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	06/23/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff the facility failed to ensure a resident, whose care plan noted she should be allowed to sit on the floor if the resident chose to do so, was treated with dignity when a Nurse Aide lifted the resisting resident to her feet and dragged her to her room. This was for 1 (Resident # 1) of 3 residents reviewed for staff treatment.The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE]. Resident # 1 had diagnoses which included profound intellectually disability and blindness in the right eye.Resident # 1's Minimum Data Set assessment, dated 4/26/26, coded Resident #1 as severely cognitively impaired and ambulatory with supervision. Additionally, Resident # 1 was coded as having behaviors that were not directed at others.Resident # 1's care plan, dated 5/15/26, revealed the following information. Resident # 1 was identified to at times have self-injurious behavior, loud vocalizations, mouthing inedible objects, and having difficulty sleeping at night. Although not all inclusive of interventions, staff were directed to provide verbal redirection, provide brief, non-restrictive physical prompts, and assess for signs of physical needs or physical discomfort and remedy if possible. The care plan also included the information that Resident # 1 was at risk for falls due to her blindness, behaviors, and cognitive impairment. The care plan further noted Resident # 1 was independently ambulatory by trailing walls/furniture in familiar settings and that she was nonverbal. An added notation on the care plan was documented as, She does have a history of getting on the floor and scooting around when agitated or when she wants to be alone. This preference will be honored, keeping her safe and free from injury while doing so.Review of facility investigative records into incidents which could potentially constitute abuse revealed the following information. On 6/15/26 the Administrator was viewing facility video hallway surveillance footage for a non-related issue to abuse or dignity. While viewing the footage the Administrator saw Nurse Aide # 1 pulling Resident # 1 at 6:11 AM from a seated position and dragging Resident # 1 down the hallway.On 6/23/26 at 12:50 PM the facility video footage was viewed by the surveyor with the Director of Nursing (DON) and other administrative staff being present. The timeframe of video watched by the surveyor was from 6:09 AM until 6:12 AM on 6/15/26. The following was observed on the facility video. There was no sound to the video. No other person could be seen on the video at the beginning of the footage except for Resident # 1. Resident # 1 was walking in the hallway before she stopped and sat down in the hallway with her back to the camera. Resident # 1 was not observed to be hitting her body against anything. Only her back could be viewed. Nurse Aide (NA) # 1 walked past Resident # 1 and then returned to where Resident # 1 was seated. Upon her return, NA # 1 walked to the back of Resident # 1. With NA # 1's back also to the camera, NA # 1 attempted to reach under Resident # 1's arms and lift Resident # 1. Resident # 1 remained seated. After being unsuccessful in lifting Resident # 1, NA # 1 then walked around Resident # 1 from the resident's backside to face Resident # 1. NA # 1 remained standing and looking down at Resident # 1 while also appearing to be talking to Resident # 1, who remained seated. Resident # 1 was not observed at that point to be resisting or pushing against NA # 1. It also did not appear Resident # 1 was doing anything self-injurious from the degree that she could be seen on video. NA # (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 then tried to lift Resident # 1 from the front by taking Resident # 1's hands and trying to pull her to a standing position. Resident # 1 then started to push back, swat at NA # 1 with her hands, and leaned back away from NA # 1 while seated. NA # 1 then walked back around from facing Resident # 1 to the back of Resident # 1. NA # 1, at that point, then had her back to the camera. NA # 1 again reached under Resident # 1's arms and in a quick movement lifted Resident # 1 to a standing position. NA # 1 appeared to use her body to brace Resident # 1 up against her while keeping her (NA # 1's) arms under the resident's arms and around Resident # 1's midsection. NA # 1 turned both her body and Resident # 1's body to the side and drug Resident # 1 down the hallway to the resident's room (Resident # 1 was not moving her feet in a walking manner but was being pulled). Upon arriving close to Resident # 1's room, NA # 1 then turned her body fully around so that Resident # 1 was totally drug backwards into the room.NA # 1 was interviewed via phone on 6/23/26 at 1:06 PM and reported the following information about the incident and what was seen on the video footage of her and Resident # 1 on 6/15/26. There was another resident (Resident # 2) who also walked hallways at times. Resident # 2 had been roaming the hallways prior to her (NA #1) taking Resident # 1 to her room. She and another Nurse Aide were assigned to 12 residents on their hall the night of the incident. The twelve residents included Resident # 1 and Resident # 2. The other Nurse Aide was busy with another resident other than Resident # 1 and Resident # 2. Resident # 1 had been walking the hallways and was making noises and screaming to the top of her lungs before the incident. When she (NA # 1) noted Resident # 1 on the hallway floor, she wanted to de-escalate the situation and get Resident # 1 back to her room. She (NA # 1) was also concerned that Resident # 2 would push or do something to Resident # 1 because Resident # 2 had a history of pushing other people out of the way if they got in her pathway. She did not want Resident # 1 hurt by Resident # 2. The only other staff member was a housekeeper on the hallway at the time Resident # 1 was on the floor. NA # 1 was further interviewed regarding what she was taught to do if a resident was resisting assistance back to a room and replied she was taught to give them time and then if needed it was allowed to bring them to a stance, cross their arms and help them to their room. NA # 1 was also interviewed if there were other staff members who could have helped on the occasion if she was worried about Resident # 1's safety and replied that there was an AOD (Administrator on Duty) and a Nursing Supervisor. NA # 1 reported she had tried to call the AOD and Nursing Supervisor while Resident # 1 was up walking and screaming and they did not pick up.The housekeeper (Housekeeper # 1) who had been present on the date of the incident, was interviewed on 6/23/26 at 2:05 PM and reported the following information. She usually arrived at work at 5:55 AM. On the date of the incident, Resident # 1 had been up in the hallway and yelling when she first arrived. She had not seen another resident at that time roaming around the hallway. Resident # 1 then sat down in the hallway. After Resident # 1 sat down, she did not yell. Resident # 1 did hold her stomach as if it was bothering her, but she was calmer and quieter on the floor. That was her safe place. Housekeeper # 1 had gone into the housekeeping closet but peeked out to see that NA # 1 had approached Resident # 1 and was talking to her. She could hear NA # 1 telling Resident # 1 such things as she (Resident # 1) needed to get up and that she (Resident # 1) could not stay there all morning because she (NA # 1) had other residents to take care of. NA # 1 appeared to be calm while talking to Resident # 1 who was also calm on the floor. Then NA # 1 reached for Resident # 1's hands to try to pull her to a standing position. When NA # 1 tried to get her up, Resident # 1 started resisting and doing extra yelling. Then NA # 1 went behind Resident # 1, and picked her up, and took her down the hallway. From what she saw, she did not think NA # 1 hurt Resident # 1 or was intending to hurt the resident.Resident # 1 was observed on 6/23/26 at 10:07 AM to be seated calmly in her rocking chair within her room and showing no signs of distress. She was not verbal.The Unit Manager of Resident # 1's and Resident # 2's Unit was interviewed on 6/23/26 at 10:09 AM and reported the following information. Resident # 1 could stand and walk on her own. She had not known Resident # 1 to be combative with others. Resident # 2 also walked independently, and she had not known Resident # 2 to be combative with others.The AOD, who had been assigned for the nightshift when the 6/15/26 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident occurred, was interviewed on 6/23/26 at 3:43 PM, and reported the following information. At times, Resident # 1 would go into behaviors. If she had been alerted on 6/15/26 that Resident # 1 had been doing so and that there had been a phone call for help, then she would have put that information in her report.Interview with the DON on 6/23/26 at 4:00 PM revealed the following information. The incident had been an incidental finding by the Administrator when the video footage was being watched for an unrelated incident. He had looked at the shift report and there had been no calls for help on 6/15/26 to the AOD or the nursing supervisor. There was always a campus nursing supervisor and a campus administrator on duty who took calls. Either of these staff members could have been called to deal with Resident # 1 if she had been having behaviors before she sat on the floor. Also, in each building there were other hallways and therefore there had been a total of 2 nurses and 8 health care technicians (nurse aides) who were on duty during the incident in Resident # 1's building. Some of these other staff members could have been called for assistance also. The resident's care plan noted she at times liked to sit on the floor. The DON's expectation was that NA # 1 should have referenced the care plan, allowed the resident to sit on the floor, and if she had been demonstrating behaviors which required assistance or was unsafe for some reason, then other staff should have been called rather than dragging her to her room. Following the incident, NA # 1 was terminated and the facility had started a complete plan of correction but had not yet completed it.The Administrator, who had other obligations off campus on 6/23/26 and was not present during the survey, was interviewed via phone on 6/23/26 at 5:15 PM. According to the Administrator, they had come across the incident while reviewing the footage, recognized it as inappropriate and were taking corrective measures.