STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abernathy Laurels	**102 Leonard Avenue , Newton, North Carolina, 28658**

(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 An unannounced recertification survey was conducted on 09/02/25 through 09/05/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D5324-H1.	E0000		
F0000	INITIAL COMMENTS A recertification survey was conducted from 09/02/25 through 09/05/25. Event ID# 1D5324-H1.	F0000		
F0689 SS = D	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 observation, record review, and Medical Director and staff interviews, the facility failed to provide care in a safe manner when a dependent rolled out of bed while care was being provided. She was sent to the hospital for evaluation and was identified with a subdural hematoma (a collection of blood between the brain's outer covering and the surface of the brain). She required no treatment at the hospital, was sent back to the facility the same day, did not experience pain as a result of the injury, and was not receiving a blood thinner. This deficient practice affected for 1 of 5 residents reviewed for supervision to prevent accidents (Resident #39). The findings included: Resident #39 was admitted to the facility on 08/22/22	F0689		

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 = D	Continued from page 1 with diagnoses that included Alzheimer's disease, neurocognitive disorder with Lewy bodies dementia with mood disorder, Parkinson's disease, hallucinations, and history of falling. Resident #39's quarterly Minimum Data Set assessment dated 01/20/25 revealed Resident #39 was severely cognitively impaired and was dependent on others for bed mobility and transfers. Resident #39 was coded as not having a fall since the prior assessment. Resident #39 was coded as not having any pain indicators, had not received scheduled or as needed pain medications, and received no anticoagulants or antiplatelet medication. The resident weighed 179 pounds and was receiving hospice services. Review of Resident #39's care plan revealed she required assistance with activities of daily living (ADL) related to weakness, had impaired cognition related to diagnoses of Parkinson's disease and Alzheimer's, required assistance from staff to ensure ADL needs were met as the resident did not recognize or report her needs, and was experiencing an overall decline in condition. Interventions in the care plan included offer and assist the resident with transfers, bed mobility, and toileting needs and ensure safety; and re-approach later if the resident refuses assistance. Resident #39's undated Kardex (a form which indicated what Resident #39's care needs were and how many staff were required to complete the indicated care) revealed Resident #39 was a one person assist with bed mobility and personal hygiene. Resident #39's active physician orders on 02/23/25 did not include anticoagulant or antiplatelet medication. Resident #39's progress notes revealed a note dated 02/23/25 written by Nurse #1 that indicated she was notified by Nurse Aide (NA) #1 that Resident #39 had fallen and was on the floor. NA #1 reported Resident #39 was on the floor, face down next to the bed with NA #1 underneath Resident #39. Unit Manager #1 was immediately notified and she and Nurse #1 assessed Resident #39, rolled her to her back and was placed back into her bed. Resident #39 was noted to have facial swelling on the right side of her head. Resident #39's responsible party, the physician, and hospice were notified of the fall. The resident was sent out for further evaluation. An interview with NA #1 via telephone call on 09/05/25 at 8:24 AM revealed she was in Resident #39's room on	F0689		

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F0689 SS = D	Continued from page 2 02/23/25 providing incontinence care with the bed at the height of NA #1's waist, and when she rolled Resident #39 toward her to continue changing her, the upper half of Resident #39's body rolled off the edge of the bed with her lower half remaining in bed. NA #1 stated she tried to catch Resident #39 to prevent her from falling onto the floor but due to her positioning, she was only able to get ahold of Resident #39's waist which resulted in both Resident #39 and NA #1 falling to the floor. NA #1 stated Resident #39's head struck the floor when they fell. She reported when she and Resident #39 came to rest on the floor, Resident #39 was lying on top of her, in her lap, and was facedown. NA #1 stated she screamed for help and Nurse #1 came to the room. NA #1 stated when Nurse #1 arrived to the room she told NA #1 to "not move" and went and retrieved Unit Manager #1. She stated Nurse #1 and Unit Manager #1 returned to the room and Resident #39 was assessed for injuries, rolled onto her back and they used a mechanical lift to get Resident #39 back into her bed. She stated Resident #39 had suffered a hematoma to the right side of her head, just to the right of Resident #39's right eyebrow. NA #1 described the swelling to be the size of a tennis ball. NA #1 reported that despite the injury to her forehead Resident #39 did not appear to be in any pain and she was not crying. NA #1 reported based on Resident #39's Kardex that was in place at the time of the 02/23/25 fall, she was a one person assist with bed mobility. She explained that due to Resident #39 being bedbound, she had not been identified as a fall risk, and therefore, there were no fall mats to the side of Resident #39's bed. NA #1 indicated that Resident #39 was ultimately sent out to the hospital. An interview with Nurse #1 via telephone call on 09/04/25 at 2:37 PM revealed she no longer worked at the facility. Nurse #1 proceeded to state that she recalled Resident #39 but stated she was "not sure" she recalled Resident #39's fall that resulted in her going to the hospital. An interview with Unit Manager #1 via telephone call on 09/05/25 at 9:27 AM revealed she did respond to Resident #39's fall on 02/23/25 and stated when she arrived at the room, Resident #39 was lying face down on top of NA #1 in a horizontal position to the bed. She reported when she asked NA #1 what happened, NA #1 reported she was providing care and when she rolled Resident #39 towards her, momentum carried Resident #39 out of the bed, on top of NA #1, and onto the floor. Unit Manager #1 reported she completed a full assessment and rolled Resident #39 onto her back and that was when she noted a hematoma on the right	F0689		

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F0689 SS = D	Continued from page 3 temporal side of Resident #39's head that she described as larger than a golf ball and was "probably approaching" the size of a tennis ball. She stated she informed Nurse #1 to notify the physician, family, and hospice provider, and to begin periodic neurological checks. Unit Manager #1 reported Resident #39's vital signs were within normal limits and that Resident #39 did not appear to be in any distress post fall. Unit Manager #1 reported Resident #39 was nonverbal and was only alert to herself. She stated Resident #39 was dependent on others for the completion of her activities of daily living and Resident #39 required a one-person assist with incontinence care at the time of the fall but has since been downgraded to a two-person assist. Unit Manager #1 stated Resident #39 was ultimately sent out to the hospital for further evaluation and treatment. Resident #39's hospital records dated 02/23/25 revealed Resident #39 had a head CT (computed tomography) scan while at the hospital. This scan uses a series of X-rays and computer processing to create detailed, cross-sectional images of bones, soft tissues, and blood vessels within the body. The results of Resident #39's head CT scan indicated there was a very thin subdural hematoma layering about the lateral right convexity anteriorly (collection of blood that has formed a crescent shape over the front side of the right cerebral hemisphere) measuring approximately 4 millimeters, potentially subacute (not life threatening) as it does not appear particularly hyperdense. There was no associated sulcal effacement (loss of normal spaces between the folds of the brain) or midline shift (displacement of the brain's midline structures from their normal symmetrical position) or acute intracranial hemorrhage (bleeding within the skull that puts pressure on the brain) identified. Resident was given ice and was sent back to the facility the same day via facility transportation. The medical record indicated Resident #39 returned to the facility with an order for morphine concentrate (opioid pain medication) dated 02/23/25 with instructions to take 5 milligrams of morphine concentrate (100milligrams/5 milliliters) orally every 4 hours as needed. Review of Resident #39's Medication Administration Record (MAR) revealed she had not received any doses of the ordered morphine supplement upon return to the facility. An observation of Resident #39 on 09/02/25 at 3:54 PM revealed she was nonverbal and in a lean back	F0689		

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F0689 SS = D	Continued from page 4 wheelchair. Resident #39 did not respond to verbal stimuli and did not appear to be in any distress. Resident #39's progress notes revealed a note written by the Medical Director dated 02/25/25 that indicated while at the hospital resident was given a head CT scan and was found with a very thin subdural hematoma layering about the lateral right convexity anteriorly measuring approximately 4 millimeters that was potentially subacute. The Medical Director noted that after speaking to the hospital physician he felt the injury was most likely acute based on Resident #39's history and physical findings. Resident #39 was not on any anticoagulant medications at that time. An interview with the Medical Director via telephone on 09/05/25 at 2:19 PM revealed he did not recall much about Resident #39's fall that occurred on 02/23/25 but stated that an acute injury would be defined as one occurring within the past day or two and that subacute would be within the past few weeks, though he stated that a radiologist may have different definitions. He also reported that he would consider a subdural hematoma a significant injury and indicated that Resident #39 was not on any anticoagulant medications at the time of the fall. An interview with the Director of Nursing on 09/05/25 at 12:31 PM revealed she was aware of Resident #39's fall on 02/23/25 and had investigated it. She reported NA #1 reenacted the incident and that NA #1 showed her that when she rolled Resident #1 over to provide care, Resident #39's upper body came off the bed and that Resident #39 and NA #1 fell to the floor. She reported Resident #39 was found face down on top of NA #1. The Director of Nursing reported Nurse #1 and Unit Manager #1 responded to the fall and Resident #39 was assessed, determined to have facial swelling and returned to her bed. She also stated that Resident #39's responsible party, the physician, and hospice care were notified. The Director of Nursing reported at the request of hospice; Resident #39 was sent out to the hospital for further evaluation and treatment. She stated when Resident #39 arrived at the hospital, she was diagnosed with an acute subdural hematoma and contusions to her face. The Director of Nursing continued, stating after her investigation into the fall, she determined the root cause to be due to Resident #39's poor trunk control. She stated at the time of the 02/23/25 fall; Resident #39 was a one person assist with care and was subsequently downgraded to a two-person assist after the fall. The Director of Nursing reported Resident #39 was not taking any anticoagulant medications at the	F0689		

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F0689 SS = D	Continued from page 5 time of the fall and reported she could not recall if Resident #39 had been identified as a potential fall risk prior to the fall. The Director of Nursing reported she did not believe that NA #1 had done anything wrong when providing incontinence care to Resident #39 but stated a resident should not fall out of bed during care. An interview with the Administrator on 09/05/25 at 12:58 PM revealed she was familiar with Resident #39 and the 02/23/25 fall. She reported it was her understanding that Resident #39 was being provided with incontinence care when NA #1 rolled Resident #39 towards her to continue care and due to Resident #39's poor trunk control, the top half of Resident #39 came off the bed. The Administrator stated NA #1 tried to gain control of Resident #39 but due to her weight, Resident #39 continued to roll off of the bed and onto NA #1 and both ended up on the floor. She stated as far as she knew, Resident #39 was assessed before being moved back into bed. The Administrator continued, stating Resident #39 was subsequently sent to the hospital for further evaluation and treatment and that the only injury she was aware of was a hematoma to Resident #39's head. She reported upon review of the hospital report; it appeared as though Resident #39 had a very thin subdural hematoma with no other injuries noted. The Administrator reported Resident #39 was not admitted to the hospital and had returned to the facility via facility transportation. The Administrator stated upon Resident #39's return to the facility, there were no ongoing indicators of pain or mental anguish. She also stated a resident should not fall during care but stated that NA #1 was doing what she expected her to do, that NA #1 had the bed at the correct height to prevent falling, rolled Resident #39 towards her while she provided care, and obviously attempted to prevent Resident #39 from falling as evidenced by NA #1 being underneath Resident #39 after the fall.	F0689		