

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345210	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER Elizabethtown Healthcare & Rehab Center			STREET ADDRESS, CITY, STATE, ZIP CODE 208 Mercer Mill Road , Elizabethtown, North Carolina, 28337	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments The survey team entered the facility on 09/02/25 to conduct a recertification and complaint investigation survey and exited on 09/05/25. Additional information was obtained on 09/16/25. Therefore, the exit date was changed to 09/16/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # ID584E-H1.	E0000		09/19/2025
F0000	INITIAL COMMENTS The survey team entered the facility on 09/02/25 to conduct a recertification and complaint investigation survey and exited on 09/05/25. Additional information was obtained on 09/16/25. Therefore, the exit date was changed to 09/16/25. Event ID # ID584E-H1. The following intake was investigated: 886404 5 of the 5 complaint allegations did not result in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G)	F0000		09/16/2025
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff, Nurse	F0689	"Past Noncompliance - no plan of correction required"	09/16/2025

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 reverse for further 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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F0689 SS = G	<p>Continued from page 1 Practitioner and the Medical Director's interviews, the facility failed to use the mechanical lift to transfer a non-weight bearing resident from a chair to the bed and instead used the stand and pivot method for transferring (A technique for moving where a resident stands with assistance and pivots on their feet then sits. This technique requires the ability to bear most of their body weight.) which resulted in a comminuted (the bone is broken into multiple small pieces) mildly displaced (bone fragments are slightly out of alignment) fracture of the distal tibia (large bone of the lower leg near the ankle) and proximal fibula (upper section of smaller bone in the lower leg just below the knee). This occurred for 1 of 3 residents reviewed for accidents (Resident #77).</p> <p>Findings included:</p> <p>Resident #77 was admitted to the facility on 2/11/22. Diagnoses included osteoarthritis of the knee (a breakdown of the protective cartilage that lines the bones and joints), osteopenia (a loss of bone density causing the bone to weaken and an increased risk of fractures) and dementia.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 6/12/25 revealed Resident #77 was severely cognitively impaired and required extensive two-person assistance with transfers, and activities of daily living (ADLs). Resident #77 had no falls, a weight of 127 pounds, and received blood thinning medication. She was on Hospice services.</p> <p>The care plan dated 6/15/25 revealed Resident #77 had an ADL self-care deficit related to weakness, poor endurance, and poor cognition. Interventions included in part; total dependence with transfers using the mechanical lift with two-person assistance.</p> <p>A progress note dated 8/4/25 at 10:30 AM documented by the Hospice nurse revealed in part; this writer received notification today from the Hospice aide that Resident #77's right lower leg was noted to be bruised, swollen, and painful to touch this morning. Upon arrival Resident #77 was resting in bed with her eyes closed and aroused easily with verbal and tactile stimuli. She was oriented to person and unable to make her needs known and appeared weak and frail. Her right lower leg was bruised, bluish purple in color, swollen, and painful to touch.. She yelled out "it hurts, it</p>	F0689		

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F0689 SS = G	<p>Continued from page 2</p> <p>hurts" when the area was touched and randomly when the area was not touched. Resident #77 was unable to state what happened to her right leg. The facility staff nurse (Nurse #2) was made aware of the right leg status. Resident #77 was medicated with Tylenol 650 milligrams during this visit for pain. Nurse Practitioner #1 is making rounds at the facility today and was notified. Resident #77 requires total assistance with all activities of daily living.</p> <p>A progress note dated 8/4/25 at 3:19 PM documented by Nurse #2 revealed Resident #77's x-ray impression revealed an acute nondisplaced oblique fracture of the proximal fibula, and distal tibia. Nurse Practitioner #1 was made aware.</p> <p>A progress note dated 8/4/25 at 6:32 PM documented by Nurse Practitioner #1 revealed in part; Resident #77 currently received hospice care. Nursing staff reported the presence of bruising on her right leg. Upon assessment, the right lower extremity exhibited mild swelling, and bluish discoloration consistent with bruising, and tenderness upon palpation. There was no active bleeding. The x-ray findings revealed an acute nondisplaced oblique fracture of the proximal fibula, and distal tibia. An orthopedic consult was ordered along with Tramadol 50 milligrams every 12 hours for pain.</p> <p>On 8/5/25 at 3:45 PM Resident #77 was transported by emergency medical services (EMS) to the hospital.</p> <p>A hospital note dated 8/5/25 at 10:56 PM revealed Resident #77 was seen in the emergency department, and vital signs were stable. X-rays showed oblique comminuted mildly displaced fracture of the distal tibial and proximal fibula. Orthopedics was consulted and recommended admission for pain control, there is no anticipated surgical intervention.</p> <p>A hospital orthopedic note dated 8/7/25 at 1:17 PM revealed Resident #77 was evaluated for a mildly displaced fracture of the distal tibial diaphysis and proximal fibular diaphysis. Impressions revealed fracture and osteoarthritis of the knee and osteopenia. Resident #77's Responsible Party stated Resident #77 had been non-ambulatory for several years, using a wheelchair and a slide board. She developed a urinary tract infection six months ago and has been bed bound</p>	F0689		

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F0689 SS = G	<p>Continued from page 3 since that time. The plan of care was to keep the splint in place and remain non-weight bearing. No orthopedic intervention was warranted at this time. Resident #77 returned to the facility.</p> <p>A facility investigation report on 8/5/25 revealed interviews were conducted with Nurse Aide #9 and #10 and concluded that the improper transfer of Resident #77 resulted in the fracture of the tibia and fibula. The Kardex audits concluded that several of the Kardex's needed to be updated and were updated today 8/5/25 by the Director of Nursing and the MDS nurse. Both Nurse Aide #9 and #10 were suspended until the investigation was complete. The timeline of events revealed:</p> <p>On 8/3/25 Resident #77 was up in her Geri chair most of the day at the nurses station. At approximately 7:00 PM Nurse Aide #9 and #10 went in to transfer Resident #77 back to bed. The lift sling was not positioned properly. They tried to reposition the sling, but Resident #77 resisted. Nurse Aide #9 and #10 got on each side and stood Resident #77 up and pivoted her a few steps to the bed from the chair.</p> <p>On 8/3/25 through 8/4/25 the night shift nurse and nurse aides (7:00 PM through 7:00 AM) reported Resident #77 rested well during the night.</p> <p>On 8/4/25 approximately 8:30 AM the nurse aide found a bruise to the outer right leg (shin) and notified Nurse #2. Nurse #2 notified the Nurse Practitioner and an x-ray was ordered. The x-ray resulted with a non-displaced fracture of the right lower leg.</p> <p>The root cause analysis determined Nurse Aide #9 and #10 did not follow the policy, or Resident #77's Kardex on the proper transfer which led to Resident #77 sustaining the injury.</p> <p>During an interview on 09/05/25 at 3:08 PM Nurse Aide #9 stated she had been a nurse aide for many years and was distraught when she learned that Resident #77 had fractured her leg after she and Nurse Aide #10 transferred Resident #77 back to bed on Sunday evening (8/3/25). Nurse Aide #9 stated they initially tried to transfer Resident #77 from the chair back to her bed using the mechanical lift, but the lift sling was not positioned right and kept sliding up her back because Resident #77 was agitated and flailing her arms. They decided since there were two of them and Resident #77 was small enough that they could get on each side of</p>	F0689		

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F0689 SS = G	<p>Continued from page 4 her and have her stand and pivot over to the bed. Nurse Aide #9 stated she was not aware that Resident #77 was non weight bearing and it never occurred to her that having Resident #77 stand and pivot could cause a fracture. She stated Resident #77 did not have any signs of an injury and no symptoms of pain or discomfort after being put back to bed or during the night. Nurse Aide #9 stated she was not aware of any injury until the following day (8/4/25) when she talked with the DON. She received education on 8/4/25 and was suspended from work. Nurse Aide #9 stated Resident #77's transfer status was listed on the Kardex which was located in her electronic medical record. Nurse Aide #9 indicated she did not review the Kardex that evening before attempting to transfer Resident #77. She stated she knew how to use the sling but due to Resident #77 becoming agitated they decided to stand and pivot her to the bed. Nurse Aide #9 stated she had provided care to Resident #77 many times and thought she would be safe to stand and pivot with two-person assistance, but she should not have done that.</p> <p>During a phone interview on 9/5/25 at 3:45 PM Nurse Aide #10 stated she and Nurse Aide #9 attempted to transfer Resident #77 back to bed that evening (8/3/25) with the mechanical lift, but the lift sling moved out of position. Resident #77 was yelling and agitated, so they decided not to use the lift and instead have her stand and pivot to her bed and thought that would be safe. Nurse Aide #10 stated she did not observe any injuries on Resident #77 after the transfer, and Resident #77 was not complaining of pain or discomfort once they got her back in the bed. She stated she did not review the Kardex which was located in the electronic medical record prior to transferring Resident #77. Nurse Aide #10 stated she was educated the following day (8/4/25) on properly transferring residents and reviewing the Kardex and was suspended from work.</p> <p>During an interview on 09/04/25 at 12:40 PM Nurse #2 stated she was the assigned nurse on Sunday 8/3/25 from 7:00 AM through 7:00 PM. Resident #77 was at her baseline and was up in her Geri chair at the nurses station for a while. She had dementia but no pain, no distress, and was talkative. When she returned to work the next morning (8/4/25) a nurse aide whose name she could not recall, asked her to come check Resident #77 because she noticed discoloration on one side of her lower leg and the area was painful to touch. Upon assessment Resident #77 would say no don't touch it. The Nurse Practitioner was in the facility at the time</p>	F0689		

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F0689 SS = G	<p>Continued from page 5 and came in to evaluate her. An x-ray was ordered which showed a right lower leg fracture. Resident #77 was administered pain medication. Nurse #2 stated the night shift nurse did not report any concerns regarding Resident #77 having pain or discomfort during the night. Nurse #2 indicated she was not sure of what the final determination was that caused the fracture and that Resident #77 had been on Hospice care. She stated Resident #77 was dependent on staff for care and required the use of the mechanical lift for transfers currently and prior to her fracture.</p> <p>An observation on 9/2/25 at 12:45 PM revealed Resident #77 was sitting up in bed being fed lunch by a staff member. She was oriented to person only and was smiling and talkative but could not engage in meaningful dialogue. A splint was in place on her right lower leg. There were no visible indicators of pain or discomfort.</p> <p>During an interview on 9/4/25 at 1:00 PM the Director of Nursing (DON) indicated Resident #77 was observed by Nurse #2 to have pain, swelling, and discoloration on the morning of 8/4/25. An x-ray was ordered and showed a lower leg fracture. An investigation on 8/4/25 determined Resident #77 was transferred inappropriately by the two nurse aides (Nurse Aide #9 and Nurse Aide #10) who worked the evening shift the previous night (8/3/25). The DON stated the nurse aides transferred Resident #77 back to bed without using the mechanical lift and instead had her stand and pivot. She stated initially Nurse Aide #9 and #10 attempted to transfer Resident #77 using the mechanical lift but the lift sling was not positioned properly underneath her. The nurse aides tried to reposition her, but Resident #77 resisted. The nurse aides then decided to get on each side of Resident #77 and have her stand and pivot to get into the bed. The DON stated Resident #77 had been non weight bearing for a while and required the use of the mechanical lift. She stated Nurse Aide #9 and Nurse Aide #10 were educated on 8/4/25 on the importance of following the Kardex (a resident care guide that shows essential information including transfer status) and correctly transferring residents, then were suspended until the investigation was completed.</p> <p>A phone interview was conducted on 9/16/25 at 3:00 PM with Nurse Practitioner #1. She stated she was notified on 8/4/25 of the bruising and swelling on Resident #77's lower leg. Nurse Practitioner #1 stated she ordered an x-ray which showed a hairline nondisplaced fracture of the tibia and fibula. During her evaluation</p>	F0689		

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F0689 SS = G	<p>Continued from page 6 of Resident #77 on 8/4/25 there were no deformities of the leg observed, and Resident #77 was not complaining of pain during that time. The decision was then made for conservative management due to being on Hospice care, having multiple comorbidities, and not being a surgical candidate. She discussed this plan of care with the Hospice nurse and Resident #77's Responsible Party who were in agreement. Nurse Practitioner #1 stated the following day the family decided to go ahead and send her to the hospital so that she could be seen by orthopedics sooner and she wrote the order on 8/5/25 to send Resident #77 out to the hospital.</p> <p>During an interview on 9/4/25 at 2:30 PM the Medical Director indicated she was made aware on 8/4/25 that Resident #77 had fractured her lower leg during a transfer. She stated Resident #77 had been non weight bearing for months and required the mechanical lift for transfers and was on Hospice services prior to the incident. The Medical Director indicted Resident #77 was able to continue to get up into the Geri chair, and she had no significant decline following the injury.</p> <p>During an interview on 9/5/25 at 3:00 PM the Administrator along with the Director of Nursing, and the Corporate Compliance Nurse each stated an investigation was initiated on 8/4/25 following the transfer that occurred on 8/3/25 which resulted in the injury. The root cause analysis determined the injury resulted when the two nurse aides (Nurse Aide #9 and #10) did not follow the policy or the Kardex on the proper transfer which led to Resident #77 sustaining the tibia- fibula fracture. The DON stated in-service training started with Nurse Aide #9 and #10 on 8/4/25, and Kardex audits began on 8/5/25 to ensure each residents transfer status was correct. The Administrator stated they made the decision to monitor residents for safe transfers and put it in their Quality Assurance (QA) program.</p> <p>The facility provided the following corrective action plan:</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 8/4/25 at approximately 8:30 AM the nurse aide found a bruise to the outer right leg (shin) and notified</p>	F0689		

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F0689 SS = G	<p>Continued from page 7</p> <p>Nurse #2. Nurse #2 notified the Nurse Practitioner and an x-ray was ordered. The x-ray resulted with a non-displaced fracture of the right lower leg. Resident #77 was assessed by Nurse Practitioner #1 on 8/4/25 and new orders were placed for an orthopedic consult and pain medications.</p> <p>On 8/4/25 the facility investigation of the injury revealed on 8/3/25 at approximately 7:00 PM Nurse Aide #9 and #10 went in to transfer Resident #77 back to bed. The lift sling was not positioned properly. They tried to reposition the sling, but Resident #77 resisted. Nurse Aide #9 and #10 stood Resident #77 up and pivoted her a few steps to the bed from the chair.</p> <p>On 8/4/25 Nurse Aide #9 and Nurse Aide #10 were given one-to-one education on the importance of following the Kardex and correctly transferring each resident to prevent injuries. The nurse aides were suspended until the investigation was completed.</p> <p>On 8/5/25 at 3:45 PM Resident #77 was sent to the emergency department per the family request for a quicker orthopedic consult.</p> <p>The Administrator and the DON completed a root cause analysis which determined Nurse Aide #9 and #10 did not follow the policy, or Resident #77's Kardex on the proper transfer which led to Resident #77 sustaining the injury.</p> <p>Address how the facility will identify other residents having the potential to be affected.</p> <p>On 8/5/25 the Director of Nursing along with the MDS nurse identified residents potentially impacted by the practice by completing Kardex audits on all current residents. The audit revealed 66 of 84 Kardex's had the correct transfer status.</p> <p>On 8/5/25 the Director of Nursing along with the MDS nurse interviewed the nurse aides and nurses on the halls for the correct transfer status of every resident and updated each Kardex. All Kardex's were updated by 8:00 PM on 8/5/25. Direct care staff were notified by the DON and the MDS nurse verbally in the facility on 8/5/25 and through in-service training conducted from 8/5/25 through 8/8/25 that the resident Kardex's had been updated and staff were to check the Kardex for all residents for accurate transfer status prior to transfers.</p>	F0689		

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F0689 SS = G	<p>Continued from page 8 On 8/5/25 the MDS nurse was informed she would be responsible for keeping the Kardex's updated to reflect the current transfer status of all residents.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 8/5/25 the Director of Nursing along with the Staff Development Coordinator in-serviced all staff including agency personnel on transfer safety, following the Kardex, and the facility transfer policy.</p> <p>All in-service training will be completed by 8/8/25. Any staff who had not completed education by 8/8/25 would not be allowed to work until training was completed.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>On 8/5/25 the decision was made by the Administrator to monitor the plan to ensure safe resident transfers and will be presented to the Quality Assurance Performance Improvement (QAPI) committee to include the Administrator, the Director of Nursing, MDS coordinator, therapist, and dietary manager.</p> <p>The Director of Nursing will monitor safe resident transfers through observations conducted on all shifts, along with reviewing resident care plans and auditing Kardex accuracy to ensure they reflect the correct transfer status using the quality assurance tool. This will be completed weekly for 2 weeks and monthly for three months to ensure compliance.</p> <p>Quality Assurance (QA) monitoring will begin the week of 8/11/25. Reports will be presented in the monthly QA committee by the Administrator or the Director of Nursing. Compliance will be monitored and the ongoing auditing program reviewed at the monthly QA meetings.</p> <p>The monthly QA meeting was held on 8/25/25 where the results of the audits and ongoing monitoring were discussed.</p> <p>The facility's alleged compliance date of the corrective action plan was 8/9/25.</p> <p>The corrective action plan was validated on 9/5/25. The</p>	F0689		

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F0689 SS = G	Continued from page 9 following documentation was reviewed along with staff interviews and observations: Validation included staff interviews regarding the incident and in-service training that was received to ensure understanding and knowledge of the training provided. All of the staff members interviewed stated they had received training. In-service training included safe resident transfers, and the importance of reviewing the residents Kardex. Inservice logs were verified, and the initial and ongoing audits were verified. A resident transfer using the mechanical lift was observed. There were no concerns identified. The compliance date of 8/9/25 was validated.	F0689		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and staff interviews the facility failed to discard expired nutritional supplements stored for use in 1 of 1 reach-in refrigerator in the kitchen. This practice had the potential to affect residents with physician ordered nutritional supplements.	F0812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. This plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 For Dietary Services, a corrective action was obtained on 09/02/2025. Based on initial tour of the kitchen, it was noted facility had failed to maintain proper storage, preparation, and sanitation in the main kitchen; out of date Ensure identified in reach - in refrigerator and sanitation bucket failed to meet PPM requirements. On 09/02/2025 expired items were discarded and sanitation buckets replaced. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 09/02/2025, the Dietary Service Director and Dietician completed a walk-through of the kitchen and nourishment rooms to ensure all areas met standards to store, prepare, and serve	09/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345210	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/16/2025
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F0812 SS = D	Continued from page 10 The findings included: An observation of the reach-in refrigerator in the kitchen was completed on 9/2/25 at 11:15 AM and revealed 10 bottles of a nutritional supplement with the expiration date 04/2025. The DM stated the nutritional supplement was expired and should not have been in the reach-in refrigerator. She further stated the staff must have just missed them when checking for expired food that morning. An interview was completed with the Administrator on 9/5/25 at 11:00 AM. The Administrator stated she was surprised to hear that there were expired nutritional supplements found in the reach-in refrigerator, because the dietary staff was very diligent about discarding expired and leftover food items. She further stated that the Registered Dietitian had just inspected the kitchen a couple of weeks ago and he had not found any expired food items. The Administrator indicated her expectation was that there be no expired food items in the kitchen or nourishment rooms.	F0812	Continued from page 10 sanitary food / beverages. 3. Systemic Changes: In - service education was provided to Dietary Staff, Nursing Staff, and Environmental Staff on 09/03/2025. Topics included: Labeling and Dating Procedures Sanitation Bucket Procedures This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance Monitoring Procedure: Dietary Service Director or assignee will monitor procedures for proper food storage and sanitation in kitchen daily x 2 weeks then weekly x 4 weeks using the F812 QA Tool which will be used to observe all food / beverages are labeled, dated, within proper dates, and chemical bucket procedures are followed correctly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated is appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance meeting. The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Dietary Manager.	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. This plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	09/17/2025

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F0880 SS = D	Continued from page 11 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 11 F880 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EHB) during high contact care for a resident with a pressure ulcer, when a nurse and the Wound Aide were providing wound care without wearing gowns for 2 of 6 staff observed for infection control. (Nurse #1 and the Wound Aide). Corrective action for resident(s) affected by the alleged deficient practice: On 9/4/2025 the SDC educated nurse #1 and the wound aide on facility policy for adhering to Enhanced Barrier Precautions. The education included when to utilize Enhanced Barrier Precautions and how to follow utilization of personal protective equipment during care of residents. On 9/5/2025 the SDC observed the nurse and wound aide for adherence to the facility policy with no further concerns identified. No other deficiencies were noted with other residents during high contact care activity. Corrective action for residents with the potential to be affected by the alleged deficient practice. The Staff Development Coordinator and Support Nurse assessed all residents to identify if the resident met CDC criteria for Enhanced Barrier Precautions on 9/8/2025. The findings included 10 residents who were identified to meet the need for Enhanced Barrier Precautions.	

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F0880 SS = D	<p>Continued from page 12</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and staff interviews, the facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EHB) during high contact care for a resident with a pressure ulcer, when a nurse and the Wound Aide were providing wound care without wearing gowns for 2 of 6 staff observed for infection control (Nurse #1 and the Wound Aide).</p> <p>The findings included:</p> <p>The facility policy titled, "Enhanced Barriers" dated 9/22 stated in part: EBP requires the use of gown and gloves when providing high contact care activities for residents identified as requiring EBP. High contact resident care activities were listed as: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs and assisting with toileting, device care or use, central lines, urinary catheter, feeding tube, tracheostomy and wound care, any skin opening requiring a dressing.</p> <p>An observation of the Wound Aide and Nurse #1 changing Resident #9's pressure wound dressing occurred on 9/4/25 at 9:48 AM in the presence of the Staff Development Coordinator (SDC). The observation revealed Nurse #1 and the Wound Aide were only wearing gloves and did not apply a gown prior to the dressing change or during the dressing change.</p> <p>An interview with the Wound Aide was completed on 9/4/25 at 10:00 AM. The Wound Aide stated she always puts a gown on when changing dressings, but she was just nervous and forgot.</p> <p>A telephone interview was completed with Nurse #1 on</p>	F0880	<p>Continued from page 12</p> <p>On 9/8/2025, the EBP bags were moved off the back of the resident doors, and placed on the back of the bathroom doors, for easier visibility. And EBP Signage outside the room doors were changed to reflect "bed A" or "bed B".</p> <p>On 9/8/2025, the SDC and Support Nurse ensured that all 10 identified residents that met the need for Enhanced Barrier Precautions had appropriate signage placed at the room entrance, appropriate PPE placed inside the room per CDC recommendations. This was completed on 9/8/2025.</p> <p>On 9/8/2025, the Director of Nurses and Staff Development Coordinator observed clinical staff for compliance with adhering to Enhanced Barrier Precautions. Five (5) of five (5) staff observed had no concerns identified as to when and how to follow the Enhanced Barrier Precaution policy.</p> <p>On 9/8/2025, MDSC ensured all identified residents that met criteria for Enhanced Barrier Precautions were care planned as appropriate. This was 100% completed on 9/8/2025.</p> <p>3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:</p> <p>On 9/ 4 /2025 the Director of Nursing and the Staff Development Coordinator (SDC) began in-servicing all clinical staff to include agency staff on Enhanced Barrier Precautions and facility policy. The Director of Nursing will ensure that any of the above-identified staff who do not complete the in-service training will not be allowed to work after 9/10/2025 until the training is completed. Education on Enhanced Barrier Precautions is incorporated in the new employee facility orientation for clinical staff and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained.</p> <p>Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.</p>	

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F0880 SS = D	<p>Continued from page 13 9/5/25 at 9:43 AM. Nurse #1 stated she didn't think she had to wear a gown since the Wound Aide was the one changing the dressing and she was just assisting with helping position the resident on her side.</p> <p>An interview with the SDC was completed on 9/5/25/at 8:50 AM. The SDC stated he was just in the room to observe the dressing change but did not think about the staff wearing gowns until he turned around and saw the personal protection equipment (PPE) on the back of the door. He stated the Wound Aide and Nurse #1 should have been wearing protective gowns while changing the dressing.</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/5/25 at 11:19 AM. The DON stated that Nurse #1 and the Wound Aide should have been wearing gowns during the dressing change. She further stated she would have expected the SDC to remind them if they forgot.</p>	F0880	<p>Continued from page 13 The Administrator and Director of Nursing and/or designee will monitor F880 to ensure Enhanced Barrier Precautions are in compliance weekly x 2 weeks and then monthly for 3 months or until resolved. The ongoing audit will begin the week of 9/15/2025. Reports will be presented to the Quality Assurance (QA) committee by the Administrator and/or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Director.</p> <p>Date of Compliance: 9/10/2025</p>	
F0919 SS = D	<p>Resident Call System</p> <p>CFR(s): 483.90(g)(1)(2)</p> <p>§483.90(g) Resident Call System</p> <p>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-</p> <p>§483.90(g)(1) Each resident's bedside; and</p> <p>§483.90(g)(2) Toilet and bathing facilities.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, and resident and staff interviews, the facility failed to ensure the bedside call light system was functioning and provide an alternate means of communicating with staff for 2 of 2 residents who were dependent on staff for assistance with activities of daily living (ADL) (Resident #59, and Resident #20).</p> <p>Findings included:</p> <p>Resident #20 was admitted to the facility on 1/13/25 with diagnoses including congestive heart failure.</p>	F0919	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. This plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>F919</p> <p>Plan of Correction for F919 – Call Bell System</p> <p>1. Corrective Action for Affected Resident(s):</p> <p>The malfunctioning call light for Resident #59 and Resident #20 were immediately replaced by fully functional units on 9/1/2025. Staff reports that the new units activate reliably.</p> <p>2. Identification of Other Residents Potentially Affected:</p> <p>Maintenance conducted a 100% audit of resident rooms on 9/1/2025 to identify any additional call system issues. No other non-functioning call lights were noted during the audit.</p> <p>3. Systemic Changes to Prevent Recurrence:</p>	09/17/2025

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F0919 SS = D	<p>Continued from page 14</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 7/14/25 revealed Resident #20 was cognitively intact. He required limited one-person assistance with transfers and was wheelchair bound.</p> <p>Resident #59 was admitted to the facility on 8/11/25 with diagnoses including right lower leg fracture.</p> <p>The Minimum Data Set admission assessment dated 8/18/25 revealed Resident #59 was cognitively intact. He required extensive assistance with transfers and ADL and was wheelchair bound.</p> <p>Interviews and an observation were conducted on 9/2/25 at 12:00 PM with Resident #20 and Resident #59. Resident #20 and Resident #59 were roommates. Resident #20 stated the call light in their room did not work for three days from Friday 8/29/25 through Monday morning 9/1/25. Resident #20 stated when emergency medical services (EMS) brought his roommate (Resident #59) back from an outside appointment on Friday the call light cord got caught when Resident #59 was being transferred back to bed which caused the whole call light device system to be pulled away from the wall causing both call lights to not work. Resident #20 stated the call lights in the room were not repaired until Monday morning. He (Resident #20) indicated he and his roommate (Resident #59) both required staff assistance with transfers and care and were not provided another means or alternate device to alert staff if assistance was needed or in the event of an emergency. Resident #20 stated the nurses and aides did check on them during the time the call light was not working. Resident #59 indicated he was not provided an alternate device, but the nurses and nurse aides did come in and check on him during that time.</p> <p>During an observation on 9/2/25 at 12:05 PM the call light system in Resident #20 and Resident #59's room was observed to be working when the call light was activated.</p> <p>During an interview on 9/3/25 at 2:15 PM Nurse #1, the assigned nurse on 8/29/25 from 7:00 AM through 7:00 PM for Resident #20 and Resident #59 stated the call light in the resident's room was broken on 8/29/25 when EMS transferred Resident #59 either to or from his bed for an orthopedic appointment that morning. She stated the</p>	F0919	<p>Continued from page 14</p> <p>Call Light Audits by Maintenance: Maintenance will perform documented weekly inspections of all call lights in resident rooms using the TELS Audit system.</p> <p>Staff Education: Nursing and Environmental staff were re-educated on 9/2/2025.</p> <p>Topics included:</p> <p>The importance of reporting call light issues immediately.</p> <p>Handbells given to residents with malfunctioning call lights until call lights are repaired.</p> <p>The need for frequent monitoring of residents with handbells in place.</p> <p>Work Order Protocol: A streamlined work order system was implemented to ensure timely repair or replacement of call system components.</p> <p>4. Monitoring / the QA Process:</p> <p>Maintenance will monitor call lights daily x 4 weeks for one month using the F919 Audit Tool beginning 9/8/2025. Ongoing monitoring will be weekly beginning on October 6, 2025 using the TELS AUDIT SYSTEM. Audit results will be presented at weekly QA meetings to ensure corrective action initiated is appropriate and compliance is in place. The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Dietary Manager and Medical Director.</p>	

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F0919 SS = D	<p>Continued from page 15 call light cords were pulled out of the wall and were not working and she verbally reported it to the Maintenance Director on Friday 8/29/25. Nurse #1 stated she checked on both residents at least every 2 hours during her shift. Nurse #1 stated when the call bells weren't functioning they had cow bells to put in the resident rooms for use, but she did not think to give a cow bell to Resident #20 or Resident #59. Nurse #1 stated she notified the assigned nurse aides that the call light was broken.</p> <p>Attempts were made on 9/3/25 at 3:40 PM and 9/5/25 at 1:05 PM to contact Nurse Aide #1 who was assigned to Resident #20 and Resident #59 on 8/29/25 from 7:00 AM through 7:00 PM. There was no response.</p> <p>During an interview on 9/3/25 at 2:30 PM the Maintenance Director stated he was not made aware that the call light system in the room Resident #20 and Resident #59 resided in was broken until Monday morning 9/1/25. He stated he was not notified on Friday, and he was at the facility until 5:30 PM on Friday 8/29/25. He stated if he had been notified on 8/29/25 he would have repaired the broken call light that day. He stated he was not in the facility over the weekend, but he could always be notified by phone on the weekends day or night if something needed to be repaired and he would have come in and repaired it. The Maintenance Director stated he was notified Monday morning (9/1/25) when he returned to work by the Director of Nursing and he fixed the call light right away. He stated it was an easy fix because he kept spare call lights on hand. He stated there was no system to notify Maintenance of needed repairs except through a phone call or finding him in the facility. He reported that he did not keep a record of when he was notified that something needed to be repaired or of what repairs were made. He stated cow bells were on hand and were kept at the nurses station to use if a call light issue occurred and stated the staff were aware that the cow bells were available for use.</p> <p>During an interview on 9/3/25 at 3:00 PM the Director of Nursing (DON) stated she was the assigned nurse for Resident #20 and Resident #59 on Friday night 8/29/25 from 7:00 PM through 7:00 AM. The DON stated the call light was not working and she emailed the Maintenance Director that night but stated she did not realize he could not check his emails outside of the facility and therefore he did not get the notification. She stated a cow bell was not offered but she checked on both residents every two hours throughout the night.</p>	F0919		

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F0919 SS = D	<p>Continued from page 16</p> <p>During an interview on 9/4/25 at 12:30 PM Nurse #2 stated she was the assigned nurse for Resident #20 and Resident #59 on Saturday 8/30/25 and Sunday 9/1/25 from 7:00 AM through 7:00 PM. She was made aware in morning report that the call light in the room Resident #20 and Resident #59 resided in was not functioning. Nurse #2 stated she and the assigned nurse aide checked on both residents at least every two hours during her shift. She indicated she did not notify the Maintenance Director, and a cow bell was not offered to the residents.</p> <p>During a phone interview on 9/5/25 at 3:00 PM Nurse #3 stated she was the assigned nurse for Resident #20 and Resident #59 on Saturday 8/30/25 and Sunday 8/31/25 from 7:00 PM through 7:00 AM. She was aware the call light was not working in their room but stated she and the assigned nurse aide checked on the residents at least every two hours during the shift. She indicated a cow bell was not offered to the residents.</p> <p>During an interview on 9/3/25 at 3:15 PM Nurse Aide #2 stated she worked 3:00 PM until 11:00 PM on Sunday 8/31/25. She stated she was assigned to Resident #20 and Resident #59 and the call lights for both of the residents were not working because the call light was pulled away from the wall. Nurse Aide #2 stated she made rounds on both residents that day and the residents did not have a cow bell in their room during that time.</p> <p>During a phone interview on 09/05/25 at 1:10 PM Nurse Aide #3 stated she worked night shift 11:00 PM through 7:00 AM on Friday 8/29/25 and 11:00 PM through 7:00 AM on Sunday 8/31/25. She noticed early on the call light in the room Resident #20 and Resident #59 resided in was not working. Nurse Aide #3 stated she made frequent checks during the night, and the residents did not have a cow bell in their room during that time.</p> <p>During an interview on 9/5/25 at 10:00 AM the Administrator stated she was not made aware the call lights were not functioning in the room Resident #20 and Resident #59 resided in until they were repaired on Monday 9/1/25. She stated the Maintenance Director was in the facility on 8/29/25 the day it was broken, and he should have been notified at that time so that it could have been repaired sooner. The Administrator</p>	F0919		

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F0919 SS = D	Continued from page 17 stated they kept the cow bells at the nurses station for use if the call lights were not functioning and the nurses were aware. She indicated the call light should have been repaired on Friday 8/29/25 since the Maintenance Director was available in the facility and had the supplies on hand to repair it. She stated Resident #20 and Resident #59 should have both been provided a cow bell to use to notify staff in case assistance was needed.	F0919		