

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Currituck Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3907 Caratoke Highway Barco, NC 27917	

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Responsible Party, Law Enforcement and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of property when a staff member (Nurse Aide #1) took checks from Resident #92 without her knowledge, cashed one of the checks for \$1000.00, and attempted to cash additional checks. The deficient practice was for 1 of 1 resident reviewed for misappropriation of resident property (Resident #92). Findings included: Resident #92 was admitted to the facility on [DATE]. An initial allegation report dated [DATE] completed by the Former Administrator showed that she (the Former Administrator) received an email from the Responsible Party of Resident #92, who also had Power of Attorney, on [DATE]. The Responsible Party of Resident #92 made the Former Administrator aware that someone had forged and cashed multiple checks from Resident #92's bank account. The report stated that the Responsible Party of Resident #92 did not accuse any one person and was working with the local police department who had initiated an investigation. A review of the 5-day investigation report dated [DATE] completed by the Former Administrator revealed that on [DATE] two officers from the local police department came to the building looking for a staff person. The investigation report stated that the staff person was Nurse Aide #1 who was not in the building at the time. The investigation report revealed that on [DATE] the Former Administrator received an email from the Responsible Party and Power of Attorney for Resident #92. The Responsible Party revealed in the email that Resident #92's checks had been taken and attempted to be cashed. The Responsible Party had notified the local police department, who had initiated an investigation and was working with the bank as well. The incident report stated that the Responsible Party of Resident #92 followed up with the Former Administrator in a phone call and revealed that Resident #92 had approximately five single checks with her at the facility. The Responsible Party informed the Former Administrator that Resident #92's bank account had been closed, and she was working with the bank and Currituck Sheriff Department regarding fraudulent charges. The incident report stated Nurse Aide (NA) #1 who was an agency staff, was suspended. Attempts made to contact NA #1 by phone on [DATE] and [DATE] were unsuccessful. A review of Resident #92's medical record revealed the resident expired at the facility on [DATE]. In an interview on [DATE] at 10:09 a.m. with Resident #92's Responsible Party, she revealed that 5 checks belonging to Resident #92 had been presented to the bank on various dates. She further revealed that the bank contacted her after one check for \$1000.00 had been cashed and 4 more checks were awaiting clearance. Resident #92's Responsible Party stated that she stopped the rest of the checks and the bank refunded the money that had been lost. She stated she reported the matter to the local police department and was not sure what happened thereafter. During an interview on [DATE] at 9:15 a.m. with Law Enforcement Officer #1, he revealed Nurse Aide #1 was arrested and charged in connection with the fraudulent checks presented to the bank. Law Enforcement Officer #1 stated that the case was still active and that he could not provide further information at this time. During an interview with the Business Office Manager (BOM) on [DATE] at 11:02 a.m. she revealed that she was not aware Resident #92 had checks with her at the facility. She revealed they discourage residents from having cash, checks, or credit cards on their person. During an interview on [DATE] at 11:50 a.m. with the Regional Director of Clinical Services, she revealed that Resident #92's Responsible Party had reached out to the facility on [DATE] around 10:00 a.m. and stated that somebody was attempting to cash checks belonging to Resident #92. She disclosed that Resident #92's Responsible Party immediately sent the facility copies of the checks, and it was discovered it was Nurse Aide #1 who was involved with the misappropriation. She stated that Nurse Aide #1's agency was contacted and her services were terminated. She further revealed Nurse Aide #1 was reported to the North Carolina Health Registry and the misappropriation of property allegation against her was substantiated. During a telephone interview with the Former Administrator on [DATE] at 9:29 a.m. she revealed she was contacted by Resident #92's Responsible Party on [DATE] about checks that had been cashed belonging to Resident #92. The Former Administrator stated that the Responsible Party had already contacted the local police department about the suspected fraud. She stated that Resident #92's Responsible Party sent her copies of the checks and that's when she noticed that Nurse Aide #1 was involved. She disclosed that the nurse aide was terminated, and the police advised the facility not to interview the nurse aide involved. The Former Administrator stated that the Responsible Party informed her that Resident #92's bank paid back all monies taken from her account. She stated that the facility completed an internal investigation after making a</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment (SCSA) after enrollment in a hospice program for 1 of 3 residents reviewed for death in the facility (Resident #6). Findings included: Resident #6 was admitted to the facility on [DATE] with a diagnosis of heart failure. A Long-Term Care Status Form dated 9/5/25 revealed Resident #6 was admitted to the hospice program at the facility on 9/5/25. His level of hospice care was routine hospice. No SCSA was found in Resident #6's medical record. In an interview on 12/2/25 at 3:51 PM MDS Nurse #1 stated Resident #6 was admitted to hospice services at the facility on 9/5/25. She reported she would have been responsible for completing an MDS SCSA for Resident #6 when he began receiving hospice services. She indicated she had missed this. MDS Nurse #1 stated she could not say why this had been missed. On 12/2/25 at 3:57 PM an interview with the Administrator indicated if Resident #6 had a significant change in status, an MDS SCSA should have been completed.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**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 area of Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident (Resident #40) reviewed for PASRR. Findings included: Resident #40 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and schizophrenia. Resident #40's PASRR Level II determination notice dated 3/12/21 revealed nursing home placement was appropriate. It included the specialized service determination of follow-up psychiatric services by a psychiatrist. This PASRR Level II determination notice had no expiration date. Resident #40's annual MDS assessment dated [DATE] revealed he was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. On 12/2/25 at 12:23 PM an interview with MDS Nurse #2 indicated she coded the PASRR section of Resident #40's MDS assessment dated [DATE]. She stated Resident #40's PASRR status was Level II and she should have coded his annual MDS assessment to reflect his status, but she had not. She stated she had not coded Resident #40's annual MDS assessment dated [DATE] accurately. In an interview on 12/2/25 at 12:40 PM the Administrator stated Resident #40's MDS assessment should have been accurately coded.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to attempt alternatives prior to the installation and use of bed rails and did not assess for risk of entrapment when completing assessments for 1 of 2 residents reviewed for bed rails (Resident #67). Findings included: Resident #67 was admitted to the facility on [DATE] with a diagnosis of hypertension. Resident #67's current comprehensive care plan revealed a focus area dated as initiated on 3/8/25 and last reviewed on 9/11/25 for bilateral quarter bed rails (bed rails which extend from the head of the bed to a quarter of the way down the bed) to promote bed mobility. The goal was for Resident #67 to not demonstrate a decline in bed mobility through the next review. An intervention was for staff to assist with bed mobility as needed. Resident #67's Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. He had no behaviors or rejection of care. He was independent with all bed mobility and transfers. He had no falls since his prior MDS assessment. Bed rails were not used as a restraint. A physician's order for Resident #67 dated 7/31/25 was for quarter bed rails bilaterally to the head of his bed. An Observation Detail List Report for Resident #67 dated 8/13/25 at 11:31 AM titled Enabler-Restraint Observation 2 completed by the Director of Nursing (DON) revealed the reason for bed rail use was that Resident #67 had a physician's order for quarter bed rails bilaterally due to weakness, had a medical condition, and they promoted independence. A list of potential negative outcomes including the potential for accidents related to bed rail use had been discussed with Resident #67. A list of potential benefits related to the use of bed rails including an increased feeling of safety and security had been discussed with Resident #67. The bilateral quarter bed rails did not restrict or prevent Resident #67's movement. Resident #67 was his own Responsible Party (RP) and had given verbal consent for the use of the quarter bilateral bed rails. There was no indication in the assessment that any alternatives to bed rail use had been attempted with Resident #67 and there was not an assessment for risk of entrapment included in this Enabler-Restraint Observation. Resident #67's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. He had no behaviors or rejection of care. He had no functional limitation of range of motion in his upper or lower extremities. He was independent with all bed mobility and transfers. He had no falls since his prior MDS assessment. Bed rails were not used as a restraint. On 12/3/25 at 8:21 AM Resident #67 was observed asleep in his bed. Bilateral bed rails measuring approximately 12 inches tall and 24 inches long, made of metal and attached to Resident #67's bedframe were in the raised position at the head of his bed. On 12/4/25 at 12:12 PM Resident #67 was observed in his room his wheelchair. Bilateral quarter bed rails were observed in the raised position at the head of his bed. In an interview conducted at that time, Resident #67 stated he used bed rails to assist himself with turning and repositioning in bed, and for transfers when he got in and out of the bed. He reported he had the bed rails since he was admitted to the facility, and he had not tried any alternatives to bed rails. 12/03/2025 at 3:00 PM an interview with the Maintenance Director he recalled Resident #67 getting his bed rails about a year and a half ago. He stated he would have gotten the assessment from either therapy or nursing that let him know Resident #67 needed bed rails and was appropriate for bed rails and then he would have installed them. He reported he no longer had the work order for the bed rails. The Maintenance Director indicated he no longer had the nursing or therapy assessment, but he was sure either nursing or therapy would have this. He reported the bed rails on Resident #67's bed had been specifically designed by the manufacturer for that bed. He stated when he installed bed rails, he assessed for entrapment risk including making sure that the mattress had no gaps between the rails and the mattress, and at the foot or head of the rails. He reported he also conducted safety inspections of all bed rails monthly. On 12/3/25 at 2:37 PM an interview with the DON indicated she was not certain why Resident #67 had bed rails. She stated a lot of times, residents had these at the hospital and would then request them when they entered the facility. She reported if this had been the case with Resident #67, then he would have been given the bed rails. The DON stated she had not attempted any alternatives to bed rail use with Resident #67 when she completed his bed rail assessment dated [DATE]. She reported bed rail assessments were conducted initially when the decision was made for bed rail use, and then at least quarterly. She further stated she did not see anywhere in Resident #67's record that alternatives to bed rail use had been attempted and had not met his needs. She reported maybe the therapy department had that information. On 12/3/25 at 2:33 PM an interview with the Therapy Director indicated nursing could do a bed rail assessment or the therapy could do</p>		