STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahoskie Health and Rehabilitation Center	604 Stokes Street East Ahoskie, NC 27910

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to update the resident's code status information when Resident #12's Responsible Party requested a change from do not resuscitate to full code. This was for 1 of 4 residents reviewed for advanced directives (Resident #12).The findings included:Resident #12 was admitted to the facility on [DATE].Resident #12's care plan revised 3/19/25 revealed he had a goal status of do not resuscitate.Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was assessed as being severely cognitively impaired.Review of a care plan meeting note dated 11/25/25 written by the MDS Nurse indicated Resident #12's responsible party stated she would like to change Resident #12's code status from do not resuscitate to full code.An attempt to contact Resident #12's responsible party was not successful on 12/18/25 at 9:39 AM.An observation of Resident #12's electronic medical record showed on the communication bar a code status icon that read do not resuscitate (DNR). On 12/15/25 at 10:47 AM an interview was conducted with the MDS Nurse who stated to locate a resident's code status she would check the medical record for the status. She reported Resident #12's code status was do not resuscitate after checking Resident #12's medical record during the interview.A follow up interview was conducted with the MDS Nurse on 12/18/25 at 10:37 AM who stated she reported to the Social Worker and the former Director of Nursing that Resident #12's responsible party requested Resident #12's code status be changed from a DNR to a full code. The MDS Nurse was unable to recall the specific date she reported this information to the Social Worker and the former Director of Nursing. She reported she recalled the care plan meeting on 11/25/25 and wrote the care plan meeting note. The MDS Nurse reported the facility Social Worker was responsible for filling out the documents for the code status change.An interview was conducted on 12/15/25 at 2:33 P.M with the facility Social Worker (SW). During the interview the SW stated when a resident's code status was updated after admission, she was responsible for changing and updating the code status on the communication bar and within the electronic medical record. She indicated she was not present when Resident 12's responsible party requested his code status be changed. The SW stated the MDS Nurse wrote the care plan meeting note but the code status was not changed. She did not recall the MDS Nurse telling her about the request for a code status change for Resident #12.An interview was conducted on 12/18/25 at 11:00 A.M with the Administrator. She stated Resident #12's code status should have been changed when Resident #12's responsible party requested it be changed from do not resuscitate to full code and the SW should have ensured Resident #12's code status was changed. The Administrator reported this was an oversight.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Assessments (MDS) for 2 of 32 residents whose MDS assessments were reviewed for accuracy (Resident #22, and Resident #25). The findings included: 1. Resident #22 was admitted to the facility on [DATE] with diagnoses that included intellectual disabilities, schizophreniform disorder, depression, anxiety and dementia. Review of Resident #22's electronic health record revealed a Preadmission Screening and Resident Review (PASRR, a federal requirement for Medicaid-certified nursing facilities to assess individuals for serious mental illness) was completed prior to his admission and indicated Resident #22 was screened as Level II determination (a comprehensive evaluation conducted to assess the needs of individuals identified as having serious mental illness or intellectual disabilities, ensuring they received appropriate care and services in the nursing home) with no end date. A review of Resident #22's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was not coded as having a Level II PASRR determination. The MDS documented diagnoses including dementia, depression, anxiety disorder and schizophrenia. In an interview on 12/18/25 at 10:34 AM the MDS Nurse stated that Resident #22 should have been coded on the MDS for a Level II PASRR determination. She indicated it was an oversight. 2. Resident #25 was admitted to the facility on [DATE] with diagnoses that included depression, schizoaffective disorder, dementia and psychosis. Review of Resident #25's electronic health record revealed a Preadmission Screening and Resident Review (PASRR, a federal requirement for Medicaid-certified nursing facilities to assess individuals for serious mental illness) was completed on 10/05/23 and indicated Resident #25 was screened as Level II determination (a comprehensive evaluation conducted to assess the needs of individuals identified as having serious mental illness or intellectual disabilities, ensuring they received appropriate care and services in the nursing home) with no end date. A review of Resident #25's care plan dated 12/21/23 revealed a plan for Level II PASRR recommendations related to serious mental illness diagnoses of schizoaffective disorder, dementia and psychosis. The goal for the plan of care was that the Resident would receive recommended care and/or services as determined appropriate by Level II PASRR through next review. Interventions included continuing to adjust and meet activities of daily living (ADL) needs. Provide occupational therapy, physical therapy and restorative nursing to be provided as needed. A review of Resident #25's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was not coded as having a Level II PASRR determination. The MDS documented diagnoses including dementia, depression, psychotic disorder and schizophrenia. In an interview on 12/17/25 at 10:11 AM the MDS Nurse stated that Resident #25 should have been coded on the MDS for a Level II PASRR determination. She indicated it was an oversight.

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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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to develop a person-centered care plan in the areas of antipsychotic medication use (Resident #8), and preferred activities (Resident #109) for 2 of 32 residents whose care plans were reviewed.The findings included: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses that included vascular dementia with psychotic disturbance. Review of Resident #8's December 2025 physician's orders revealed a medication order dated 07/22/25 for olanzapine (antipsychotic medication) 5 milligrams (mg) one (1) tablet every 12 hours for psychotic disorder. Review of Resident #8's current comprehensive care plan last reviewed on 10/24/25 did not reveal a care plan focus area related to receiving an antipsychotic medication. Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and was coded for antipsychotic medication use. Review of Resident #8's December 2025 medication administration record for the period of 12/01/25 through 12/17/25 revealed Resident #8 received olanzapine 5mg one (1) tablet every 12 hours as prescribed. An interview was completed with the MDS Nurse on 12/18/25 at 12:06 pm who revealed she was responsible for the development of resident care plans. The MDS Nurse stated Resident #8 should have had an antipsychotic medication care plan with interventions in place. The MDS Nurse stated the missing care plan was due to an oversight. An interview was completed on 12/18/25 at 12:33 pm with the Director of Nursing (DON). The DON revealed the MDS Nurse was responsible for resident care plans. The DON stated resident care plans were reviewed during care plan meetings and Resident #8 should have had a care plan initiated for antipsychotic medication use when the medication was prescribed. An interview was completed with the Administrator on 12/18/25 at 12:41 pm. The Administrator revealed the MDS Nurse was responsible for reviewing and developing residents' comprehensive care plans. The Administrator stated the MDS Nurse was responsible for developing Resident #8's care plan for antipsychotic medication use. The Administrator revealed the care plan was missed due to an oversight by the MDS Nurse. 2. Resident #109 was admitted to the facility on [DATE] with diagnoses that included vascular dementia. Resident #109's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired. The assessment revealed it was very important for Resident #109 to listen to music, participate in groups, participate in favorite activities, and participate in religious services. (continued on next page)

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	A progress note dated 10/26/25 revealed Resident #109 was taken from the dementia care unit to the main unit to attend a religious service. Review of Resident #109's current comprehensive care plan last reviewed on 10/28/25 did not reveal a care plan focus area related to activities. An interview was conducted with Nurse Aide #1 on 12/17/25 at 2:34 PM who stated Resident #109 frequently attended activities on the dementia care unit. An interview was completed with the Activities Director on 12/18/25 at 9:58 AM who revealed she was responsible for the development of resident care plans related to activities and residents should have a focus related to activities on their care plan. She reported that sometimes the MDS Nurse ensured there was a focus related to activities on resident care plans. She stated it was an oversight that activities was not included in the comprehensive care plan. During an interview with the MDS Nurse on 12/18/25 at 10:32 AM she stated sometimes she assisted the Activities Director and placed a focus related to activities on resident care plans, but it was the Activities Director's responsibility to ensure this was completed. She reported that if she noticed there was not a focus related to activities on the care plan, she would place one. She stated she was not aware that Resident #109 did not have a focus related to activities on her care plan. An interview was completed with the Administrator on 12/18/25 at 11:00 AM. The Administrator revealed the Activities Director was responsible for developing residents' comprehensive care plans related to activities. The Administrator revealed the focus of activities on the care plan was missed due to an oversight by the Activities Director.

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F 0690 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to secure the indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 1 resident reviewed for indwelling urinary catheter (Resident #11).The findings included:Resident #11 was admitted to the facility on [DATE] with diagnoses that included bladder rupture and urinary retention.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact. She was coded as having an indwelling urinary catheter.A Physicians' Order dated 12/16/25 indicated Resident #11 had an indwelling urinary catheter for urinary retention.An observation was conducted on 12/17/25 at 10:22 AM of Nurse Aide #2 performing catheter care for Resident #11. The indwelling catheter tubing had no securement device to prevent pulling of the catheter tubing. There was no tension on the catheter tubing during observation.An interview was conducted with Nurse Aide #2 on 12/17/25 at 10:30 AM. NA #2 stated she was assigned to Resident #11 and had provided care for this resident. NA #2 stated the nurse caring for the resident was responsible for making sure the indwelling catheter tubing had a securement device.An interview was conducted with Resident #11 on 12/17/25 at 11:22 AM. Resident #11 stated that staff did not consistently place a securement device on her indwelling urinary catheter. During an interview with Nurse #1 on 12/18/25 at 10:44 AM, she stated that the nurse was responsible for making sure residents had a securement device on urinary catheter tubing. Nurse #1 stated the nurse aide usually informed the nurse if the securement device was missing or soiled.An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 12:36 PM The DON stated the nurse aide, or nurse could apply the securement device for the urinary catheter. The DON stated that she expected that indwelling urinary catheter would have a securement device in place.During an interview with the Administrator on 12/18/25 at 1:00 PM, the Administrator stated she expected that staff would have placed a urinary catheter securement device and checked for placement each shift.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a resident receiving dialysis had a physician's order for dialysis for 1 of 2 sampled residents reviewed for dialysis (Resident #6). The findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease requiring dialysis.The resident's care plan, last updated on 10/21/24, documented chronic renal failure and the potential for complications related to hemodialysis. Interventions included:- Communicating with the dialysis center regarding medications, diet, and lab results.- Coordinating care with the dialysis center.- Monitoring the shunt site daily and as needed for signs of infection, pain, or bleeding.- Notifying the physician of absence of thrill or bruit.Review of a hospital note dated 11/18/25 revealed that Resident #6 was hospitalized on [DATE] for a critical procedure for patients requiring long-term dialysis access. The resident continued receiving hemodialysis.Upon readmission to the facility on [DATE], the physician's orders did not include dialysis services.The Minimum Data Set, dated [DATE] coded the resident as having end-stage renal disease and receiving dialysis services.During an interview on 12/18/25 at 11:17 AM, the [NAME] Annex Unit Manager confirmed there was no dialysis order in the chart following the resident's return from the hospital. She stated the order was not reinstated after readmission.In an interview on 12/18/25 at 11:34 AM, the Director of Nursing reported she was unaware that the dialysis order was missing and acknowledged staff likely failed to re-enter the order upon readmission.In an interview on 12/18/25 at 11:32 AM, the Administrator stated the dialysis order should have been immediately reinstated after the resident's return from the hospital.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, the facility failed to monitor the North Carolina (NC) Nurse Aide (NA) Registry to ensure 1 of 6 nurse aides employed at the facility remained listed on the NC Nurse Aide Registry with an active Nurse Aide I certification (NA#1).The findings included:A review of Nurse Aide #1's employment record reported a hired date as [DATE]. The Nurse Aide Registry Verification form revealed the facility requested verification of Nurse Aide #1's certification on [DATE] and the NA's certification was current.During an interview with the Nurse Aide Registry Representative on [DATE] at 10:38 am, she stated NA #1's Nurse Aide I Registry expired on [DATE]. She stated NA #1's Nurse Aide registry was submitted and processed on [DATE].A review of NA #1's time sheet since [DATE] listed NA #1 worked the following dates:On [DATE] at 06:59 am to 07:01 pm as a Nurse AideOn [DATE] at 06:54 am to 07:01 pm as a Nurse AideOn [DATE] at 07:14 am to 07:04 pm as a Nurse AideOn [DATE] at 07:08 am to 07:00 pm as a Nurse AideOn [DATE] at 07:09 am to 07:01 pm as a Nurse AideOn [DATE] at 07:00 am to 07:02 pm as a Nurse AideOn [DATE] at 07:00 am to 07:01 pm as a Nurse AideOn [DATE] at 07:15 am to 07:01 pm as a Nurse AideOn [DATE] at 06:56 am to 07:03 pm as a Nurse AideOn [DATE] at 06:54 am to 07:04 pm as a Nurse AideOn [DATE] at 06:54 am to 06:54 pm as a Nurse AideOn [DATE] at 06:53 am to 06:56 pm as a Nurse AideOn [DATE] at 06:52 am to 01:28 pm as a Nurse AideOn [DATE] at 06:55 am to 07:00 pm as a Nurse AideOn [DATE] at 06:53 am to 06:55 pm as a Nurse AideOn [DATE] at 06:55 am to 06:57 pm as a Nurse AideOn [DATE] at 06:54 am to 07:03 pm as a Nurse AideOn [DATE] at 06:53 am to 06:56 pm as a Nurse AideOn [DATE] at 06:54 am to 07:06 pm as a Nurse AideOn [DATE] at 06:55 am to 07:05 pm as a Nurse AideOn [DATE] at 07:03 am to 07:07 pm as a Nurse AideOn [DATE] at 06:56 am to 07:01 pm as a Nurse AideOn [DATE] at 06:59 am to 07:01 pm as a Nurse AideOn [DATE] at 06:54 am to 07:05 pm as a Nurse AideOn [DATE] at 07:09 am to 07:00 pm as a Nurse AideOn [DATE] at 06:53 am to 07:08 pm as a Nurse AideOn [DATE] at 07:05 am to 07:06 pm as a Nurse AideOn [DATE] at 06:54 am to 07:02 pm as a Nurse AideOn [DATE] at 06:57 am to 06:59 pm as a Nurse AideOn [DATE] at 06:52 am to 07:04 pm as a Nurse AideOn [DATE] at 06:53 am to 06:59 pm as a Nurse AideOn [DATE] at 06:55 am to 07:01 pm as a Nurse AideOn [DATE] at 06:57 am to 06:59 pm as a Nurse AideOn [DATE] at 07:09 am to 06:58 pm as a Nurse AideOn [DATE] at 07:00 am to 07:01 pm as a Nurse AideOn [DATE] at 07:05 am to 07:06 pm as a Nurse AideOn [DATE] at 07:01 am to 07:00 pm as a Nurse AideOn [DATE] at 07:03 am to 06:59 pm as a Nurse AideOn [DATE] at 07:11 am to 07:05 pm as a Nurse AideOn [DATE] at 06:53 am to 06:58 pm as a Nurse AideOn [DATE] at 06:54 am to 07:02 pm as a Nurse AideOn [DATE] at 06:59 am to 07:00 pm as a Nurse AideOn [DATE] at 07:00 am to 07:00 pm as a Nurse AideOn [DATE] at 07:00 am to 07:00 pm as a Nurse AideOn [DATE] at 07:00 am to 07:00 pm as a Nurse AideOn [DATE] at 07:00 am to 07:00 pm as a Nurse AideOn [DATE] at 06:59 am to 07:02 pm as a Nurse AideOn [DATE] at 06:59 am to 07:00 pm as a Nurse AideOn [DATE] at 06:50 am to 06:58 pm as a Nurse AideOn [DATE] at 06:54 am to 06:58 pm as a Nurse AideOn [DATE] at 06:53 am to 07:00 pm as a Nurse AideOn [DATE] at 06:53 am to 07:01 pm as a Nurse AideOn [DATE] at 06:55 am to 07:01 pm as a Nurse AideOn [DATE] at 06:52 am to 07:09 pm as a Nurse AideOn [DATE] at 06:58 am to 03:32 pm as a Nurse AideDuring an interview with Nurse Aide #1 on [DATE] at 10:32 AM, she stated that her Nurse Aide certification had expired at the end of August. NA #1 stated she was not aware that her certification had expired because she did not receive any notification via mail or email. NA #1 stated she had worked about a month when she found out that her Nurse Aide certification had expired. NA #1 stated that she completed the necessary online forms and got the nurse to sign off. NA #1 reported this was close to the end of [DATE].An interview was conducted with Nurse Manager #1 on [DATE] at 11:04 PM. Nurse Manager #1 stated she had signed off electronically on (continued on next page)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA #1's Nurse Aide Registry renewal form the end of [DATE].A follow up phone call was made to the Nurse Aide Registry Representative on [DATE]. She stated the process was for the Nurse Aide to complete their section of the electronic Nurse Aide Registry renewal form. The Nurse Aide Registry Representative stated once the Nurse Aide completed her section, she would then notify the Registered Nurse (RN) to go in and fill out her section on the renewal form. The Nurse Aide Registry Representative added that if the RN waited longer than 7 days to complete her section, the renewal form would reset, and the process would restart and the Nurse Aide had to resubmit her section. The Nurse Aide Registry Representative further stated that Nurse Aides were to check the system to see when the Nurse Aide Registry renewal was effective.On [DATE] at 12:33 PM an interview was conducted with the Human Resources (HR) Director. The HR Director stated she was responsible for reviewing the Nurse Aide Registry verifications. The HR Director stated she reviewed all Nurse Aide Registry verifications every six months. She stated that it was human error that she had missed that NA #1's Nurse Aide certification had expired.During an interview with the Administrator on [DATE] at 12:28 PM, she stated the HR Director was responsible for notifying staff that their Nurse Aide Registry renewal was due before the end of the month. She stated NA #1's certification expiration was an oversight.

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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 ensure accurate daily staff nursing postings for 13 of 30 days reviewed for accurate nurse staffing information (11/17/25, 11/18/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/27/25, 11/29/25, 11/30/25, 12/2/25, 12/11/25, 12/12/25 and 12/13/25).The findings included:The daily staff nursing postings from 11/15/25 through 12/15/25 did not include the resident census on 11/17/25, 11/18/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/27/25, 11/29/25, 11/30/25, 12/2/25, 12/11/25, 12/12/25 and 12/13/25.An interview conducted with the Director of Nursing (DON) on 12/18/25 at 12:11 PM revealed she was responsible for updating the daily nurse staffing information postings. The DON stated the daily nurse staffing posting was usually filled out the previous evening and updated with the current daily census after the morning clinical meeting. The DON stated that Unit Manager #2 was responsible for updating the census on the weekends and the daily nurse staffing postings had been overlooked by the Unit Manager on the days it was not updated.An interview conducted with the Administrator on 12/18/15 at 12:54 PM revealed she expected that the daily staff posting would be completed to include the resident census.

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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 - Few	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, manufacturers' instructions, and staff and Pharmacy Consultant interviews, the facility failed to remove one (1) multi-dose insulin injector pen that was expired and 2 bottles of expired eye drops in 1 of 4 medication carts (East Annex Medication Cart #1) reviewed for medication storage and labeling.The findings included: The manufacturer's instructions for insulin lispro injector pen stated it should be discarded 28 days after opening. The manufacturer's instructions for latanoprost solution (eye drop used to treat glaucoma) stated once the bottle was opened it could be used for 6 weeks. The manufacturer's instructions for dorzol/timolol solution (eye drop used to treat glaucoma) stated once bottle was opened it should be discarded 28 days after opening. An observation of the East Annex medication cart #1 on 12/17/25 at 2:09 pm revealed one (1) insulin lispro injector pen that was open which had an opened date of 11/3/25, one (1) bottle of latanoprost solution 0.05 percent (%) which had an opened date of 10/29/25 with an expiration date handwritten on the bottle of 12/10/25, and one (1) bottle of dorzol/timolol solution which had an opened date of 11/13/25 and an expiration date handwritten on the bottle of 12/11/25. During an interview with Nurse #2 during the medication cart observation on 12/17/25 at 2:09 pm she stated the insulin pen should have been removed after 28 days and the eye drops should have been discarded on the expiration dates written on the bottles. During a phone interview with the Pharmacy Consultant on 12/17/25 at 4:53 pm, he stated the insulin pen should have been discarded 28 days after opening, the latanoprost eye drops should have been discarded 6 weeks after opening and the dorzol/timolol eye drops should have been discarded 28 days after opening. During an interview with the Director of Nursing (DON) on 12/18/25 at 11:55 am, she explained the Unit Managers and floor nurses were responsible for checking the medication carts for expired medications on a daily basis and discard any expired medications. The DON further stated her expectations of the nursing staff were to check the medication carts daily and remove any expired medications. During an interview with the Administrator on 12/18/25 at 12:04 pm, she stated her expectations were the nursing staff would check the medication carts daily and have no expired medications in the medication carts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahoskie Health and Rehabilitation Center	604 Stokes Street East Ahoskie, NC 27910

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to maintain 1 of 2 nourishment room refrigerators and freezer clean, and in a sanitary manner to prevent cross contamination by failing to clean up spills (South Unit refrigerator). The findings included:On 12/17/25 at 11:17 AM the South Unit nourishment refrigerator was observed with the South Unit Nurse. The clear refrigerator drawers were noted with small, dried food particles and there was a brown sticky substance spilled on the bottom shelf of the freezer section. The South Unit Nurse indicated during the observation she was not aware who was responsible for cleaning the refrigerator.A second observation of the South Unit nourishment room, on 12/18/25 at 10:36 AM revealed the refrigerator and freezer were in the same condition.In an interview on 12/18/25 at 10:25 AM Housekeeper #1 stated that she was assigned to clean the South Unit refrigerator once a week and had not looked at or cleaned the freezer that week. In an interview on 12/18/25 at 11:29 AM the Administrator stated the dietary department was responsible for cleaning the nourishment room refrigerators and she expected them to be clean.