with no concerns noted. Audits were reviewed with no concerns noted. Staff interviews confirmed they had received Education on residents transfer needs and they stated they had the opportunity to ask questions on resident code/ transfer status. The facility's corrective action plan completion date of 5/13/2025 was validated. 2. Resident #85 was admitted to the facility on [DATE] with diagnoses that included profound intellectual disabilities, seizure disorder and dysphagia. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 was severely cognitively impaired, at risk for falls, was dependent on staff when walking and requiring assistance with activities of daily living (ADL). Resident #85's care plan initiated on 7/21/20 revealed a care plan was in place for assistance to the toilet for bowel elimination needs. The resident was further care planned for staff to aid him when he is walking with a gait belt or to sit him in the wheelchair and not leave Resident #85 alone in the bathroom for toileting. Care plan showed staff were required to stay close by to prevent falls or injury. Review of HCT (Heath Care Technician) #5's written statement provided to the facility on 4/9/25 revealed that on 4/7/25 she took Resident #85 to the bathroom between 10:00 and 10:30 p.m. and sat him in the toilet and went to the breakroom. HCT #5 stated that she sat down in the breakroom and put her head down because her head was hurting. HCT #5 stated that she then heard the nurse say that there was a client who fell, and it was her client. HCT #5 stated that she had left Resident #85 on the toilet for a few minutes and when she got to the bathroom another staff member had placed Resident #85 on his wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of HCT #3's written statement provided to the facility on 4/9/25 revealed that on 4/7/25 at 10:30 p.m. he noticed that HCT #5 had taken Resident #85 to the bathroom but took too long to return. HCT #3 stated that he went down the hall thinking HCT #5 was in Resident #85's room but no one was in the room. HCT #3 stated that he walked to the bathroom and saw Resident #85 on the floor laying beside the toilet. HCT #3 stated that he asked HCT #4 to come and witness. HCT #3 stated he called Nurse #1 who came and did an assessment on Resident #85. HCT #3 stated that Nurse #1 reported that she had seen HCT #5 in the breakroom sleeping. HCT #3 stated that after he assisted Resident #85 in the wheelchair, HCT #5 walked into the bathroom around 11:20 p.m. and took Resident #85 to his room and took his vitals. A review of the facility Internal Investigation Report dated 4/11/25 revealed that after interviews of staff during the incident and reviewing the surveillance video, it was determined that HCT #5 was off the facility for an extended period of about 44 minutes leaving Resident #85 unattended the whole time. HCT #3 and HCT #5 did not respond to attempts to contact them via telephone for an interview. In a phone interview 10/8/25 at 12:08 p.m. the Floor Shift Nurse Supervisor stated that HCT #3 called her to come to the bathroom where Resident #85 had fallen after the resident was left unsupervised in the toilet by HCT #5. She stated HCT #5 should have remained with Resident #85 while he was using the toilet as per his care plan. She further revealed that HCT #5 was immediately sent home for failure to supervise Resident #85 while he was in the bathroom. In a phone interview with HCT #4 on 10/8/25 at 11:05 a.m. she stated that HCT #3 called her to come to the bathroom to witness Resident #85 on the floor after a fall. She stated she came to the bathroom and Nurse 1 arrived accompanied by the Floor Shift Nurse Supervisor. She stated she left the bathroom immediately after to attend to her residents. In a phone interview on 10/08/25 at 3:23 p.m. with Nurse #1 she stated that she witnessed HCT #5 sleeping in the breakroom earlier at about 11:00 p.m. and saw Resident #85 on the bathroom floor when she was called by HCT #3. She stated that she assessed and completed neuro checks on Resident #85. Nurse #1 stated that HCT #5 was supposed to stay with Resident #85 in the bathroom as per care plan but did not. During an interview on 10/9/25 at 8:59 a.m. with the Deputy Director of Standards she stated that HCT #5 should have exchanged responsibility with another HCT to come and supervise Resident #85 in the bathroom before she left the resident in the bathroom. An interview on 10/09/25 at 12:32 p.m. with the Administrator revealed it was standard practice that a resident cannot be left in the bathroom unsupervised. She stated that HCT #5 should have asked another staff member to supervise the resident while she was away but did not. The facility provided the following corrective action plan with a completion date of 6/26/25: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately after finding the resident on the bathroom floor at approximately 11:08pm on 4/8/25, HCT #3, requested another HCT #4 come to the bathroom while he called the nurse. HCT #4, came to the bathroom at 11:09pm. By 11:10pm, HCT #3 had called the nurse and notified Nurse #1 that a resident was found on the floor of the bathroom. At 11:21pm Nurses #1 and #2 responded. The resident has a small bruise on the left side of his head. He appeared otherwise, normal. As evident by him smiling and twirling string between his fingers. He showed no signs of distress. The resident should be visually supervised while toileting. Floor Shift Nurse Supervisor and Facility Support Specialist were notified. Facility Support Specialist called the Director who instructed her to ensure a plan of protection was in place and the Floor Shift Nurse Supervisor assisted the staff with making a report to advocacy. The staff responsible, HCT #5 was relieved of her duties by the Floor Shift Nurse Supervisor and placed on investigatory leave on 4/8/25 while management and advocacy conducted investigations into the incident. The resident's guardian was contacted by the Home Life Specialist on 4/9/25. Management and advocacy investigations were initiated on 4/9/25 and concluded on 4/11/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents could potentially be impacted by lack of supervision, a negligent practice. As a result, the following was put into place: Beginning on 4/9-17/25 all CNAs, and Nursing staff were re-in-serviced on supervision levels for all residents assigned and the Code Status Condition sheets were reviewed by the Unit Nurse Manager and Floor Shift Nurse Supervisors for accuracy and clarity with updates made as needed. Supervision levels will be monitored daily by the Home Life Support Assistant or charge person for every group home. The cluster management staff will monitor every 2 hours to ensure proper supervision is being provided and to support staff as need. This information was shared with the Unit Nurse Managers on 4/9/25 by the Director of Nursing and they shared with their management teams. Completed on 4/17/25. 3. Address what measures were put in place to ensure the deficient practice will not recur: - Code status and Condition sheets were reviewed for the entire facility. They were updated to ensure that all levels of supervision are clearly identified, and all staff were in-serviced on the Code Status and Condition Sheet for the residents. This was completed on 4/9/25 by the Unit Nurse Managers. - Care Plans were reviewed by the MDS Nurses to ensure that supervision levels are clearly identified in the care plan. Completed 4/11/25. All staff were in-serviced on Neglect by the managers/supervisors or designee of the area. Staff not present were in-serviced prior to working with residents. Completed 4/17/25. The investigation process was in-serviced with all staff to include the plan of protection and completing the 24-hour investigation report to Health and Regulations by Department Heads, Compliance Officer, Managers/Supervisors, Unit Nurse Managers and Floor Shift Nurse Supervisors. Completed 4/17/25. All direct care staff were in-serviced on the exchange of responsibility expectation by their Floor Shift Nurse Supervisor, or Unit Nurse Manager. Completed 4/17/25 On 4/10/25, in-servicing was initiated by the Unit Nurse Managers to include all nursing staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10-11/25 all staff were in-serviced by the compliance officer, managers, and supervisors' campus wide. All in-services were completed by 4/17/25 or before staff worked in a resident's home. 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. A 100% audit was initiated on 4/9/25 that was completed on 4/14/25 concerning supervision levels of residents. This was completed by the unit consultant and the risk manager. The Risk manager reported all areas reviewed were in 100% compliance with supervision levels and have the code status and condition sheet on their person. She found that due to new admissions some code status and condition sheets were in the process of being updated (Cluster 1). The unit consultant found that 30% of the areas he monitored were out of compliance and immediate steps were taken to correct the issues/concerns noted. The Floor Shift Nurse Supervisors will monitor their assigned areas daily for one week to ensure proper supervision is maintained for all residents. The unit nurse managers will monitor daily for one week. Performance Improvement Specialist will randomly monitor all homes to ensure compliance and to address any concerns noted as needed for two weeks. The results of their monitoring will be submitted to the Quality Data Manager who will compile the information, conduct an additional audit of 15% of the population served to determine compliance. This information will be shared during Clinical Review Team meetings as needed based upon the development of trends or lack of improvement in areas identified and discussed during QAPI meetings quarterly to determine next steps and opportunities for improvement. Implemented 4/9/25 and completed on 4/17/25. Performance Improvement Specialist will monitor for 3 months with the Quality Data Manager following up with an additional audit of 15% of the population randomly selected. This will be discontinued once we have 100% compliance with maintaining supervision levels as identified by the Care Plans. First meeting was held on 5/13/25. The management team met and discussed the incident and outcomes on 6/24/25 and presented it to the clinical review team on 6/25/25. Per report we continued 100% compliance with staff following supervision levels and staff having the code status and condition sheets on their person. Validation of the plan of correction. A review was completed of the signature pages for the in-service training for staff campus wide on abuse, neglect, exploitation, exchange of responsibility, code status and condition sheet and plan of protection. Interview with staff showed they received in-service training regarding abuse, neglect, exploitation, exchange of responsibility, code status and condition sheet and plan of protection. A review of the audit tool used by the facility to monitor performance was found to be completed according to the plan of correction. The monitoring documentation showed the audits were completed on 7/17/25. The facility's corrective action plan completion date of 6/26/25 was validated.