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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rocky Mount Rehabilitation Center | 160 S Winstead Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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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|---|---|
| F 0628<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide the resident or Responsible Party (RP) the bed hold policy for 2 of 4 residents reviewed for hospitalization (Resident #12 and Resident #15).The findings included:1a. Resident #12 was admitted to the facility on [DATE].The nursing progress note dated 8/08/25 revealed Resident #12 was sent to the hospital.The medical record indicated Resident #12 was discharged from the facility on 8/08/25 and returned to the facility on 8/13/25.The medical record was reviewed and no documentation was noted that the facility provided Resident #12 or the RP the bed hold policy.b. The nursing progress note dated 8/20/25 revealed Resident #12 was transferred to the hospital.The medical record indicated Resident #12 was discharged from the facility on 8/20/25 and returned to the facility on 8/29/25.The medical record was reviewed and no documentation was noted that the facility provided Resident #12 or the RP the bed hold policy.An interview was conducted with Resident #12 and the RP on 9/21/25 at 2:28 pm. Resident #12 and the RP revealed they did not receive any information regarding the bed hold policy when the resident was transferred to the hospital on 8/08/25 or 8/20/25.An interview was conducted with the admission Director on 9/23/25 at 9:07 am who revealed she was responsible for providing residents and their RP with copies of the bed hold policy when a resident was transferred to the hospital. The admission Director stated she did not normally discuss the bed hold policy when a resident was transferred to the hospital unless she needed to use the room for some reason. The admission Director stated she did not discuss the bed hold policy with Resident #12 or the RP when he transferred to the hospital on 8/08/25 or 8/20/25.During an interview with the [NAME] President of Operations on 9/03/25 at 9:10 am he stated the admission Director was the person that would discuss the bed hold policy for Resident #12. He reported that the facility was unable to locate any documentation that the bed hold policy was discussed for Resident #12's transfers to the hospital.2. Resident #15 was admitted to the facility on [DATE].The nursing progress note dated 9/19/25 revealed Resident #15 was transferred to the hospital.The medical record indicated Resident #15 was discharged from the facility on 9/19/25.The medical record was reviewed and no documentation was noted that the facility provided Resident #15 or the RP the bed hold policy.A telephone interview was conducted with Resident #15's RP on 9/25/25 at 9:18 am who revealed she was not notified about the bed hold policy or procedure when Resident #15 was transferred to the hospital on 9/19/25.During an interview on 9/25/25 at 9:16 am with the admission Director, she revealed she did not contact Resident #15's RP for the 9/19/25 transfer to the hospital to discuss the bed hold policy. The admission Director stated she would not have contacted Resident #15's RP to discuss the bed hold policy unless she needed the room for another resident. An interview was conducted with the [NAME] President of Operations on 9/25/25 at 9:06 am who revealed the facility had no documentation about the bed hold policy communication with Resident #15's RP. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to follow professional standards of care when the nurse did not remain at the bedside to ensure the resident had taken all the medications. The deficient practice was observed for 1 of 1 resident observed with medications at bedside (Resident #74).The findings included:Resident #74 was admitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis.Review of the medical record revealed a physician order dated 2/21/25 for Lanthanum Carbonate 500 milligram (MG) Chewable Tablet (a medication used to decrease the amount of phosphate in the blood caused by kidney disease). Give 3 tablets by mouth before meals.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 was cognitively intact.Resident #74's care plan last reviewed 8/18/25 did not include self-administration of medication.There was not an assessment of Resident #74 in the medical record to determine if it was safe for the resident to self-administer medications.On 9/21/25 at 12:37 PM Resident #74 was observed with a large white pill with the number 500 sitting in a cup on her bedside table. Resident #74 reported she took the medication before breakfast, lunch, and dinner daily. Resident #74 reported she was going to take the medication and had placed the medication in the cup on the bedside table.An interview was conducted with Nurse #5 on 09/21/2025 at 1:43 PM. Nurse #5 stated she was supposed to watch the resident take her medication and make sure that she took all the medication before she left the room. Nurse #5 stated Resident #74 normally took all of her medication when given. An interview was conducted with Resident #74 with the Director of Nursing (DON) present on 09/21/2025 at 1:52 PM. Resident #74 stated that she took 2 of the tablets with the nurse there at the bedside. Resident #74 stated she must have forgotten to take the third pill. During an interview with the DON on 9/21/25 at 2:00 PM she stated Nurse #5 should have stayed with Resident #74 and watched her take the medication before exiting the room. An interview was conducted with the Administrator on 9/25/25 at 1:10 PM. The Administrator stated he expected the staff would make sure all medications were taken prior to leaving the resident. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 4 residents reviewed with a urinary catheter (Resident #11).The findings included:Resident #11 was admitted to the facility on [DATE]. Her cumulative diagnoses included urostomy, spina bifida, seizures, and chronic kidney disease. Resident #11's care plan included an area of focus related to the resident having an indwelling urinary catheter in place (Initiated on 7/16/25). An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had severely impaired cognition. She experienced fluctuating disorganized thinking but no rejection of care behaviors. The assessment indicated Resident #11 required substantial/maximal assistance with all activities of daily living (ADL). The MDS reported Resident #11 had an indwelling urinary catheter.An observation was conducted on 9/21/25 at 12:35 PM as Resident #11 was lying in bed with a urinary catheter collection bag hanging from the left side of the bed frame. At the time of this observation, 3 inches of the bottom of Resident #11's urinary catheter bag was on the floor. During an interview on 9/21/25 at 1:29 PM with Nurse Aide #1, who was assigned to Resident #11, she stated that the catheter bag should not be touching the floor. However, when Resident #11's bed went up and down, the catheter bag would touch the floor if the bed was too low. Nurse Aide #1 stated she normally emptied the bag at the end of her shift, so she did not know how long the catheter bag/cover was touching the floor. Nurse Aide #1 then raised Resident #11's bed so that the catheter bag/cover was off the floor. An interview was conducted with the interim Director of Nursing (DON) on 9/24/25 at 9:15 AM. She revealed that the catheter bag should not be touching the floor or hanging above the abdomen. Resident #11's catheter bag should never have been on the floor, and it should have been placed in a location that did not compromise her with a possible infection. The interim Administrator was interviewed on 9/24/25 at 10:23 AM. He revealed that Resident #11's catheter bag should have been hung so when the bed was lowered it did not touch the floor. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to provide nutritional support through enteral feeding (a method of delivering nutrition directly into the gastrointestinal (GI) tract, typically through a feeding tube) as ordered by the physician for 1 of 2 residents reviewed for tube feedings (Resident #79).The findings included: Resident #79 was readmitted to the facility on [DATE]. His diagnoses included anoxic brain damage, and dysphagia. The care plan dated 3/13/24 revealed Resident #79 was at risk for malnutrition and dehydration related to a past medical history of aphasia, anoxic brain damage, gastrostomy tube (g-tube) feedings, heart failure, coronary artery disease, hypertension, gastroparesis, epilepsy, colostomy status, quadriplegia, and vitamin D deficiency. There was a need for enteral nutrition and on medications with signs and symptoms of appetite and weight changes. Interventions included: Administer g-tube feedings and water flushes as ordered. Observe for signs and symptoms of dehydration. Monitor and evaluate weight/weight changes. Monitor/record/report signs and symptoms of malnutrition. The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #79 was severely cognitively impaired and was totally dependent on staff for all activities of daily living (ADL). He had no speech and rarely/never understood/understands. The MDS indicated Resident #79's nutrition was approached with the use of tube feedings, and he received more than fifty one percent of his calories and more than five hundred and one milliliters of fluid intake per day from his tube feedings. The physician order dated 9/5/25 revealed Resident #79 was ordered fortified nutritional supplement at seventy-five milliliters (mL) per hour for twenty-two hours from two o'clock in the afternoon to twelve o'clock in the afternoon via g-tube. Medication Administration Record (MAR) dated September 2025 revealed fortified nutritional supplement at seventy-five milliliters (mL) per hour for twenty-two hours from two o'clock in the afternoon to twelve o'clock in the afternoon via g-tube. Nurse #5 documented on the MAR that the tube feeding was administered on 9/21/25 as scheduled. During a continuous observation on 9/2125 from 11:08 AM until 11:48 AM, Resident #79 was observed lying in bed, and the tube feeding pump screen was black with a green light signifying the battery was charging. The tube feeding formula was hanging with date/time identifiers, and the bottle was just about full (missing 1/8th of the amount). At 11:36 AM on 9/21/25, Nurse #5 was observed walking past Resident #79's room, looking in, and continued down the hall. An interview and observation with Nurse #5 were conducted on 9/21/25 at 11:49 AM. Nurse #5 confirmed that the tube feeding was supposed to be off from 12:00 PM - 2:00 PM every day. She stated she was not aware that Resident #79's tube feeding was not infusing from 11:08 AM - 11:49 AM. Nurse #5 indicated that perhaps Nurse Aide #2 provided care for Resident #79, turned off the tube feeding pump, and forgot to turn it back on. Nurse Aide #2 was interviewed on 9/21/25 at 11:52 AM. She revealed that she provided care to Resident #79 at 7:00 AM the same morning. Normally, when she performed care for Resident #79, she would place the tube feeding pump on hold and then when finished with care, she would unlock the hold. Nurse Aide #2 stated she never turned the tube feeding pump off completely. She further stated that she could not say when she was in the room last but had passed by the room since 7:00 AM and did not notice if the tube feeding pump was off. During an interview with the Director of Nursing (DON) on 9/24/25 at 9:35 AM, she revealed that Resident #79's tube feeding pump should not have been turned off from 11:08 AM - 11:48 AM. Nurse #5 should have followed the physician order to hold the feeding from 12:00 PM until 2:00 PM. The interim DON stated that rounds were performed every two hours by Nurse Aide #2 and anytime Nurse #5 went into the room to give medication. The Administrator was interviewed on 9/24/25 at 10:24 AM. He revealed that the physician's order for Resident #79's continuous tube feeding should have been followed as ordered. Unless care was provided, the tube feeding pump should be kept on. |

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

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observations, record review and staff interviews, the facility failed to ensure nursing staff were competent to provide tracheostomy (surgical hole in the windpipe) care when Nurse #2 was observed picking oxygen tubing off the floor and attaching it to the corrugated tubing connected to the humidifier (adds moisture to the oxygen). During interviews Nurse #4 indicated she had not received any education from the facility regarding tracheostomy care and Nurse #7 indicated no one had evaluated her performance for tracheostomy care since her most recent return 2 months ago. In addition, the facility was unable to locate any nursing skills competency check off information for tracheostomy care for any of the nursing staff. The deficient practice occurred for 3 of 8 nursing staff reviewed for tracheostomy care competencies (Nurse #2, Nurse #4, and Nurse #7). The findings included:Review of a competency and training fair held at the facility on 6/29/25 with various specialists to provide education to facility staff revealed that the Respiratory Therapist provided training to nurses about tracheostomy/respiratory care. However, there was no evidence that Nurse #2 and Nurse #4 attended the training. a. 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 and wanted to observe Nurse #1 for training. She also stated that she did not attend the tracheostomy care training at the facility on 6/29/25 provided by the Respiratory Therapist. At 11:33 AM, Nurse #2 was observed picking up the oxygen tubing off the floor and reattached 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. 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. b. Nurse #4 was interviewed via telephone on 9/24/25 at 4:30 PM. She revealed that she was an agency nurse, worked the 11:00 PM to 7:00 PM shift at the facility, and picked up shifts every now and then. Nurse #4 stated that she had tracheostomy care experience from her nursing history but had not received any education from the facility regarding tracheostomy care, including the training provided on 6/29/25 by the Respiratory Therapist. She further stated that she did perform tracheostomy care for Resident #9, and the tracheostomy care that she performed during her shift included changing the gauze dressing around the stoma (opening created by a surgeon) because it was usually soiled. c. Nurse #7, who worked with Resident #9 during the day shift from 7:00 AM until 3:00 PM on 9/22/25 and 9/23/25, was interviewed on 9/24/25 at 2:04 PM. She revealed she worked at the facility previously, left about 2 years ago, and returned to the facility 2 months ago. She stated no one had evaluated her performance for tracheostomy care since her most recent return 2 months ago. In the last 2 months since she has been back, there had not been any paper education or any other kind of training provided related to tracheostomy care. A telephone interview was conducted with the Respiratory Therapist on 9/24/25 at 2:31 PM. The Respiratory Therapist stated she last provided tracheostomy care education on 6/29/25 during a skills fair for some of the nurses who dropped in for a 15-minute instruction. There were 2 to 3 nurses at a time that would watch a video about suctioning/tracheostomy care and then performed the same process on a practice dummy. The drop in training was a 4-hour window and was usually provided 1 to 2 times per year and per the facility's discretion. The Respiratory Therapist indicated that the Staff Development Coordinator/previous Director of Nursing helped schedule the drop-in class. If she (the Respiratory Therapist) noticed that a nurse needed extra help, she would notify the DON; however, no nurses needed extra help on 6/29/25. During an interview with the Staff Development Coordinator/previous Director of Nursing (from 4/1/25 through 9/9/25) on 9/24/25 at 4:56 PM, she revealed that she was not aware of the tracheostomy care education protocol. The respiratory skills were included in orientation with a 10-minute video and then time for questions and answers. The Staff Development Coordinator/previous Director of Nursing stated the previous Staff Development Coordinator left abruptly without notice on 6/7/25, and the role had not been filled since then until 9/9/25. She indicated that nurse competencies for tracheostomy care were not performed during this time except for the on-site skills fair on 6/29/25. However, not all nurses attended. The Staff Development Coordinator/previous Director of Nursing stated she was not aware of any tracheostomy care training prior to 6/7/25 and there was no documentation to support that it was provided |

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| | 345260 | A. Building<br>B. Wing | 11/21/2025 |

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| Rocky Mount Rehabilitation Center | 160 S Winstead Avenue<br>Rocky Mount, NC 27804 |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation, record review and staff interviews, the facility failed to post daily nurse staffing sheets at the beginning of each shift for 1 of 5 days of the survey (9/21/25). In addition, the facility was unable to locate a copy of the daily nurse staffing sheet for 1 of 31 days reviewed (9/20/25).The findings included: An observation on 9/21/25 at 10:14 AM revealed the daily posted staffing sheet posted in the lobby was dated 9/19/25. Review of the facility's daily posted nurse staffing sheets from 8/21/25 through 9/20/25 revealed the 9/20/25 staffing sheet was missing.During an interview with the Scheduler on 9/23/25 at 9:57 AM, she revealed that she was responsible for posting the nurse staffing information. The Scheduler explained she was not aware that she could print the nurse staffing information for the day ahead or the day before but rather only for the current day. The Scheduler stated the previous scheduler told her that she printed out the weekend posting on Friday's and placed the sheets in the medication room for the nurses to display at the front entrance. The interview further revealed the Scheduler could not say if the nurse staffing information was printed and posted during the weekends or the entire month of September. An interview was conducted with the interim Administrator on 9/24/25 at 10:26 AM, and he stated the weekend nursing staff should have access to the nurse staffing information to ensure that it was displayed timely and accurately. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and Pharmacist interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 25 opportunities. The 3 medication errors resulted in a medication error rate of 12% for 1 of 4 residents observed during medication administration (Resident #96).The findings included:Resident #96 was admitted to the facility on [DATE].a. An active physician order was in place for cholecalciferol tablet (Vitamin D3) 1000 units give 2 tablets by mouth one time a day for vitamin D deficiency.During a continuous medication administration observation on 9/23/25 at 8:04 am through 8:10 am, Nurse #6 was observed to prepare and administer two vitamin B12 500 microgram (mcg) tablets to Resident #96.An interview was conducted with Nurse #6 on 9/24/25 at 10:39 am who confirmed Resident #96 was administered two vitamin B-12 tablets during the morning medication pass observation. Nurse #6 reviewed the physician order and completed an internet search for the cholecalciferol tablet and confirmed it was a vitamin D3. Nurse #6 stated she thought the vitamin B-12 was the correct medication listed in the order, but she should have checked to make sure before she administered it to Resident #96.A telephone interview was conducted on 9/24/25 at 3:52 am with the Pharmacist who revealed there was no medical concern with Resident #96 being administered the vitamin B-12 instead of cholecalciferol (vitamin D3).During an interview on 9/24/25 at 11:31 am the Director of Nursing (DON) stated Nurse #6 should have checked the order against the pill bottle and if she was still unsure the nurse should have looked up the medication. The DON stated Nurse #6 should not have administered medication to Resident #96 if she was unsure if it was the correct medication.b. An active physician order was in place for fluticasone propionate 50 mcg nasal spray instill one spray per nostril one time a day for allergies.During a continuous medication administration observation on 9/23/25 at 8:04 am through 8:10 am, Nurse #6 was observed to enter Resident #96's room and open the nasal spray and pump the spray to release one dose in the air. Nurse #6 was then observed to administer two sprays per nostril of the fluticasone propionate nasal spray to Resident #96 and exited the room.An interview was conducted with Nurse #6 on 9/24/25 at 8:13 am who revealed sometimes it did not feel like the full dose of medication goes in when she pushed down on the nasal spray pump, so she administered the two sprays to make sure the resident got enough of the medication.A telephone interview was conducted on 9/24/25 at 3:52 am with the Pharmacist who revealed there was no medical concern with Resident #96 being administered two sprays per nostril of the fluticasone propionate nasal spray.During an interview on 9/24/25 at 11:31 am with the Director of Nursing (DON) she revealed Nurse #6 should have administered the medication as ordered by the physician to Resident #96.c. An active physician order was in place for levothyroxine sodium 50 microgram (mcg) tablet give 1 tablet every day in the morning upon rising for hypothyroidism.During a continuous medication administration observation on 9/23/25 at 8:04 am through 8:10 am, Nurse #6 was observed to prepare Resident #96's morning medications which included the one levothyroxine 50 mcg tablet. The medication blister pack card had a yellow sticker which read take on an empty stomach. Resident #96 was observed sitting in a chair eating breakfast with approximately half of her meal remaining. Nurse #6 administered the medications, which included the levothyroxine tablet to Resident #96 and exited the room.An immediate interview was conducted with Nurse #6 on 9/23/25 at 8:13 am who revealed she was aware the medication was supposed to be given on an empty stomach, and she thought it would have been given on the night shift, but the medication was listed for her to administer. Nurse #6 stated she did not check if any medications had to be given before breakfast when she started her shift and she did not think to hold the medication since Resident #96 had already eaten breakfast. Nurse #6 reviewed the blister pack and confirmed the package had a sticker that stated the levothyroxine was to be administered on an empty stomach. A telephone interview was conducted on 9/24/25 at 3:52 pm with the Pharmacist who revealed the levothyroxine medication was recommended to be administered first thing in the morning on an empty stomach because the medication absorbs best on an empty stomach. The Pharmacist stated the medication blister pack had an information label that reminded staff to administer the medication on an empty stomach.An interview was conducted with the Director of Nursing (DON) on 9/24/25 at 11:31 am, she revealed the facility administered medications upon rising which was generally between 7:00 am and 11:00 am unless the medication had specific administration instructions. The DON stated that the levothyroxine was to be administered an empty stomach and Nurse #6 should have administered the medication before Resident #96 ate her breakfast. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observations, and staff and Pharmacist interviews the facility failed to (1) remove expired medications from the medication refrigerator in 1 of 1 medication storage room observed (Nursing Station), and (2) remove expired medication and (3) refrigerate medications according to the manufacturer's recommendations for 2 of 3 medication carts reviewed (Hall 100 and Hall 200).The findings included:1. During an observation of the medication refrigerator in the medication storage room (Nursing Station) with the Director of Nursing (DON) on 9/24/25 at 8:32 am the following was observed. The DON confirmed all findings before the removal of the identified items.One box with 5 COVID-19 mRNA vaccine injections with an expiration date of 9/06/25.One open plastic bottle of cephalexin (antibiotic) 250 milligrams per 5 milliliters (mg/ml) oral suspension with an expiration date of 8/31/25.One open plastic bottle of vancomycin hydrochloride (antibiotic) 250 mg/5 ml oral solution with an expiration date of 8/17/25.An immediate interview was conducted with the DON on 9/24/25 at 8:56 am who revealed the Unit Manager was responsible for checking the medication room and removal of expired medications.An interview was conducted with the Unit Manager on 9/24/25 at 8:57 am who revealed she tried to check the medication storage room every few weeks to make sure expired items were removed.2. An observation of the Hall 100 medication cart was conducted on 9/24/25 at 10:28 am with Nurse #1. Nurse #1 confirmed the findings before the removal of the identified item.One fluticasone, furoate, umeclidinium and vilanterol 200 micrograms (mcg)/62.5 mcg/25 mcg inhalation powder (medication used to treat chronic obstructive pulmonary disease (COPD) and asthma) was observed open with an open date of 8/02/25. The outer package of the fluticasone, furoate, umeclidinium and vilanterol inhalation powder read to discard after 6 weeks of opening.An immediate interview was conducted with Nurse #1 on 9/24/25 at 10:32 am who revealed she did not know the medication should have been removed 6 weeks after opening.During an interview on 9/24/25 at 11:24 am with the Director of Nursing (DON) she revealed she was new to the facility and had not yet implemented a process for the medication carts to be checked for expired medications.3. The manufacturer's recommendations for insulin lispro recommended that unopened insulin be stored in the refrigerator at approximately 36 to 46 degrees Fahrenheit.An observation was conducted on 9/24/25 at 9:53 am of the 200 Hall medication cart with Nurse #2. Nurse #2 confirmed the findings before the removal of the identified items.Two insulin lispro (rapid-acting) 100 units per milliliter (ml), 3 ml injector pen was observed unopened with 300 units of the 300 units of insulin remaining. The insulin lispro was in a clear plastic bag with blue lettering which read refrigerate and a label was attached to the injector pens which read refrigerate until opened.An immediate interview was conducted with Nurse #2 on 9/24/25 at 9:56 am who revealed the unopened insulin lispro pens should have been placed in the refrigerator when they were delivered from pharmacy until they were needed. A telephone interview was conducted on 9/24/25 at 3:56 pm with the Pharmacist who revealed the insulin lispro injector pens needed to be stored in the refrigerator until opened. The Pharmacist stated when new insulin pens were sent to the facility they were in a clear plastic bag with the word refrigerate stamped on the bag in large blue letters and a label attached to the pen which read the same. She stated labeling to refrigerate was done to remind the staff to store the medication in the refrigerator until ready to use.An interview was conducted with the Director of Nursing (DON) on 9/24/25 at 11:24 am. The DON revealed the insulin pens should have been placed in the refrigerator as labeled when they were delivered to the facility. |

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| F 0838<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>Based on staff interviews and record review, the facility failed to have an accurate facility assessment that recorded the current Administrator, Director of Nursing (DON), Infection Preventionist, Rehabilitation Manager, Staff Development Coordinator, and Maintenance Director. This deficient practice had the potential to affect 109 of 109 residents. The findings included:The facility assessment was reviewed and recorded the last update and review by the facility's quality assurance, performance, and improvement (QAPI) committee occurred on 10/31/24. Page one of the facility assessment recorded the names of the following former staff positions: Administrator, Director of Nursing (DON), Infection Preventionist, Rehabilitation Manager, Staff Development Coordinator, and Maintenance Director.The interim Administrator was interviewed on 9/23/25 at 10:31 AM. He revealed the facility assessment was managed by the Administrator. However, there had been multiple changes in leadership since 10/31/24. He stated the assessment was completed in the last year, and it was due 10/31/25 for all updates. The Administrator indicated that since he began as interim Administrator on 9/9/25, the administrative personnel listed in the facility assessment were not accurate. |

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

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| F 0839<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a medical record was complete and accurate regarding tracheostomy care. This was for 1 of 5 sampled residents whose medical record was reviewed for documentation (Resident #1).Resident #9 was readmitted to the facility on [DATE]. Physician orders for Resident #9 revealed that tracheostomy care every shift and as needed was entered into the electronic medical record on 6/10/25 by the previous Infection Preventionist. During an interview with the Staff Development Coordinator/previous Director of Nursing (from 4/1/25 - 9/9/25) on 9/24/25 at 4:56 PM, she revealed that when the order for tracheostomy care every shift and as needed was entered by the previous Infection Preventionist, she chose the standard option instead of the option that populated onto the Treatment Administration Record (TAR) or Medication Administration Record (MAR). She explained that the standard option only showed in the orders section of the electronic medical record, it did not activate the order to display for nurses to see or record their activity. Resident #9's TAR/MAR from 6/10/25 through 9/24/25 revealed the physician order dated 6/10/25 for tracheostomy care every shift and as needed was not listed. The only order related to Resident #9's tracheostomy that populated on the TAR/MAR was an as needed order for nurses to change Resident #9's tracheostomy and/or tracheostomy collar as needed with a size 6 Shiley (tracheostomy tube size). There was no evidence on the TAR/MAR that tracheostomy collar was changed on 8/27/25. Nurse #7, who worked with Resident #9, was interviewed on 9/24/25 at 2:04 PM. She revealed that she changed the tracheostomy collar on 8/27/25 but forgot to document in the TAR/MAR. Nurse #7 indicated that she did not notice Resident #9 did not have any tracheostomy care orders in the TAR/MAR. An interview was conducted with Nurse #8 on 9/24/25 at 3:16 PM. He worked with Resident #9 during the evening shifts from 3:00 PM - 11:00 PM on 9/22/25 and 9/23/25. Nurse #8 revealed that he usually performed tracheostomy care early in his shift and would normally document this activity in the TAR. However, Nurse #8 stated he did not document tracheostomy care for Resident #9 because there was no order in the TAR/MAR. During a telephone interview with Nurse #4 on 9/24/25 at 4:30 PM, she revealed that she worked with Resident #9 during the night shift from 11:00 PM - 7:00 AM on 9/17/25, 9/22/25, and 9/23/25. Nurse #4 stated that she did perform tracheostomy care for Resident #9, and the tracheostomy care that she performed during her shift. She could not recall there being a section to sign off on in the TAR/MAR for Resident #9's tracheostomy care. When asked why she did not report the order missing from the TAR/MAR, she stated because she just realized now when talking about Resident #9's tracheostomy that there was no section to sign off for care. An interview was conducted with the Director of Nursing on 9/25/25 at 1:38 PM. She revealed that tracheostomy care for Resident #9 was included as a physician order; however, it was not entered properly to populate for nurses to sign off on in the TAR/MAR. The Administrator was interviewed on 9/25/25 at 2:16 PM. When asked to discuss what caused the failure related to complete and accurate medical records for Resident #9, the Administrator did not provide an answer. He stated that the facility will need to review the process to ensure that nurses have access to document the care provided. |