STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Rocky Mount Health and Rehabilitation	3322 Village Road Rocky Mount, NC 27804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review and staff interviews, the facility failed to date opened medications and discard expired medications for 3 of 5 medication carts (North Hall 3 medication cart, North Hall 1 medication cart and South Hall medication cart) and in 1 of 2 medication rooms (South Hall Medication Storage Room), reviewed for medication storage.The findings included:a. An observation conducted of the North Hall 3 medication cart with Nurse #6 on 4/10/26 at 2:09 PM revealed:- one undated, opened and used bottle of Erythromycin Ophthalmic Ointment 0.5%. The manufacturer's instruction stated discard 28 days after opening.- one undated, opened and used Trilogy Elipta inhaler. The manufacturer's instruction on outside of box read to discard 6 weeks after opening.- one undated, opened and used Nystatin Cream tube. The manufacturer's instruction stated to discard 14 days after opening.- one undated, opened and used bottle of Clotrimazole Betamethasone Dipropionate. The manufacturer's instruction stated to discard 6 months after opening. - on undated, opened and used bottle of Rhopressa 2.5 milligram (mg) eye drops. The manufacturer's instruction on the bottle stated once open store at room temperature for up to 6 weeks.- one undated, opened and used bottle of artificial tears. The manufacturer's instruction stated to discard 30 days after opening.An interview was conducted with Nurse #6 on 4/10/26 at 2:10 PM. Nurse #6 stated all medications in the medication cart were supposed to be dated when opened. Nurse #6 stated it was the nurse assigned to the medication cart's responsibility to check the cart.b. An observation was conducted of the North Hall 1 medication cart with Certified Medication Aide (CMA) #1 on 4/10/26 at 2:10 PM revealed one opened and used bottle of multivitamin with iron with remaining pills and an expiration date of 3/2026. An interview was conducted with CMA #1 on 4/10/26 at 2:10 PM. CMA #1 stated she checks the medication cart for expired medications every day and just missed that bottle.c. An observation conducted of the South Hall medication cart for 100 and 200 halls with CMA #2 on 4/10/26 at 2:21 PM revealed:-one opened and used bottle of Melatonin 1 mg tablet with an expiration date of 2/2026,-one unopened box with 2 tubes of microdot glucose gel 37.5 grams (g) with an expiration date of 2/2025,-four undated opened and used bottles of Fluticasone Propionate nasal spray 50 microgram (mcg) spray. The manufacturer's instruction stated to discard 90 days after opening.-one undated opened and used Nystatin Cream tube. The manufacturer's instruction stated to discard 14 days after opening.An interview was conducted with CMA #2 on 4/10/26 at 2:27 PM. CMA #2 stated she checks the medication cart one to two times a week. CMA #2 stated she did not see the identified concerns.d. An observation conducted of the South Hall medication room with the South Unit Manager on 4/10/26 at 2:34 PM revealed: -two unopened bottles of one a day multivitamin with an expiration date of 2/2026.-one undated and accessed bottle of Tuberculin purified protein derivative (PPD) solution 5 tuberculin unit (TU)/0.1 milliliters (ml) in the refrigerator.An interview was conducted with the South Unit Manager (UM) on 4/10/2026 at 2:40 PM. The South Unit Manager stated she was responsible for the medication room. She stated she tried to check the South Hall medication room once a week for expired medications or more often when cluttered. The South Unit Manager stated the medications rooms were to be checked weekly by the (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unit managers. She stated the Central Supply Clerk does come in to stock the over-the-counter medications and she checks the expiration dates as well. The South Unit Manager stated the PPD should have been dated when opened by the nurse. The South Unit Manager further stated the medication refrigerator was to be included when checking the medication room. An interview was conducted with the Director of Nursing (DON) on 4/10/2026 at 2:42 PM. The DON reported that Nursing Administration was responsible for checking the medication rooms and medication carts on the halls. The DON stated the assigned nurse should be checking the medication carts, dating opened medications and discarding expired medications. The DON further stated the medication carts and medication rooms had been checked on Wednesday by the Nursing Administration team, but she was unsure how the identified concerns were missed.An interview was conducted with the Administrator on 4/10/26 at 2:48 PM. The Administrator stated nurses should be checking medication carts each shift. The Administrator further stated the Nursing Administration team should be checking the medication carts and medication rooms weekly as part of their weekly tasks.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to post accurate licensed and unlicensed nursing staffing data for 28 of 31 days reviewed for sufficient staffing (3/08/26, 3/09/26, 3/10/26, 3/11/26, 3/12/26, 3/14/26, 3/15/26, 3/16/26, 3/17/26, 3/18/26, 3/19/26, 3/20/26, 3/21/26, 3/22/26, 3/23/26, 3/24/26, 3/25/26, 3/26/26, 3/27/26, 3/28/26, 3/30/26, 3/31/26, 4/01/26, 4/03/26, 4/04/26, 4/05/26, 4/06/26, and 4/07/26).The findings included:A review of the posted Report of Nursing Staff Directly Responsible, the daily staffing schedule, and the Salaried Employee Sheet from 03/08/26 through 04/07/26 revealed the following:a. A review of the daily nursing schedule form for the 7:00 am-3:00 pm shift revealed the licensed and unlicensed nursing staff was not recorded accurately for the following days:3/08/26-Report of Nursing Staff Directly Responsible for recorded 0 Registered Nurse (RN), 4 Licensed Practical Nurses (LPN), and 11 Nurse Aides (NA); the daily staffing schedule recorded one (1) RN, 3 LPN, and 10 NA.3/09/26- Report of Nursing Staff Directly Responsible for recorded 11 NA; the daily staffing schedule recorded 10 NA.3/14/26- Report of Nursing Staff Directly Responsible for recorded 12 NA; the daily staffing schedule recorded 10 NA.3/15/26- Report of Nursing Staff Directly Responsible for recorded 12 NA; the daily staffing schedule recorded 11 NA.3/16/26- Report of Nursing Staff Directly Responsible for recorded 6 LPN and 12 NA; the daily staffing schedule recorded 7 LPN and 10 NA.3/19/26- Report of Nursing Staff Directly Responsible for recorded 2 RN; the daily staffing schedule recorded 2 RN. The Salaried Employee Sheet revealed one (1) of the 2 RNs scheduled was noted as off. 3/20/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 4 LPN.3/25/26- Report of Nursing Staff Directly Responsible for recorded 6 LPN; the daily staffing schedule recorded 5 LPN.3/26/26- Report of Nursing Staff Directly Responsible for recorded 2 RN; the daily staffing schedule recorded one (1) RN. 3/27/26- Report of Nursing Staff Directly Responsible for recorded 2 RN; the daily staffing schedule recorded one (1) RN.4/03/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 4 LPN.4/05/26- Report of Nursing Staff Directly Responsible for recorded 0 RN, 4 LPN; the daily staffing schedule recorded one (1) RN and 3 LPN. 4/07/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 6 LPN.b. A review of the daily nursing schedule form for the 3:00 pm-11:00 pm shift revealed the licensed and unlicensed nursing staff was not recorded accurately for the following days:3/08/26-Report of Nursing Staff Directly Responsible for recorded 11 Nurse Aides (NA); the daily staffing schedule recorded 10 NA.3/09/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 3 LPN.3/10/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.3/11/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN and 11 NA; the daily staffing schedule recorded 3 LPN and 10 NA.3/12/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.3/14/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN and 13 NA; the daily staffing schedule recorded 2 LPN and 11 NA.3/15/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN and 13 NA; the daily staffing schedule recorded 3 LPN and 11 NA.3/16/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 3 LPN.3/17/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.3/18/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.3/19/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.3/21/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN and 14 NA; the daily staffing schedule recorded 3 LPN and 12 NA.3/22/26-Report of Nursing Staff Directly Responsible for recorded 5 LPN and 14 NA; the daily staffing schedule recorded 3 LPN and 12 NA.3/23/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN and 11 NA; the daily staffing schedule recorded 3 LPN and 13 NA.3/24/26- Report of Nursing Staff Directly (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Responsible for recorded 4 LPN and 11 NA; the daily staffing schedule recorded 3 LPN and 12 NA.3/25/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 2 LPN.3/26/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.3/28/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN and 13 NA; the daily staffing schedule recorded 3 LPN and 11 NA.3/30/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 3 LPN.3/31/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.4/01/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.4/04/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN and 13 NA; the daily staffing schedule recorded 3 LPN and 11 NA.4/05/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 2 LPN.4/06/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.c. A review of the daily nursing schedule form for the 11:00 pm-7:00 am shift revealed the licensed and unlicensed nursing staff was not recorded accurately for the following days:3/22/26-Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 2 LPN.3/24/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN and 8 NA; the daily staffing schedule recorded 2 LPN and 7 NA.3/25/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 2 LPN.4/03/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN and 7 NA; the daily staffing schedule recorded 2 LPN and 8 NA.4/05/26- Report of Nursing Staff Directly Responsible for recorded 9 NA; the daily staffing schedule recorded 8 NA.During an interview on 4/08/26 at 11:02 am with the Staff Development Coordinator (SDC) she revealed she was responsible for the master schedule of the nursing department, but she did not complete the Report of Nursing Staff Directly Responsible that was posted in the lobby of the facility daily. The SDC reported that the Scheduler prepared the daily staffing schedule based off the master schedule and would then give the daily staffing schedule to the Receptionist to complete and post the Report of Nursing Staff Directly Responsible. The SDC stated that nursing staff work 8 and 12-hour shifts and were identified on the daily staffing schedule by a slash between the two staff names when staff were splitting an 8-hour shift. An interview was conducted on 4/09/26 at 9:50 am with Receptionist #1 who completed the Report of Nursing Staff Directly Responsible on 3/21/26 and 4/04/26. Receptionist #1 stated she received the daily staffing schedule from the Scheduler via email the night before and she used that information to complete the report. She stated she was trained to complete the form by the previous Business Office Manager, and she did not know when staff split a shift that both staff members listed equaled only one person for the shift, so she just counted each name listed as one person. Receptionist #1 stated she did not update the Report of Nursing Staff Directly Responsible after she posted it first thing in the morning and she was not sure if anyone reviewed or updated the information posted throughout the day if changes were made to the staffing schedule. A telephone interview was conducted on 4/09/26 at 2:00 pm with Receptionist #2 who completed the Report of Nursing Staff Directly Responsible Monday through Friday. Receptionist #2 stated she was trained by Receptionist #3, Receptionist #4, and the previous Business Office Manager on how to complete the daily report. Receptionist #2 stated she was educated to count each person listed on the nursing schedule as one person for the shift staff totals. She stated she did not know that the facility had staff that worked 12-hour shift that required staff splitting shifts so she would not know how to count any staff member that split a shift. Receptionist #2 stated she completed and posted the form in the morning and did not adjust the numbers after she posted it because she would not know if changes were being made. Receptionist #3 was interviewed via telephone on 4/09/26 at 2:12 pm who revealed she completed the Report of Nursing Staff Directly Responsible every other weekend when she worked. She stated she was educated on how to complete the form by the previous Business Office Manager. Receptionist #3 stated she counted each person on the schedule as one person and did not know that some staff work (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	half a shift. Receptionist #3 stated did not adjust or correct the form because she did not take call outs for nursing staff so she would not know if any corrections needed to be made to the form once it was completed. An attempt to conduct a telephone interview with Receptionist #4 on 4/09/26 at 2:11 pm was unsuccessful. The Scheduler was interviewed on 4/09/26 at 2:28 pm who revealed she prepared the daily staffing schedule based off the monthly master schedule from the SDC. She stated she did not complete the Report of Nursing Staff Directly Responsible and she did not take staff call outs to notify the receptionist of any changes in the daily staffing schedule. The previous Business Office Manager was interviewed on 4/10/26 at 9:42 am. She confirmed she had trained the reception staff on how to complete Report of Nursing Staff Directly Responsible based on the staffing schedule provided by nursing. The previous Business Office Manager stated she was not aware that if two people were listed for the same assignment for the shift that meant they were splitting a shift, so she had educated all staff to count each person listed to get the total number of staff per shift.An interview was conducted with the Business Office Manager on 4/10/26 at 12:22 pm who revealed she was gaining an understanding on the process and receiving training on completing the Report of Nursing Staff Directly Responsible.During an interview on 4/10/26 at 12:29 pm with the Administrator she revealed she should have been reviewing the Report of Nursing Staff Directly Responsible for accuracy prior to being posted. The Administrator stated she had just begun checking the form for accuracy the last several days but had not reviewed the form prior.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of use of a wander/elopement alarm (Resident #11) and the use of anticoagulant medication (Resident #10) for 2 of 25 residents whose MDS assessments were reviewed. The findings included: 1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included hypertension. A physician order dated 2/20/26 for clopidogrel (an antiplatelet medication) 75 milligram (mg) give one tablet by mouth daily was observed in Resident #10's record. No anticoagulant medication had been ordered. Review of the Medication Administration Record (MAR) for February 2026 revealed Resident #10 received clopidogrel 75 mg daily as ordered. No anticoagulant medication had been received. The admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #10 had been taking anticoagulant medication during the assessment period. The MDS did not include antiplatelet medication use during the assessment period. An interview was conducted with the MDS Nurse on 4/9/26 at 11:43 AM. The MDS Nurse stated that coding the anticoagulant medication was an error. The MDS nurse stated during the review of Resident #10's physician's orders, she saw an order to monitor signs and symptoms related to anticoagulant therapy. The MDS nurse confirmed the admission MDS assessment should have been coded for the use of antiplatelet medication instead of anticoagulant medication. An interview was conducted with the Administrator on 4/10/26 at 2:15 PM. The Administrator stated she expected that the antiplatelet medication would have been coded correctly in Resident #10's MDS assessment. 2. Resident #11 was originally admitted to the facility on [DATE] with diagnoses which included unspecified dementia severe without behavioral disturbance. The care plan revealed Resident #11 had a wander guard in place related to attempting to exit the facility without alerting staff and safety awareness which was implemented on 8/28/25. The care plan further noted the wander guard was on the right ankle. Resident #11 was discharged to the hospital on [DATE] and returned on 12/24/25. The elopement risk assessment completed on 12/24/25 revealed Resident #11 had a wander/elopement alarm bracelet placed. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #11 had severe cognitive impairment and was not coded for the use of a wander/elopement alarm. Review of the active physician orders was completed and revealed Resident #11 did not have a physician order for the wander/elopement alarm bracelet. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	An observation was conducted of Resident #11 on 4/08/26 at 3:30 pm. Resident #11 was noted to have a wander/elopement alarm bracelet on the right ankle. During an interview with the MDS Nurse on 4/10/26 at 11:13 am she stated that normally she would review physician orders, complete observations, and talk with staff to complete the MDS assessments for a resident. The MDS Nurse stated she knew Resident #11 had a wander/elopement alarm bracelet in place, but she must not have coded it because there was not an order. The Administrator was interviewed on 4/10/26 at 12:33 pm who revealed the MDS Nurse should have done a physical observation and assessment or talk with nursing staff to determine if a wander/elopement alarm bracelet was in place for Resident #11 to ensure the assessment was coded accurately.