

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345510	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
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NAME OF PROVIDER OR SUPPLIER Tarboro Health and Rehabilitation LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 911 Western Boulevard , Tarboro, North Carolina, 27886
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(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 and complaint investigation survey was conducted on 4/13/2026 through 4/16/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22DCB9-H1	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/13/2026 through 4/16/2026 Event ID# 22DCB9-H1. The facility is in substantial compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey). The following intakes were investigated: 2963015, 2959534, and 2602008. 6 of 6 complaint allegations did not result in deficiency.	F0000		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641		

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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<p>F0641 SS = A</p>	<p>Continued from page 1</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and staff and resident interviews, the facility failed to accurately code restraints on an annual Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for restraints (Resident #38).</p> <p>Findings included:</p> <p>Resident #38 was admitted to the facility on 5/1/25. Her active diagnoses included cerebral infarction and moyamoya disease (a progressive cerebrovascular disorder causing strokes, mini-strokes, seizures, and headaches).</p> <p>Resident #38's Care Plan dated 2/4/26 revealed the resident was care planned for the use of 1/8 side rail for bed mobility and activities of daily living assistive device. The interventions included to provide grab bars as needed for mobility assistance.</p> <p>Resident #38's MDS assessment dated 4/2/26 revealed the resident was assessed as moderately cognitively impaired. The resident was also coded to have a physical restraint bed rail used daily.</p> <p>During an interview on 4/13/26 at 1:45 PM Resident #38 stated the facility had never placed any form of a physical restraint on her in any way. She stated she used her bedside rail to turn and reposition.</p>	<p>F0641</p>		

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F0641 SS = A	Continued from page 2 During an interview on 4/14/26 at 9:35 AM the MDS Coordinator stated the facility was doing side rail assessments and for some reason during the MDS assessment she saw bed rails as an option in the restraint section and selected it and did not realize it was indicating it was a physical restraint. She thought the MDS was just assessing for side rails, and this was the reason it was coded inaccurately. During an interview on 4/14/26 at 9:41 AM the Administrator stated the side rail for Resident #38 was an enabler and not a restraint and should not have been coded as a restraint on the MDS.	F0641		