STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mount Rehabilitation Center	160 S Winstead Avenue Rocky Mount, NC 27804

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident and Pharmacist interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication for 2 of 4 residents reviewed for misappropriation of property (Resident #38 and Resident #83).The findings included:The facility's Abuse and Neglect Prohibition policy last revised 8/2023 indicated that each resident had the right to be free from abuse which included misappropriation of property which was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.a. Resident #38 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, gout, and long-term use of opiate analgesic (a type of opioid pain medication). Resident #38 had a physician order dated 8/21/25 for oxycodone (opioid pain medication) 5 milligrams (mg); one tablet by mouth three times a day for pain.A pharmacy proof of delivery shipment summary dated 8/26/25 revealed a delivery for Resident #38's oxycodone 5 mg tablets with a quantity of 90 tablets (3 medication cards with 30 tablets per card) on 8/27/25. Resident #38's Medication Administration Record (MAR) was reviewed for August 2025 and September 2025 and the oxycodone 5 mg tablet was administered as ordered.An interview was conducted with Resident #38 on 9/21/25 at 11:10 am who revealed she had no concerns related to pain management.b. Resident #83 was admitted to the facility on [DATE] with diagnoses which included chronic pain and peripheral vascular disease.Resident #83 had a physician order dated 8/15/25 for oxycodone 7.5 mg/acetaminophen 325 mg (an opioid pain medication); give one tablet by mouth every 4 hours for chronic pain.A pharmacy proof of delivery shipment summary dated 8/15/25 revealed a delivery for Resident #83's oxycodone 7.5 mg/acetaminophen 325 mg tablets with a quantity of 180 tablets (6 medication cards with 30 tablets per card) on 8/15/25.Resident #83's MAR was reviewed for August 2025 and September 2025 and the oxycodone 7.5 mg/acetaminophen 325 mg tablet was administered as ordered.An interview was conducted with Resident #83 on 9/21/25 at 12:52 pm. Resident #83 stated the facility managed her pain well and she did not have any concerns related to pain management.The initial allegation report completed by the Administrator revealed the facility became aware of misappropriation of resident property on 8/31/25 when the Staff Development Coordinator (SDC) and the Regional Clinical Director notified the Administrator that Resident #38 and Resident #83 had missing narcotics and the medications were unable to be located in the facility. The Administrator submitted an initial report to the Division of Health Service Regulation for misappropriation of resident property for Resident #38 and Resident #83 on 8/31/25. The police department was notified of suspicion of crime on 8/31/25 at 3:53 pm. A review of the 5-day investigation report completed by the Administrator dated 9/05/25 revealed that the allegation of misappropriation of resident property identified two residents (Resident #38 and Resident #83) who were affected and the allegation was not substantiated by the facility. The facility's investigation indicated that Resident #38 had one medication card, which contained 30 tablets, of oxycodone 5 mg tablets and Resident #83 had one medication card, which contained 30 tablets of oxycodone 7.5 mg/acetaminophen 325 mg tablets, that were each unable to be located in the facility. Nurse #11, who was the named agency nurse in the investigation report, was placed on the do not return list. The local police department, Adult Protective Services, and the Drug Enforcement Agency (DEA) were notified of the missing narcotics.Attempts to conduct a telephone interview with Nurse #11 on 9/24/25 at 3:44 pm and 9/25/25 at 9:30 am were unsuccessful.An interview was conducted with Nurse #9 on 9/24/25 at 1:16 pm who revealed she worked on the medication cart utilized for the hall Resident #38 and Resident #83 resided on during the 7:00 am-3:00 pm shift on 8/28/25 and 8/29/25. Nurse #9 stated she arrived to work on 8/29/25 for the 7:00 am-3:00 pm shift and she completed the narcotic count for the medication cart with Nurse #11. Nurse #9 stated when they completed the narcotic count the number of narcotic medication cards in the locked drawer of the medication cart matched the number of the narcotics noted on the controlled drug count record (used to monitor narcotics that were added and removed from the medication cart), which she recalled was noted as 25 narcotic medication cards. Nurse #9 stated she had worked the previous day (8/28/25) and recalled the number of narcotic reconciliation for the medication cart was 27 when she completed her shift at 3:00 pm and she could not recall any of the narcotics being close to empty. Nurse #9 explained that narcotic cards were only removed when discontinued or the pack was empty and she knew nothing was close to empty when she left the previous today. Nurse #9 further explained that she felt like something was off with the narcotic medication card count throughout her shift even though the

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Medical Director interviews, the facility failed to have effective systems in place for entering tracheostomy care orders, so they were placed on the Treatment Administration Record (TAR) for completion by nursing staff. Nurse #2 did not provide tracheostomy care consistent with professional standards of practice when she was observed picking up the oxygen tubing off the floor and attaching it to the corrugated tubing connected to the humidifier (adds moisture to the oxygen). In addition, the facility failed to have effective systems in place for identifying an avoidable open moisture-associated skin damage in Resident #9's skin fold on her neck. The deficient practice occurred for 1 of 2 residents reviewed for tracheostomy care (Resident #9). The findings included:Resident #9 was readmitted to the facility on [DATE] with diagnoses that included anoxic brain damage and tracheostomy status. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed that Resident #9 had no speech, rarely/never understood/understands, and was severely cognitively impaired. She was totally dependent on staff for all activities of daily living (ADL) and was coded for tracheostomy care. Review of Resident #9's care plan updated on 5/13/25 revealed that she had impaired gas exchange/ineffective airway clearance related to respiratory failure with brain injury, tracheostomy, and history of COVID. Interventions included tracheostomy care. Review of physician orders dated 6/10/25 revealed that Resident #9 was to receive tracheostomy care every shift and as needed and suctioning as needed for secretions, mucus, and/or increased shortness of breath. The order was entered by the previous Infection Preventionist and there were no specifics regarding tracheotomy care included in the order. Review of a skin assessment dated [DATE] and completed by Nurse #8 revealed that Resident #9 did not have any new skin concerns. Nurse #8 was interviewed on 9/24/25 at 3:16 PM and stated when performing skin checks the areas observed included were the sacrum, heels, and any other bony prominence (normal breakdown spots). He stated that he would only check the head or neck area if nursing staff alerted him of a new skin issue. Review of the June 2025 through September 2025 Treatment Administration Records (TAR) revealed there were no orders for tracheostomy care as the order did not populate on the TAR for completion from 6/10/25 through 9/24/25. A continuous observation of tracheostomy care and interviews were conducted on 9/24/25 from 11:17 AM through 12:12 PM. Nurse #2 was the assigned nurse for Resident #9; however, the facility asked Nurse #1 to perform the tracheostomy care. Nurse #2 stated that she had never performed tracheostomy care at the facility for Resident #9 and wanted to observe Nurse #1 for training. Nurse #2 stated that the overnight shift usually performed the tracheostomy care. At 11:33 AM, Nurse #2 was observed picking up the oxygen tubing off the floor and reattaching it to the corrugated tubing connected to the humidifier. Nurse #1 responded: You can't do that. Nurse #1 then instructed Nurse #2 to retrieve all new oxygen and corrugated tubing that was sterile. The concern of the tubing on the floor was related to infection control purposes. When Nurse #2 returned to the room with the new tubing, she stated that the oxygen tubing often disconnected from the corrugated tubing during her shift, and she normally reconnected the tubing without changing any of the tubing. Nurse #1 stated that Nurse #2 should have disconnected and replaced all tubing when the oxygen tubing was found on the floor. Nurse #2 stated that she thought the opening to the corrugated tubing was not a sterile site. At 12:12 PM, as Nurse #1 was disconnecting the tracheostomy tie on the right side of Resident #9's neck, she noticed an open moisture-associated skin damage (MASD) area within the skin fold. She then took used her sterile gloves and put sterile water on a piece of gauze and treated the area. Bright red blood was found on the used gauze. An interview was conducted with the Wound Nurse on 9/24/25 at 4:48 PM. She revealed that Resident #9's newly discovered skin issue found on 9/24/25 was caused by MASD. Her neck area was moist and sweaty. The Wound Nurse had to open the skin folds on the neck to see it. She stated that she contacted the wound provider, and she wanted to try antifungal powder as well as interdry (moisture wicking fabric with antimicrobial properties) sheets. The Wound Nurse stated that skin areas that hold moisture should have interdry sheets in between. The Wound Nurse indicated when the trach ties were changed, the nurses should inspect in between the skin folds of the neck. Skin assessment entails head-to-toe observation and not only boney prominences. With heavier residents, skin folds need to be assessed every shift or included with weekly skin checks. Nurse #8, who was assigned to Resident #9 during the 3:00 PM to 11:00 PM shift on 9/22/25 and 9/23/25, was interviewed on 9/24/25 at 3:16 PM. Nurse #8 revealed that he had performed Resident #9's tracheostomy

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review, Maryland Board of Nursing (MBON) and North Carolina Board of Nursing (NCBON) verification registries and staff interviews, the facility failed to verify a staff member from another state working as a registered nurse (Staff #1) had an active professional nursing license for 1 of 14 nursing staff reviewed. Staff #1 did not have a professional nursing license and performed the job responsibilities of a nurse from 2/24/25 through 6/15/25. The findings included: A review of Staff #1's employment application with the facility indicated she was hired as a Registered Nurse (RN) on 2/14/25. Her date of birth and middle name were included on her Maryland driver's license. A MBON licensure verification dated 2/14/25 located in Staff #1 's employment folder indicated the same first and last name as Staff #1 was listed as an active RN with a compact state license that included North Carolina. The middle name was not included on the nursing license. Record review indicated Staff #1's nurse competencies were reviewed after hire during her training with another staff member. The record showed this competency verification was completed in full with no areas of concern identified. A review Staff #1's personnel file revealed no evidence of performance issues or disciplinary action. A review of Staff #1's timecard report from 2/14/25 through 6/15/25 recorded Staff #1 worked the following hours as an RN on the following dates: 2/24/25 8:00 am - 12:30 pm, 1:00 pm - 3:00 pm2/25/25 9:01 am - 3:39 pm2/26/25 7:00 am - 3:21 pm3/4/25 7:00 am - 3:16 pm3/6/25 10:44 pm - 7:18 am3/8/25 10:39 pm - 7:49 am3/9/25 10:38 pm - 7:12 am3/10/25 10:43 pm - 7:15 am3/13/25 10:40 pm - 7:35 am 3/17/25 10:45 pm - 7:30 pm3/19/25 10:26 pm - 7:57 am3/20/25 10:40 pm - 7:40 am3/22/25 10:48 pm - 8:00 am3/23/25 10:54 pm - 7:34 am3/24/25 10:44 pm - 7:35 am3/27/25 10:32 pm - 7:35 am3/31/25 10:53 pm - 8:57 am4/2/25 10:43 pm - 8:32 am 4/3/25 10:43 pm - 7:19 am4/4/25 10:52 pm - 7:56 am4/5/25 10:50 pm - 8:14 am4/6/25 10:55 pm - 7:35 am4/7/25 10:47 pm - 7:57 am4/14/25 10:59 pm - 7:19 am4/16/25 10:52 pm - 7:55 am4/17/25 10:46 pm - 7:55 am4/19/25 10:46 pm - 7:45 am4/20/25 10:54 pm - 8:39 am4/24/25 10:42 pm - 7:42 am4/28/25 10:46 pm - 7:34 am4/30/25 10:40 pm - 7:41 am5/1/25 10:45 pm - 7:36 am5/3/25 10:40 pm - 8:08 am5/4/25 10:45 pm - 8:07 am5/5/25 10:44 pm - 7:46 am5/8/25 10:46 pm - 8:06 am5/9/25 10:45 pm - 7:46 am5/12/25 10:44 pm - 7:49 am5/14/25 10:45 pm - 11:15 pm5/21/25 11:28 pm - 7:47 am5/23/25 10: 45 pm - 7:40 am5/26/25 11:10 pm - 8:38 am5/27/25 11:05 pm - 7:38 am5/28/25 11:29 pm - 7:33 am5/29/25 11:39 pm - 7:39 am5/30/25 10:45 pm - 7:45 am5/31/25 10:56 pm - 8:36 am6/1/25 10:47 pm - 7:22 am6/2/25 11:27 pm - 8:05 am6/5/25 11:46 pm - 7:44 am6/9/25 11:38 pm - 7:38 am6/11/25 11:40 pm - 7:46 am6/12/25 11:30 pm - 7:54 am6/14/25 10:40 pm - 7:45 am6/15/25 10:45 pm - 7:37 am The Former Scheduler was interviewed via telephone on 9/23/25 at 12:02 PM. She indicated that she received a call from a Staffing Agency Owner on 7/7/25 asking if Staff #1 currently worked at the facility. Staff #1 no longer worked for the facility at that time and had applied to the Staffing Agency. The Staffing Agency Owner told the Former Scheduler that Staff #1 was not a nurse. She explained that she personally knew the Director of Nursing (DON) at Facility #2 and was aware Staff #1 had worked there in the role of a nurse as well. The Former Scheduler indicated that the Staffing Agency Owner asked her to stay on hold while she called the DON at Facility #2. When taken off hold, the Staffing Agency Owner merged the call with the Former Scheduler and the DON at Facility #2. The Staffing Agency Owner told them that Staff #1 applied at the Staffing Agency and the agency could not find a matching social security number or a valid nursing license for Staff #1 and stated that, therefore, Staff #1 was not a licensed nurse. The Former Scheduler indicated that she did not do anything further with that information. The Staffing Agency Owner was interviewed via telephone on 9/23/25 at 12:04 PM. She stated that Staff #1 never applied to her company, and she denied contacting the facility on 7/7/25. Facility #2's Administrator, the other facility where the Staffing Agency Owner indicated Staff #1 worked, was interviewed via telephone on 9/23/25 at 10:19 AM. She revealed that Staff #1 was hired at Facility #2 as an RN. She indicated when Facility #2's DON performed an independent search to verify Staff #1's credentials, they could not connect her name to the Maryland Nursing and Interstate Compact License because the full name of Staff #1 did not match exactly. When Staff #1 was approached about the questionable search results, she became angry and would not answer any questions. Facility #2's Administrator reported that Staff #1 told her and Facility #2's DON that she was in Nurse Practitioner school at a local community college. During a telephone interview with Facility #2's DON on 9/23/25 at 10:48 AM, she revealed that the Staffing Agency Owner initiated a call between herself and the Former Scheduler of Facility #1 on 7/7/25 at 9:00 PM. The Staffing Agency Owner reported the agency had some concerns about Staff #1, and they were considering hiring her. The Staffing Agency Owner questioned