STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 8/4/24 to conduct a recertification and complaint investigation survey and were unable to return to the facility on 8/7/24 due to adverse weather of a tropical storm and unsafe travel conditions. Additional information was obtained remotely on 8/8/24, 8/9/24, and 8/12/24 through 8/14/24. Onsite validation of immediate jeopardy removal was conducted on 8/15/24. Additional information was obtained remotely on 8/20/24 through 8/26/24. An additional onsite validation of immediate jeopardy removal was conducted on 8/29/24. Additional information was obtained remotely on 8/30/24. Therefore, the exit date was changed to 8/30/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# BEX011.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 8/4/24 to conduct a recertification and complaint investigation survey and were unable to return to the facility on 8/7/24 due to adverse weather of a tropical storm and unsafe travel conditions. Additional information was obtained remotely on 8/8/24, 8/9/24, and 8/12/24 through 8/14/24. Onsite validation of immediate jeopardy removal was conducted on 8/15/24. Additional information was obtained remotely on 8/20/24 through 8/26/24. An additional onsite validation of immediate jeopardy removal was conducted on 8/29/24. Additional information was obtained remotely on 8/30/24. Therefore, the exit date was changed to 8/30/24.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2024

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.

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F 000	Continued From page 1	F 000		

The following intakes were investigated: NC00205170, NC00205194, NC00205359, NC00210660, NC00211173, NC00211414, NC00211881, NC00212743, NC00212746, NC00214277, NC00215587, NC00216588 and NC00220228.

5 of the 40 complaint allegations resulted in deficiency.

Intake NC00212746 and NC00211881 resulted in immediate jeopardy.

Past-noncompliance was identified at:
CFR 483.12 at tag F600 at a scope and severity (J)

Immediate jeopardy began on 12/28/23. The facility came back into compliance effective 12/31/23.

Immediate Jeopardy was identified at:
CFR 483.10 at tag F580 at a scope and severity (J)
CFR 483.25 at tag F689 at a scope and severity (K)
CFR 483.25 at tag F690 at a scope and severity (J)

Immediate Jeopardy began for tags F580 and F690 on 6/10/24 and was removed on 8/15/24.

Immediate Jeopardy began for tag F689 on 6/27/24 and was removed on 8/15/24.

The tags F600, F689 and F690 constituted Substandard Quality of Care.

An extended survey was conducted.

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		9/16/24

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F 578	Continued From page 3 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to accurately document code status in the electronic medical record for 1 of 8 residents (Resident #63) reviewed for advance directives. The findings included: Resident #63 was admitted to the facility on 3/18/24. His diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction. A physician order dated 3/19/24 by Physician #1 stated full code status. The electronic medical record (EMR) revealed a Do Not Resuscitate (DNR) form dated 03/20/24 signed by Resident #63 and Physician #1. The care plan revised 6/26/24 indicated Resident #63 had chosen DNR status. Review of the quarterly Minimum Data Set (MDS) assessment dated 7/11/24 revealed Resident #63 was severely cognitively impaired. On 08/06/24 at 01:16 PM an interview was conducted with the Admissions Coordinator. She stated she verified advance directives/code status upon admission. If a newly admitted resident had no advance directive in place, she explained to them what advance directives were. An interview was conducted on 08/05/24 at 01:04	F 578	Regarding F578: 1. Resident #63's physician was notified and the order corrected to match the face sheet which was the correct code status. Completed 8/5/2024. 2. All current residents are at risk for deficient practice, therefore a 100% audit was completed for all current residents on 9/11/2024 by the clinical leadership team. Any identified concerns will be addressed by verifying resident's wishes and obtaining a provider/s order for code status. 3. To prevent this from occurring, by 9/12/2024, all licensed nursing staff and the interdisciplinary team were educated by the regional director of clinical services and the director of nursing/designee on the requirement to ensure the residents have accurate medical records for code status. Any staff who did not receive the education will complete the education prior to working their next shift. The resident code status will be reviewed by the social services director/designee at least quarterly for any changes during the care plan review. During clinical morning meeting any new orders for code status will be followed up on to ensure compliance. Any new hires or agency staff hired after 9/12/2024 who are responsible for this compliance will receive this education. 4. Ongoing Compliance Monitoring: Beginning week of 9/9/2024, the	

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F 578	Continued From page 4 PM with Nurse #1 who stated to verify code status on a resident she looked in the EMR and checked the physician order. During the interview, Nurse #1 reviewed Resident #63's EMR and verified there was both an order for full code status and a signed DNR form. An interview was conducted with Nurse #11 on 08/09/24 at 04:09 PM. He stated he checked for a resident's code status in three locations: the EMR on the resident's main screen, the DNR book at the nurses' station, and the physician's order. An interview was conducted on 08/12/24 at 10:56 AM with the Assistant Director of Nursing (ADON). She stated for new admissions she obtained code status information from the discharge summary. She added she verified code status by the face sheet in the EMR and physician order. She stated the Social Worker (SW) audited advance directives. An interview was conducted on 08/05/24 at 03:23 PM with the SW. She stated advance directives were addressed initially at the Your Path meeting (care planning meeting) which was done within 72 hours of admission. Advance directives were also reviewed quarterly and documented in the care plan conference notes. She added the facility conducted an audit of residents on 5/16/24 regarding code status, at which time they called every single family member and verified a resident's code status. The SW could not provide a reason why Resident #63 was not found in the audit conducted on 5/16/24. She further stated with the new documentation system (EMR) some of the nurses didn't realize they needed to change the DNR status in two separate areas.	F 578	administrator/designee will monitor and review all new admissions weekly for twelve weeks to ensure the resident's medical record reflects accurate code status documentation. The administrator/designee will audit the medical record of five residents per month for three months beginning September 2024, who had a quarterly care plan review completed, to ensure the residents medical record code status documentation is accurate. Any identified concerns will be addressed immediately by verifying resident's wishes and obtaining a provider's order for code status. Results to be reported in q1uality assurance performance mprovement committee for three months by the administrator/designee. 5. The administrator is responsible for compliance. Date of Compliance: 9/16/24	

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F 578	Continued From page 5 On 08/06/24 at 05:11 PM an interview with the Director of Nursing (DON) was conducted. She stated in the event a discrepancy was found with advanced directives, she would verify code status, review documentation, and would notify the resident's physician. She added the facility recently migrated to a new EMR system and staff are still getting used to it. She added the old system automatically updated the code status to match the order, however the new system does not do that. Physician#1 was out of the country and unavailable for interview during the survey. An interview was conducted on 08/09/24 at 12:54 PM with the Medical Director. He stated staff needed to make sure the information on code status was correct and reconciled in the system. On 08/13/24 at 08:51 AM an interview was conducted with the Administrator. She stated the Admissions Coordinator attempted to verify/obtain advance directives as part of the admission process. The SW also addressed advance directives during the care plan meeting with the family. The interdisciplinary team confirmed a resident's code status and reviewed it quarterly in case there were any changes made. She added copies of DNRs were scanned into the EMR and copies kept at the nurse's station. Nurses typically verified the resident's code status in the EMR and checked the physician order.	F 578		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		9/16/24

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F 580	Continued From page 6	F 580		

consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in

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	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 580	Continued From page 7 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, physician and laboratory customer service staff, the facility failed to notify the physician when Resident #6 experienced a change of condition. Resident #6 received a positive result from a urinalysis (UA) and culture and sensitivity (C&S), which indicated the resident had a urinary tract infection (UTI) with extended-spectrum beta-lactamase (ESBL, an enzyme produced by some bacteria that makes them resistant to many antibiotics) in her urine and failed to notify the physician of the C&S results after the report was received from the facility. These deficient practices affected 1 of 4 residents reviewed for a experiencing a change of condition related to a UTI (Resident #6). Resident #6 was sent to the emergency department on 6/22/24 after being found with seizure-like symptoms, requiring hospital admission for acute metabolic encephalopathy (an alteration in consciousness caused by large-scale brain dysfunction from impaired cerebral metabolism) caused by the UTI with ESBL. The resident's antibiotics were changed due to the results of the hospital C&S, noting the antibiotic started in the facility was ineffective, and the resident began to improve in the hospital. The resident readmitted to the facility on 6/26/24. The immediate jeopardy began on 6/10/24 when the results of the urine C&S results were not	F 580	Regarding F0580: 1. Resident #6 remains in the facility. This urinary tract infection resolved and she has had no further urinalysis culture and sensitivity test or urinary tract infections since survey exit. Regional director of clinical services reviewed medical chart to ensure no other labs or diagnostics had been missed. Completed 8/8/2024. 2. The director of nursing/designee reviewed all resident's urinalysis culture and sensitivity results obtained since June 10, 2024 to ensure results were communicated to the provider and appropriate antibiotic was ordered. Completed 8/14/2024. 3. On 8/13/2024 the implementation of integrated laboratory services was completed which enhances staff and physician's ability to access lab results twenty-four hours a day for timely communications and treatment plans; on 8/13/2024 the Director of Nursing/designee initiated education for all nurses on the process for obtaining lab results and communicating to the physician. Additional education was completed on 9/12/2024. Any staff who did not receive the education will complete the education prior to working their next shift. All new employees and agency staff	

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F 580	Continued From page 8	F 580		

communicated to Resident #6's physician. The immediate jeopardy was removed on 8/15/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "D" (no actual harm with potential for more than minimal harm) to ensure monitoring systems put into place are effective.

The findings included:

Resident #6 was admitted to the facility on 05/07/24 with diagnoses including renal (kidney) insufficiency

Review of Resident #6 nursing progress notes dated 06/06/2024 written by the Assistant Director of Nursing (ADON) revealed it was reported from the floor nurses and nursing aides (NA) resident had become increasingly more agitated and combative with staff. The ADON assessed the resident and noted that resident was not acting as she normally did. The ADON contacted the physician, who ordered laboratory tests including a UA and C&S.

Review of preliminary laboratory results dated 06/08/2024 revealed Resident #6's urine sample was collected on 06/07/2024 and positive for 1+ bacteria (normal range was none). The preliminary report indicated identification of the bacteria and sensitivity results would be on a following report. The physician reviewed and signed the results on 06/12/24.

Review of Resident #6's C&S results dated 06/10/2024 revealed the bacteria identified was Escherichia coli (E. coli), which was positive for ESBL. There was no evidence the physician was

responsible for this compliance who are hired after 9/12/2024 will received this education as a part of orientation.
4. Ongoing Compliance Monitoring: Beginning the week of 9/9/2024, the director of nursing/designee will audit all urinalysis culture and sensitivity lab results weekly for twelve weeks, to ensure timely physician notification was completed. Results will be reported in quality assurance performance improvement committee for three months by the Director of Nursing.
5. The director of nursing is responsible for compliance.
Date of Compliance: 9/16/24

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F 580	Continued From page 9	F 580		

notified of the results when the results became available.

In an interview on 8/12/24 at 6:03 pm, the Customer Representative for the facility contracted laboratory stated the final results of the UA were uploaded to the communication portal on 06/07/2024 and the finalized C&S results were uploaded to the portal on 6/10/24 at 10:38 am and would have been available to the facility at those times. The facility used the communication portal to obtain results directly instead of waiting for a faxed copy.

Review of Resident #6's nursing progress notes dated 06/11/2024 written by Nurse #12 revealed the resident's UA results were received. The physician was notified and said to wait for the C&S report. There was no indication the C&S results were reviewed with the physician.

In an interview on 8/13/24 at 10:04 am, Nurse #12 said she did not remember any additional information about Resident #6's UTI or reporting the results to the physician.

Review of Resident #6's nursing progress notes dated 6/17/24 by the ADON revealed the C&S results dated 6/10/24 were reviewed with the physician, who ordered the antibiotic levofloxacin 500 mg every day for 7 days entered.

In an interview on 8/12/24 at 2:45 pm, the ADON said she went out of town the week of 6/11through 6/17/24. When she came back to work on 6/17/24, she reviewed the laboratory results in the laboratory portal from the week she was out and found the C&S had not been reported to the physician, so she called him with

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F 580	Continued From page 10	F 580		

the results. The physician ordered levofloxacin 500 mg every day for 7 as a result of the C&S report. She was not sure why the results had not been reported to the physician earlier. She said not obtaining orders delayed the treatment of the UTI.

Continued review of Resident #6's C&S results dated 6/10/24 revealed the bacteria was resistant to the effects of the antibiotic levofloxacin.

In an interview on 8/12/24 at 3:53 pm, Nurse #13 said if he called and gave C&S results to the physician or if he noted the physician had ordered an antibiotic that the microorganism was resistant to, he was supposed to call the physician and get clarification of the order because the antibiotic would not actually kill the bacteria.

In an interview on 8/12/24 at 4:20 pm, the ADON said she didn't know how she didn't catch that the bacteria was resistant to the antibiotic. She said both her and the physician reviewed the results together and the physician signed off on the order. She did not know why neither of them caught the error. She said that giving an antibiotic that the bacteria was resistant to delayed the effective treatment of the UTI.

In an interview on 8/13/24 at 10:01 am, Nurse #4 said she was passing breakfast trays on 6/22/24 on Resident #6's hallway but didn't normally work on that hall. She brought Resident #6 her breakfast tray and set it up. Resident #6 began eating and then her roommate requested assistance with being moved in bed. While Nurse #4 was assisting Resident #6's roommate, she heard Resident #6 make an unusual noise. Nurse #4 said she turned and saw the resident

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	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 580	Continued From page 11	F 580		

was having a seizure

Review of Resident #6's nursing Situation, Background, Appearance, and Review (SBAR) Communication Form to the provider dated 6/22/24 completed by Nurse #12 noted she was unresponsive after a seizure.

Review of the EMS Patient Care Record dated 6/22/24 revealed EMS was called to the facility for Resident #6 due to being unresponsive after a seizure. When they arrived, they found Resident #6 sitting upright in bed with an oxygen mask on. The oxygen was set at 15 liters per minute (lpm). Staff reported to EMS that Resident #6 was eating breakfast and started to seize. Her body went rigid. EMS noted she was awake but not oriented to person, place, or time. She was breathing on her own and started to try to verbalize and move her extremities. She had a weak pulse in both wrists. EMS transferred her to the hospital

Review of Resident #6's hospital ER evaluation dated 6/22/24 revealed her symptoms were consistent with an acute UTI complicated by acute metabolic encephalopathy. The provider did not believe the resident suffered a seizure but instead experienced rigors (sweats and uncontrollable shivering attacks due to a severe infection). The emergency room (ER) provider noted she had altered mental status, was recently diagnosed with UTI, and had been taking Keflex (levofloxacin). When she arrived to ER she was noted to be bradycardic (low heart rate) with tachypnea (rapid, shallow breathing that is faster than normal for a person's age and physiological condition). The provider noted that given the resident's urine, it appeared Keflex was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

treating the UTI adequately and it had progressed causing encephalopathy.

Review of Resident #6' hospital discharge summary dated 6/26/24 revealed she was placed on meropenem intravenous (IV) antibiotics in the hospital. The resident was noted to be alert, eating, drinking, voiding, improved, and stable at discharge. Resident #6 discharged with orders for meropenem 1 gram in 100 milliliters of normal saline IV every 12 hours until 6/29/24.

In an interview on 8/12/24 at 3:22 PM, the Director of Nurses (DON) said Resident #6's UA and C&S results should have been reported to the physician sooner. The DON said the expected procedures were for the charge nurses to check the laboratory portal and report the results to the physician that shift. The DON said she knew of several instances when the procedures weren't followed because the floor nurses were used to the nurse managers reviewing them. The nurse managers would then review the laboratory results the next day. If the resident' UTI was not treated and resolved, the resident would experience further complications.

In an interview on 8/20/24 at 1:00 pm, Resident #6' physician said he expected to be notified of UA and C&S results the same day they were reported to the facility from the laboratory. He expected the nurse to review the C&S and what antibiotics the C&S indicated would be effective with him so he could make an informed decision. If he ordered an antibiotic that was noted in the C&S to be resistant and ineffective, he expected the nurse to let him know and review options of what antibiotic would be effective so the UTI could be effectively treated. If a UTI was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 580	Continued From page 13	F 580		

treated, the resident could develop sepsis, which may cause further inflammation, metabolic encephalopathy, seizures, and other complications.

The Administrator was notified of an immediate jeopardy on 8/13/24 at 2:09 pm.

The facility provided the following credible allegation of immediate jeopardy removal plan.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
6/6/24: A UA C & S was ordered by nursing for Resident #6 with the UA results received on 6/7/24 positive for a Urinary Tract Infection (UTI).
6/10/24: C & S results were received for Resident #6.
6/11/24: Positive results for the Urinalysis (UA) were reported to the physician. Nursing staff did not identify that the Culture & Sensitivity test (C & S) results had also been received with the UA. Nursing staff did not communicate the C & S results to the physician. The physician indicated waiting for the C & S results before initiating treatment orders.
6/17/24: The Assistant Director of Nursing (ADON) identified that the physician had not been made aware of the C & S results and communicated with the physician the lab results. The physician ordered an antibiotic that the organism was resistant to.
6/22/24: Nursing staff noted Resident #6 with seizure-like activity and she was sent to the hospital for further evaluation. The hospital record indicates that Resident #6 was bradycardic and tachypneic upon arrival. The hospital record indicates that the antibiotic was not treating the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14	F 580		

UTI causing encephalopathy. Resident #6 was transitioned to a new type of antibiotic via intravenous (IV).
6/26/24: Resident #6 returned to the facility. Readmission diagnoses included acute metabolic encephalopathy and UTI secondary to Escherichia coli (ESBL E. coli).
8/13/24: The Director of Nursing (DON) and ADON began reviewing all resident ' s UA C&S results obtained since June 10, 2024 to ensure results were communicated to the provider and an appropriate antibiotic was ordered. Completed by 8/14/24. Any identified problems will be addressed immediately by the DON/ADON to include communication with the physician.
All residents had the potential to be affected as a result of noncompliance with provision of necessary care and services to treat infection.
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
8/13/24: The Quality Assurance and Performance Improvement team met to discuss the failure and initiate a plan of correction.
8/13/24: Implementation of integrated laboratory services was completed. With the integration services, all licensed nursing staff will have the ability to transcribe laboratory test orders and have the ability to view test results from the electronic medical record.
8/13/24: The Assistant Director of Nursing/ Human Resources Director initiated education for all licensed nurses on the process for obtaining and following up on test results. Charge Nurses will be responsible for communication of all test results to the physician. Nursing staff will be notified of lab results on the electronic medical record dashboard alert screen which is the first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 15	F 580		

screen nurses see upon logging into the medical record. Education included how to transcribe laboratory orders correctly to utilize the integration system effectively, the process for obtaining results, as well as reporting procedures including provider notification and required documentation of physician and responsible party notification of test results. The Human Resources Director provided education to all licensed nursing via the facility broadcast text communication through the time and attendance system. The Assistant Director of Nursing initiated education for all licensed nurses in house, including completion of Lab and Diagnostic Results Reporting Competency. All licensed nurses will complete education on the test results reporting procedures prior to the start of their next shift. Nursing staff was reeducated as a part of the new integrated system that it is their responsibility to address lab results as results come in during their work shift and to ensure the appropriate treatment is started for the identified diagnosis. The ADON is leading the education and will be tracking for competency and completion on 8/14/24.
8/13/24: The DON provided education to the ADON and Unit Managers on the process for reviewing UA C&S test results and verifying an appropriate antibiotic including organism susceptibility to the medication being ordered during the morning clinical meeting. The medication is reviewed for appropriateness by the Charge Nurse when received, 7 days a week. The DON, ADON and Unit Managers will audit antibiotic orders Monday through Friday during the morning clinical meeting. Completed 8/13/24. All new hires will be educated on the process for lab results and physician communication during the department orientation led by the ADON. Alleged date of immediate jeopardy removal is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 580	Continued From page 16 8/15/24. The validation process for the IJ removal plan was completed on 8/15/2024. Licensed nursing staff who worked different shifts were interviewed and verified receiving training on entering laboratory test and reviewing laboratory results in the facility ' s electric health record system and documenting in the progress notes notification of the physician of laboratory test results. The licensed nursing staff also demonstrated using the facility ' s electronic health record system to enter and review laboratory test ordered. The facility provided a list of all licensed nursing staff and in-service training sheets that included verbalization and demonstration on entering, reviewing and documenting notification of the physician of laboratory tests were reviewed for all licensed staff randomly interviewed. There were no new hired licensed nursing staff and licensed nursing staff (medical leave, vacation) will not be able to work until receiving the education training on entering, reviewing and documenting notification of the physician of laboratory test in the facility 's electronic health record system. The immediate jeopardy removal date of 08/15/24 was validated	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

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F 582	Continued From page 17	F 582		

for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 582	Continued From page 18 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services for 1 of 3 (Resident #30) residents reviewed for beneficiary protection review. The findings included: Resident #30 was readmitted to the facility on 4/3/23 and admitted to Medicare Part A services. Resident #30's Medicare Part A skilled services ended on 4/24/24 with days remaining and she remained in the facility. Review of Resident #30's medical records revealed a NOMNC (Notice of Medicare Non-Coverage) was given by phone to the resident's power of attorney on 4/22/24. Record review revealed no SNF ABN was provided to the resident or the resident's power of attorney. An interview was conducted with the facility Social Worker on 8/05/24 at 4:33 PM who stated she was responsible for issuing the NOMNC with the resident or responsible party. She said she usually issued the SNF ABN form with the	F 582	Regarding F0582: 1. Resident #30 still resides in the facility and was provided the Advance Beneficiary Notice information with no concerns verbalized by the daughter or resident on 8/29/2024. 2. All residents who received Medicare A skilled benefits are at risk for this deficient practice. On 8/23/2024, the administrator reviewed the last seven days of discharges to identify residents who were on a skilled part A stay to ensure proper discharge notices were given. 3. To prevent this from reoccurring, on 8/22/2024, the social worker and administrator initiated weekly meetings to review recent discharges and upcoming discharges to ensure compliance and the social worker was educated. Any new employees or agency staff hired after 8/22/2024, who are responsible for this compliance will received this same education. 4. To monitor for ongoing compliance, beginning the week of 9/9/2024, all discharges will be reviewed each week by the administrator/designee for the next twelve weeks to ensure appropriate notification is in place. Results will be reported in quality assurance performance improvement committee for three months by the administrator/designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 19 NOMNC when a resident remained in the facility after Medicare Part A skilled services ended. She could not say why Resident #30 did not receive a SNF ABN. In an interview on 8/06/24 at 9:35 AM, the Administrator confirmed the SNF ABN should have been completed for residents who have days remaining and who choose to remain in the facility for long-term care.	F 582	5. The administrator is responsible for compliance. Date of Compliance: 9/16/24	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed protect a resident's right to be free from abuse when a moderately cognitively impaired resident (Resident #29) punched severely cognitively impaired resident (Resident #231) in the face. Resident #231 was prescribed and received a blood thinner daily. Resident #231 sustained bruising and swelling to the left	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

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F 600	Continued From page 20	F 600		

side of his face. Resident #231 stated he was scared and did not want to be near Resident #29. Resident #29 and Resident #231 were immediately separated. Resident #29 was moved to another room by himself. Resident #231 requested to be sent to emergency room for evaluation and did not return to the facility. Resident #231 transferred from the hospital to a different facility. Resident #231's family member stated Resident #231 had never emotionally recovered from the incident and still does not want to be in a room with someone else. This deficient practice affected 1 of 3 residents reviewed for abuse.

The findings included:

Resident #231 was re-admitted to the facility on 12/18/23. Resident #231 diagnoses included hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, vascular dementia, psychotic disturbance, and anxiety.

Resident #231's care plan dated 11/23/23 revealed he was care planned for at risk for bleeding, bruising, abnormal labs related to receiving blood thinning medication. The interventions included avoid activities that could result in injury and handle gently during hands-on care. Resident #231 was care planned for difficulty communicating with interventions which included approach resident from the front and use gestures and simple sentences. Resident #231 also cared planned for left side hemiplegia/hemiparesis related to stroke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 21	F 600		

Review of Resident #231's physician orders dated 12/18/23 revealed an order for Warfarin Sodium Oral Tablet (blood thinner) 5 mg by mouth once daily.

Resident #231's 5-day Minimum Data Assessment dated 12/25/23 revealed Resident #231 was severely cognitively impaired. Resident #231 had impairment on the left side of upper and lower extremities, totally dependent upon staff for activities of daily living (ADL) and transfers.

Resident #29 was admitted to the facility on 11/17/23 with diagnoses that included anxiety disorder, hypertension, cardiac arrest, and malignant neoplasm of larynx.

Resident #29's care plan dated 12/11/23 revealed he was care planned for physical aggressive behavior with other residents. The interventions included 4/9/23 resident on one-to-one observation related to an altercation with another resident, resident removed from current roommate situation and placed on every 15-minute checks for 72 hours to ensure new room does not become triggered by room situation or roommate and keep all sharp objects including butter knife out of patient's room.

Resident #29's quarterly Minimum Data Assessment (MDS) dated 12/15/23 revealed Resident #29 was moderately cognitive impaired. Resident #29 was independent with all activities of daily living (ADL's), independent with transfers and independent ambulation with a walker.

Nurse Aide (NA) #13's written statement with no date revealed NA #13 checked on Resident #231

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

around 2:00 am and gave him some water. NA #13 reported he emptied Resident #231's urinary catheter bag. NA #13 reported he returned to the nurses' station to chart. NA #13 reported he returned to Resident #231's room about 3:00 am to give him some more water. Resident #231 started telling NA #13 that Resident #29 punched him in his eye. NA #13 reported he talked to Resident #231 and Resident #29 for about 30 minutes. NA #13 indicated Resident #29 admitted to punching Resident #231. NA #13 went to the nurses' station and reported the situation to Nurse #7. Nurse #7 began procedures according to facility protocol. NA #13 explained he did not hear or see the altercation.

Attempts were made to interview NA #13 via phone on 8/9/24 and 8/12/24 and were unsuccessful. NA #13's phone would not accept messages with each attempt.

Nurse #7's written statement dated 12/28/23 revealed he was called down to Resident #231's room after an altercation at around 2:00 am. Nurse #7 stated when he entered the room with NA #13 both residents were laying in their beds. Resident #231 stated he was struck by Resident #29. Resident #29 stated he heard Resident #231 calling out for help. Resident #29 went to the door to find help and Resident #231 asked Resident #29 to get him some water. Resident #29 further stated while Resident #231 was drinking he grabbed Resident #29's arm and kicked him in the side. Resident #29 reported he punched Resident #231 in the face. Resident #231 had redness to his face with no complaints of pain. Resident #29 had no signs of injury or bruises. Resident #231 and Resident #29 calmed down. Resident #29 stated he would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

help Resident #231 or go over to Resident #231's side of the room. Nurse #7 explained approximately 30 minutes later Resident #231 indicated he felt unsafe and wanted to go to the hospital. Nurse #7 called the on-call supervisor. Nurse #7 stated he was told to wait to hear from the Administrator for decisions. Nurse #7 revealed Resident #29 was moved to another room around 3:20 am. Resident #231 was taken to the hospital. Nurse #7 stated both Resident #231 and Resident #29 were questioned by the police around 3:45 am. Nurse #7 indicated the police would issue a summons to Resident #29 in the morning and did not need to arrest Resident #29.

Review of a progress note written by Nurse #7 on 12/28/23 at 4:13 am revealed redness to Resident #231's face due to altercation with roommate. Medical Doctor (MD) was notified via phone. Orders received to send Resident #231 to Emergency Room (ER) for evaluation and treatment. Resident #231 was informed of transfer to hospital and Resident Representative (RR)/family informed of Resident #231's transfer via phone.

In a phone interview with Nurse #7 on 8/9/24 at 5:00 pm, he recalled the incident on 12/28/23 between Resident #29 and Resident #231. He stated Nursing Aide (NA) #13 was called to Resident #231's room by Resident #231. Resident #231 reported to NA #13 that he was hit by his roommate (Resident #29). NA #13 reported to Nurse #7. Nurse #7 went to Resident #231's room with NA #13. Resident #231 reported to him that Resident #29 jumped on him and started hitting him. Nurse #7 stated Resident #231 had swelling and bruising noted on the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

side of his face. He further stated Resident #231 was scared and wanted Resident #29 out of the room. Nurse #7 described Resident #231 as bed bound and required total care. Nurse #7 indicated he questioned whether Resident #231 could have kicked Resident #29 due to his medical condition of left-sided hemiplegia (complete paralysis on one side of the body) and left-sided hemiparesis (partial weakness on one side of the body). Resident #231 was in the A bed (on the right side of the room) by the door with the foot of the bed facing towards the bathroom. Resident #29 was in the B bed (on the left side of the room) by the window with the foot of the bed facing towards the wall. He indicated Resident #29 had a previous history of physical aggressive behavior.

Nurse #15's written statement dated 12/28/23 at 3:23 am revealed she received a call from Nurse #7. Nurse #7 reported an altercation between Resident #231 and Resident #29. Resident #29 had hit Resident #231 in the face. Nurse #15 asked had the residents been separated and Nurse #7 confirmed they had been separated. Nurse #15 asked when this incident happened, and Nurse #7 reported approximately 30 minutes ago. Nurse #15 then asked was Resident #231 okay and Nurse #7 responded Resident #231's face had some swelling. Nurse #15 instructed Nurse #7 to start neurological checks (assessing mental status and level of consciousness, and pupil response), and skin checks. Nurse #15 then called the Administrator at 3:28 am and reported the incident which was reported to her. Nurse #15 went to the facility to assist with protocol and begin education.

An interview with Nurse #15 via phone on 8/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 25	F 600		

at 10:38 am, she indicated she was the on-call clinical staff for the night of the incident on 12/28/23. She stated Nurse #7 called her and reported the resident-to-resident altercation. She called the previous Administrator, and she was enroute to the facility. Nurse #15 stated she honestly did not know what happened. NA #13 reported Resident #231 had called out and NA #13 responded to his call. NA #13 further reported to her that Resident #231 stated Resident #29 had hit him. Resident #231 and Resident #29 were separated immediately. Resident #231 was sent to the emergency room for evaluation and never returned to the facility. Nurse #15 was told Resident #29 had a history with physical aggressive behavior, but she had never witnessed this behavior.

During a phone interview with the previous Social Worker on 8/9/24 at 4:06 pm, stated she recalled Resident #29 struck Resident #231. Resident #231 was sent to the emergency room. Resident # 231 did not return to the facility. Resident #29 was placed on one-to-one observation (1:1).

Review of an email sent to the previous Administrator from the previous Social Worker on 12/28/23 revealed the previous Social Worker interviewed Resident #29 on 12/28/23 at 10:50 am. Resident #29 could not recall what happened with Resident #231. Resident #29 stated he was asleep when he heard Resident #231 say "Hey". Resident #29 further stated he remembered Resident #231 being taken out of the room. Resident #29 indicated he went back to sleep. Resident #29 explained he had no remembrance of any physical altercation with Resident #231. Resident #29 stated he had not assisted Resident #231.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 600	Continued From page 26	F 600		

A progress note completed by the previous Administrator on 12/28/23 revealed the previous Administrator spoke with Resident #29's Resident Representative (RP). The RP was informed of the resident-to-resident altercation which happened that morning. The previous Administrator explained to Resident #29's RP that Law Enforcement had been notified along with Adult Protective Services. The previous Administrator further explained Law Enforcement would be returning to the facility potentially providing Resident #29 a summons. RP was informed Resident #29 would have a room change on 12/28/23.

In a phone interview with the previous Administrator on 8/9/24 at 3:12 pm, she stated she recalled the incident on 12/28/23 which involved Resident #29 and Resident #231. She recalled it was reported to her that Resident #29 went to give Resident #231 some water and Resident #29 punched Resident #231 in the face. The residents were separated. Resident #29 was placed on one to one (1:1) supervision. Law Enforcement and APS (Adult Protective Services) were notified. Resident #231 was sent to hospital emergency department (ED) for evaluation. Resident #231 did not return to the facility. She further stated Resident #29 had a history of physical aggressive behavior. She explained the Interdisciplinary Team (IDT) would talk about new admissions in the morning meetings. The team would discuss any concerns about the residents and which room to place them. She also added they would do room changes if necessary.

The police report was completed on 12/28/23 at 3:42 am. Resident #231 was listed as the victim

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 600	Continued From page 27	F 600		

with minor apparent injury due to a simple assault.

A review of the Emergency Medical Services (EMS) report dated 12/28/23 revealed 83-year-old male patient with chief complaint of eye and face injury. The patient had gotten into a fight with another resident at the nursing home and was punched several times in the face. There was swelling and tenderness on both sides of his face but no significant injury. Patient was alert and oriented, patent airway, and warm dry skin. "Patient wanted to be transported to hospital for evaluation and he did not feel safe at the nursing home." Patient noted he was not in any pain. Arrived at hospital 4:45 am.

A review of the Emergency Room's (ER) report dated 12/28/23 revealed Resident #231 was brought in by ambulance at 4:45 am after being involved in a fight with another resident. Resident #231 had some redness on bilateral eyes and slight bruising around the left eye. Computed Tomography (CT) scan of the Spine (which is a procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of spine) was completed with no acute fracture noted. CT scan of the head was completed which showed no skull fracture. Clinical Impression: closed heady injury, assault, and old cerebrovascular accident (CVA).

The police returned to the facility on 12/28/23 at 11:36 pm with a Criminal Summons for Misdemeanor Assault and Battery and was served to Resident #29 which indicated a court date of 2/9/24.

Several attempts to interview the investigating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 600	Continued From page 28	F 600		

officer via phone were unsuccessful on 8/12/24 and 8/13/24. The Sheriff's Office Dispatch operator stated the officer was on vacation.

During an interview with Resident #29 on 8/5/24 at 11:06 am, he was able to communicate verbally that he did not remember the incident on 12/28/23 which involved his former roommate.

Resident #231 was not able to be interviewed.

A phone interview with Resident #231's family on 8/8/24 at 7:44 pm, revealed the family member stated that Resident #231 could not defend himself. Resident #231's family member stated, "that man beat the hell out of my daddy". Family member indicated Resident #231 previously had 2 strokes. Resident #231's family member further stated Resident #231 had never emotionally recovered from the incident on 12/28/23. Resident #231 still does not want to be in a room with someone else.

A phone interview was conducted with the Admissions/Marketing Director on 8/9/24 at 1:37 pm. The Admissions/Marketing Director stated she was not sure why Resident #231 was not placed in his previous room after hospitalization in early December 2023. She explained the process of how room placement with new admissions and/or readmissions were determined. She indicated fall history and medical conditions were determining factors in room placement. If a resident was considered high risk room placement would be near the nurses' station. The Admission/Marketing Director indicated she thought the incident on 12/28/23 was determined to be a mutual incident with Resident #231 and Resident #29. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

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F 600	Continued From page 29	F 600		

Admission/Marketing Director stated she was not aware of Resident #29's history of physical aggressive behaviors. She indicated this was Resident #29's first roommate since 11/20/23. She further explained if a resident had a history of physical aggressive behavior, they would not place a resident in the room with that resident.

A phone interview with Nurse #8 on 8/9/24 at 4:05 pm, stated she was not in the facility at the time of the incident on 12/28/23. Nurse #8 stated she had heard about the incident on 12/28/23. She further stated she was aware Resident #29 had a history of physical aggressive behaviors. She recalled another incident in April 2023 where Resident #29 hit another resident with an open hand on the back of his neck. Resident #29 was transferred to a room with no roommate.

Attempts to interview the Medical Doctor via phone were unsuccessful on 8/9/24 and 8/10/24.

During a phone interview with the Director of Nursing (DON) on 8/14/24 at 1:25 pm, she stated she had been in her position since May 2023. She remembered the incident on 12/28/23 between Resident #231 and Resident #29. She stated Resident # 29 had struck Resident # 231. Resident #29 was immediately removed from the room and placed on one-to-one (1:1) observation. She further stated she was aware of Resident #29's physical aggressive behavior but had never witnessed.

The Administrator was notified of Immediate Jeopardy on 8/12/24 at 4:45 pm.

The facility provided the following corrective action plan with a completion of 12/31/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 600	Continued From page 30	F 600		

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The facility failed to prevent resident from physical abuse on 12/28/23 at approximately 2:00 am Nurse #7 was notified by NA #13 that Resident #231 reported Resident #29 punched him in the face. Resident #29 was immediately removed from Resident #231's room and moved to a private room where he was placed on 1:1 staff supervision to ensure all residents safety. Timely notifications made to the Administrator who ensured appropriate reporting requirements were made to the North Carolina Department of Health and Human Services (NC DHHS), local police department, and Adult Protective Services (APS).

On 12/28/23 Resident #231 and Resident #29 were immediately separated by nursing staff on the unit. Law Enforcement, Adult Protective Services (APS), physician, responsible parties and facility abuse coordinator were notified Nurse #7.

On 12/28/23 Resident #231 was assessed by Nurse #7 redness to his face was noted. He was sent to the emergency room for evaluation by the same nurse. Resident #29 was assessed by Nurse #7 and no injury was noted.

On 12/28/23 immediately after staff was notified of the altercation, Resident #29 was removed from the room for both resident's safety. Resident #231 was sent to the hospital for further evaluation. Resident #29 was returned to the same room by himself, with no roommate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 31	F 600		

Resident #29 has remained in the facility but has had no roommate since 12/28/23.

Resident #231 did not return to the facility from the hospital on 12/28/23. This decision was made by the resident and his resident representative.

On 12/28/23 Resident #29 was placed on one-to-one monitoring for behavior by the DON until reassessed by the physician and interdisciplinary team. Resident #29 would remain on one-to-one monitoring with decreasing frequency as long as the resident did not exhibit any aggressive or abusive behaviors. One to one monitoring would continue until he consistently demonstrated appropriate behaviors and interactions as determined by the interdisciplinary team.

Resident #29 was under psychiatry care. The DON emailed Psychiatry Provider requesting an additional visit. This visit was scheduled for 1/9/24.

On 12/29/23 Physician Provider saw Resident #29. No acute issues reported, vital signs were stable, and the physician indicated to continue current plan of care with no new orders.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

12/28/23: Skin checks were completed on cognitively impaired residents with no negative findings by the DON/designee.

12/28/23: Resident interviews were conducted with no reports of residents experiencing abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 32	F 600		

or neglect by the Social Worker/designee.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

12/28/23 thru 12/30/23: 100% of Staff received education on abuse identification, types of abuse and reporting procedures and de-escalation techniques by the DON/designee. New staff are educated by the DON/designee during initial orientation and prior to department assignments.

For new admissions to the facility, the medical records are screened by the Admissions Coordinator for indications of a history of negative behaviors. If there is any indication of possible aggressive or abusive behaviors during the referral process, the resident is reviewed with the interdisciplinary team in our morning meeting to determine appropriate placement within the facility. Due to the incident on 12/28/23, the facility began putting existing residents with behaviors, new admissions with behaviors or readmissions with behaviors into a private room until resident demonstrates consistent positive interaction with other residents. The Admissions Coordinator was educated on 12/29/23 as a part of all staff education. Admissions serves on the interdisciplinary team as available.

Effective 12/28/23, all current residents and readmitted residents with known behaviors that increase the risk for physical aggression are reviewed by the interdisciplinary team to determine if they should reside in a private room.

The interdisciplinary team was educated by the DON/designee on this process and de-escalation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 33	F 600		

techniques on 12/28/23 through 12/30/23.

Any residents with an indication of a change in behavior, such as increased aggression, are reviewed during the interdisciplinary weekly meeting to identify trends and triggers of behaviors and implement interventions to decrease or eliminate those behaviors. The interdisciplinary team consists of the Administrator, DON, Assistant DON, Social Worker, Clinical Managers with input from Psychiatrist and/or physician, and at times Dietary, Activities or Therapy.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

12/28/23: The Administrator scheduled an ad hoc Quality Assurance and Performance Improvement meeting following the incident. The interdisciplinary team, consisting of the Administrator, DON, Assistant DON, Medical Director, Social Worker and Clinical Managers, decided to initiate reviews of residents demonstrating similar behaviors for at least 12 weeks.

12/28/23: The interdisciplinary team reviewed residents with known aggressive behaviors via progress notes or care plan updates initially for 12 weeks.

Their care plans and interventions were reviewed for effectiveness. Care plans were revised as appropriate. The interdisciplinary team continues to review residents with behaviors during the weekly clinical meeting and proper placement in private rooms are made as deemed appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 600	Continued From page 34	F 600		

12/28/23 thru 3/13/24: Social worker/designee conducted five random resident interviews per week for 12 weeks. The interviews included questions to determine if the residents had witnessed or experienced any form of abuse or felt unsafe in their environment.

12/28/23 thru 3/13/24: DON/designee conducted skin assessments on five non-interviewable residents for 12 weeks to ensure there were no signs of abuse.

The alleged date of immediate jeopardy removal and date of compliance was 12/31/23.

On 8/14/24 the facility's corrective action plan was validated by the following: Staff interviews revealed they had received education on the facility's Abuse policy and procedure which included the types of abuse, recognizing and understanding behavioral symptoms, and de-escalation techniques, residents' right to be free from abuse, and to immediately report any concerns of abuse to their immediate supervisor, DON, and/or Administrator. Review of the attendance sign-in sheets revealed education was completed on 12/28/23. New staff will be educated by the DON/designee during initial orientation. New admissions to the facility, the medical records will be screened by the Admissions Coordinator for indications of a history of negative behaviors. If any indication of possible aggressive and/or abusive behavior was identified during the referral process, the interdisciplinary team will review and determine appropriate placement within the facility. Current residents and readmitted residents with known behaviors that increased the risk for physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 600	Continued From page 35 aggression were reviewed by the interdisciplinary team to determine if that resident would reside in a private room. Education provided to the interdisciplinary team by the DON/designee on this process and de-escalation techniques on 12/28/23 through 12/30/23. Residents with a change in behavior such as increased aggression were reviewed in interdisciplinary weekly meetings and implemented interventions to decrease or eliminate the behaviors. The Administrator scheduled an ad hoc Quality Assurance and Performance Improvement meeting following the incident on 12/28/23. The interdisciplinary team reviewed residents which demonstrated similar behaviors for 12 weeks. Care plans and interventions were revised as necessary. Skin assessments were completed on all cognitively impaired residents with no concerns identified. Alert and oriented residents were interviewed who all reported they felt safe in the facility, were aware of their rights to be free from abuse and knew how and who to report any concerns. One-to-one observation sheets were reviewed. The IJ removal date of 12/31/23 was validated. The compliance date was validated as 12/31/23.	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code smoking, the use of antiplatelets (medications that prevents blood cells from clumping together to form a clot), and	F 641	Regarding F0641: 1. Resident #31 no longer resides in the facility. Residents #54 and #3 remain at the facility but suffered no adverse	9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 641	Continued From page 36 the use of opioids (medications used for relieving pain) for 3 of 33 residents whose Minimum Data Set (MDS) assessments were reviewed (Resident # 3, Resident #54 and Resident #31). Findings included: 1.Resident #31 was admitted to the facility on 1/27/24 with diagnosis which included chronic obstructive pulmonary disease (COPD). A Smoking Assessment completed by nursing staff dated 1/27/24 indicated Resident #31 was a "non-smoker or intended not to smoke." Nursing documentation dated 1/31/24 written by Nurse #2 revealed Resident #31 had gone outside to smoke and had taken his oxygen off before lighting his cigarette. Resident #31's Admission Minimum Data Set (MDS) dated 2/3/24 revealed he had moderate cognitive impairment and was on oxygen therapy. The Current Tobacco use section was marked "No". During an interview with Resident #31 on 8/5/24 at 9:01 am, he stated he had been smoking since he was 15 years old. He further stated he had smoked since his admission to the facility. The Director of Nursing (DON) was interviewed on 8/6/24 at 9:09 am. She indicated the floor nurses assess residents for smoking when they're admitted, readmitted, quarterly, and with any significant change in the resident's condition. The MDS assessment should have been correctly coded at the time of admission.	F 641	outcomes due to the deficient practice. The minimum data sets for residents #54 and #3 were corrected by the minimum data sets coordinator to reflect accurate medication coding. 2. All current residents as of 9/12/2024 who smoke, receive opioids or antiplatelet medications are at risk for this deficient practice. Therefore, the regional reimbursement specialist/designee completed a review of most recent minimum data set for all residents receiving opioids or antiplatelet medications and for those residents who smoke, to ensure their assessment was accurate based upon resident assessment instrument guidelines. Any negative findings were corrected. 3. To prevent this from reoccurring, the regional reimbursement specialist educated the minimum data set coordinator on the requirement of accurate minimum data set coding on 8/23/2024. The minimum data set coordinator will review the medical record when coding the assessment to ensure the assessment is accurately coded for medication and tobacco use. Any new employees or agency staff hired after 8/23/2024 who are responsible for this compliance will receive this education. 4. Monitoring for compliance: Beginning the week of 9/9/2024, an audit of five minimum data set assessments will be completed each week by the reginal reimbursement specialist/designee for twelve weeks to ensure the assessment reflects the most recent and current information for that individual resident for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 37 During an interview with the Administrator on 8/6/24 at 10:30 am she indicated the MDS should have reflected Resident #31's smoking status. 2. Resident #3 was admitted the facility on 7/11/2024 with diagnoses including stroke. Physician's orders dated 7/12/2024 included Aspirin (an antiplatelet that prevents the blood cells from sticking together to from a clot) 325 milligrams (mg) once a day. A review of the July 2024 Medication Administration Record indicated Resident #3 received Aspirin as ordered from 7/12/2024 to 7/31/2024. The admission Minimal Data Set (MDS) assessment dated 7/17/2024 indicated Resident #3 was severely cognitively impaired and was receiving anticoagulants (medications that increase the time it takes for blood to clot) In a phone interview with the Regional MDS Consultant on 8/14/2024 at 1:09 pm, she stated Aspirin was an antiplatelet and Resident #3's MDS should have been coded for antiplatelets and not anticoagulants. She explained the facility was currently training a new MDS nurse for the MDS position that was abruptly vacated. In an interview with the Administrator on 8/15/2024 at 4:18 pm, she stated Resident #3's MDS assessment needed to be an accurate document of Resident #3 receiving an antiplatelet and not an anticoagulant. 3. Resident #54 was admitted to the facility on 9/3/2022 with diagnoses including stroke with	F 641	medication class and tobacco use. Results will be reported in quality assurance performance improvement committee for three months by the minimum data set coordinator. 5.The administrator is responsible for compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 641	Continued From page 38 hemiplegia (paralysis or weakness of one side of the body) Physician orders dated 3/4/2024 for Resident #54 included oxycodone (an opioid medication used to treat moderate to severe pain) 10 milligrams (mg) three times a day for pain. A review of the June 2024 Medication Administration Record reported Resident #54 was administered oxycodone three times a day as ordered from 6/1/24 to 6/30/24. The quarterly Minimal Data Set (MDS) assessment dated 6/29/2024 indicated Resident #54 was severely cognitively impaired and received scheduled and as needed pain medications. Resident #54's MDS was not coded for the use of opioids. In a phone interview with the Regional MDS Consultant on 8/14/2024 at 1:09 pm, she explained the facility's MDS Nurse had not been diligent (conscientious) in conducting MDS assessments and had ended her employment without a notice. She stated due to Resident #54 receiving oxycodone daily, the MDS should have been coded for the use of opioids. In an interview with the Administrator on 8/15/2024 at 4:29 pm, she said Resident #54's MDS should reflect physician's orders and treatments of opioids accurately on the MDS.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 656	Continued From page 39	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 656	Continued From page 40 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement an comprehensive individualized person centered care plan in the areas of smoking and antipsychotic medications for 2 of 32 residents reviewed for comprehensive care plans (Resident #65, Resident #31). Findings included: 1. Resident #31 was admitted to the facility on 1/27/24 with diagnosis which included chronic obstructive pulmonary disease (COPD). A Smoking Assessment completed by nursing staff dated 1/27/24 indicated Resident #31 was a "non-smoker or intended not to smoke." Nursing documentation dated 1/31/24 written by Nurse #2 revealed Resident #31 had gone outside to smoke and had taken his oxygen off before lighting his cigarette. Review of the Admission Minimum Data Set (MDS) dated 2/3/24 revealed Resident #31 had moderate cognitive impairment and was coded "No" for current tobacco use. A Smoking Assessment 4/18/24 completed by nursing staff indicated Resident #31 was a "safe smoker." At the bottom of the smoking assessment form is a check box marked to continue the current plan of care.	F 656	Regarding F0656: 1. Resident #31 no longer resides in the facility. On 8/22/2024, resident #65 care plan was updated to reflect current use of psychotropic medications. 2. All residents who smoke and who receive antipsychotic medications are at risk for same deficient practice, therefore on 9/12/2024, care plans for all residents that smoke or who are receiving antipsychotic medication were reviewed by the regional director of clinical services/designee and updated as needed to accurately reflect the medication or tobacco use. 3. To prevent this from reoccurring, on 8/21/2024, the regional reimbursement specialist provided education to the minimum data set coordinator on the expectation of compliance and how to create and update care plans reflect accurate plan of care needs. Resident change of conditions and new orders will be reviewed in clinical morning meeting and care plan will be initiated or updated as needed. All new employee and agency staff who are hired after 8/21/2024 who are responsible for this compliance will receive this education. 4. Ongoing compliance monitoring: Five resident records will be reviewed weekly to ensure any new orders for antipsychotic medications or change in smoking status	

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	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 656	Continued From page 41 During an interview with Resident #31 on 8/5/24 at 9:01 am, he stated he had been smoking since he was 15 years old. He further stated he had smoked since his admission to the facility. During an interview with the Social Worker on 8/6/24 at 1:22 pm, she stated the MDS coordinator was responsible for developing Resident #31's care plan. During a phone interview with the MDS Regional Consultant on 8/13/24 at 3:25 pm she indicated Resident #31 was care planned for smoking on 7/29/24. She stated the facility switched from Point Click Care (PCC) to Matrix on 3/4/24. She explained during the switch care plans were written on paper. The MDS Regional Consultant was unable to provide a copy of Resident #31's paper care plan. Resident #31's care plan was revised by the Administrator on 7/29/24. A new category of behavioral symptoms was added to reflect Resident #31 had a history of smoking. The goal added was Resident #31 would follow policies and procedures regarding smoking. The approaches added included Resident #31 would adhere to policies and procedures regarding smoking, would be accepting of staff redirection as indicated, and would verbalize understanding of the risks associated with continued smoking. During an interview with the Administrator on 8/6/24 at 10:30 am, she indicated she was new to the facility and unaware the facility had failed to implement this in Resident # 31's care plan. She further stated MDS nurse was unavailable for interview and the MDS Regional Consultant could	F 656	will be completed and care plans updated as indicated by the director of nursing/designee. Results to be reported in quality assurance performance improvement committee for three months by the director of nursing/designee. 5. The administrator is responsible for compliance. Date of Compliance: 9/16/24	

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F 656	Continued From page 42	F 656		

be contacted.

2. Resident #65 was admitted to the facility on 8/24/2023 with diagnoses including Alzheimer's and dementia with behavioral disturbances.

Resident #65 was discharged from the facility on 4/29/2024 and re-admitted on 5/3/2024.

Physician orders dated 5/3/2024 included Risperidone (an antipsychotic medication that treats mental health conditions) 0.25 milligrams(mg) at bedtime.

Resident #65's care plan dated 5/9/2024 and last reviewed on 6/1/2024 did not include a focus for the use of psychotropic medications.

The quarterly Minimal Data Set (MDS) assessment dated 5/11/2024 indicated Resident #65 was cognitively intact and was receiving antipsychotics on a routine basis.

A review of Medication Administration Record from 5/3/2024 to 8/6/2024 reported Resident #65 received Risperidone 0.25mg at night.

In an interview with the Director of Nursing on 8/15/2024 at 3:21 pm, she explained nursing staff did not know how to update care plans and were not expected to update care plans. She stated the MDS nurse was responsible for updating Resident #65's care plan. She said Resident #65 should have been care planned for the use of antipsychotics and she could not explain why Resident #65's care plan did not include the use of antipsychotic medications.

In a phone interview with the Regional MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 43 Consultant on 8/14/2024 at 1:09 pm, she stated the MDS Nurse was responsible for updating Resident #65's care plan and was unable to provide a reason why Resident #65's care plan did not include the use of antipsychotic medications after re-admission to the facility on 5/3/2024. She explained the MDS Nurse had vacated the MDS Nurse position abruptly and since the resident was receiving Risperidone, an antipsychotic, Resident #65 should have been care planned for the use of antipsychotics. In an interview with the Administrator on 8/15/2024 at 4:34 pm, she stated the MDS Nurse was responsible for the completing and updating comprehensive care plans, and Resident #65 should have been care planed for the use of antipsychotics.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be	F 660		9/16/24

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F 660	Continued From page 44	F 660		

updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent

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	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 660	Continued From page 45 the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and Family Member, Adult Protective Services, Home Health Agency, staff, and physician interview, the facility failed to provide a safe discharge planning process for 1 of 1 resident (Resident #277) reviewed for discharge from the facility. Resident #277 was discharged home on 8/1/24 to an independent living apartment. The facility failed to ensure the resident had a caregiver who could provide care, ensure that resident had a means to obtain medications needed at home, and secure a home health provider for continuity of care. Findings included: Resident #277's hospital discharge summary dated 7/17/24 noted that prior to hospitalization, Resident #277 was living with Family Member #1, who said she was no longer able to care for the resident. The summary noted the resident was bedbound, required a lot of family support, and	F 660	Regarding F0660: 1. Resident #277 no longer resides in the facility. 2. All residents who discharged to home are at risk for this deficient practice therefore a seven day look back for 9/1/2024 to 9/7/2024 was reviewed and there were no residents who discharged home during that period.Completed 9/12/2024. 3. To prevent this from reoccurring, the social worker was educated on 8/21/2024 by the administrator on the facility discharge planning policy and requirement of this citation to include ensuring items are in place to promote a safe and successful discharge. Any new employees or agency staff who are responsible for this compliance after 8/21/2024 will receive this education. 4. Ongoing compliance monitoring:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 660	Continued From page 46 refused to eat and to take her medications at home. Resident #277 was admitted to the facility on 7/17/24 with diagnoses including a urinary tract infection, sepsis (a life-threatening emergency to the body's response to an infection), a chronic disease of the immune system, muscle weakness, adult failure to thrive, and a history of deep vein thrombosis in both legs (blood clots). Resident #277's comprehensive care plan dated 7/18/24 revealed Resident #277 believed she was capable of increased independence in bed mobility, transfer, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene. Interventions included assistance for activities of daily living (ADL) and physical and occupational therapy. The resident's discharge goal was for the facility to ensure Resident #277 would have access to necessary services to promote adjustment to their new living environment and/or post discharge from facility. Resident #277's admission Progressive Approach to Home (PATH) assessment dated 7/19/24 revealed the resident's discharge goal was to return home with her spouse, who was her primary caregiver. The assessment noted that the resident had 5 steps to enter her home and had not previously had home health therapy or nursing. An admission Minimum Data Set Assessment dated 7/23/24 indicated Resident #277 was cognitively intact and required extensive/maximum assistance (caregiver does more than half of the effort) for toileting, upper	F 660	Beginning the week of 9/9/2024, an audit of each documented discharge plan will occur weekly for the next twelve weeks by the administrator/designee to identify potential problems or gaps in the discharge process. Any negative findings will be followed up. Results will be reported in quality assurance performance improvement committee for three months by the administrator/designee. 5. The administrator is responsible for compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 660	Continued From page 47	F 660		

and lower body dressing, personal hygiene, and transfers.

Resident #277's subsequent PATH assessment dated 7/25/24 revealed she needed minimal to moderate assistance (caregiver does 50% of the effort) with transfers using a rolling walker and needed minimal assistance (caregiver does 25% of the effort) with upper and lower body ADLs. The assessment noted the resident's plan to discharge home with her spouse.

A Notice of Medicare Non-Coverage form was signed by Resident #277 on 7/29/2024 and it stated her last insurance covered day was 7/31/2024.

Resident #277's Physical Therapy (PT) Discharge Evaluation dated 7/31/2024 revealed she was able to transfer with minimum assistance with a front wheeled walker and walk with a front wheeled walker 10-20 feet with minimum assistance or contact guard assistance (caregiver physically touching the resident). The PT recommendations were for a home exercise program, home health services, an assistive device for safe functional mobility, and a wheelchair.

Resident #277's Occupational Therapy (OT) Discharge Evaluation dated 7/31/2024 revealed she could do meal preparation and clean up with minimum assistance, dress her lower body with minimum assistance, and bathe with moderate assistance. The OT recommended home health services, an assistive device for safe functional mobility, an elevated toilet seat or a commode, grab bars, and assistance with her ADLs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 660	Continued From page 48	F 660		

Resident #277's physician progress notes dated 7/31/2024 revealed she had weakness in her legs, had progressed in therapy and was planning to go home. The physician wrote she was to have home health PT and OT for continued strengthening and education. He noted that upon discharge she would need a wheelchair to enable her to be mobile within the home and that the wheelchair would enable her to complete ADL in a timely fashion.

Resident #277's SW progress notes dated 7/31/2024 at 4:22 PM revealed the hall nurse notified the SW that Family Member #1, not the spouse, called the facility the previous evening and told the nurse that resident was staying in the facility for long-term care. The SW noted she attempted to contact Family Member #1 to discuss the resident's plan to discharge but was unsuccessful and left a voicemail to call the SW. The SW noted Resident #277 was alert and oriented and able to make her own decisions. The SW noted that the Interdisciplinary Team had only spoken with the resident throughout her stay to discuss goals and discharge plans. Resident #277 planned to discharge to home the next day and stated Family Member #6 would be picking her up around 2:30 PM. The SW noted she sent referrals for home health care and ordered the resident a wheelchair for home use.

In a subsequent SW progress note written on 7/31/2024 at 4:34 PM, the SW noted she spoke with Resident #277 to confirm her discharge plan. Resident stated she was going home the next day and that Family Member #1 did not make decisions for her. The SW notified the resident that home health and the wheelchair had been ordered. The SW noted the resident was already

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 660	Continued From page 49	F 660		

packing boxes with her belongings to prepare for discharge the next day.

Resident #277's physician orders dated 8/1/2024 did not reveal a discharge order for the resident. The orders noted Resident #277's was taking Bactrim (an antibiotic) 800-160 milligrams, half of a tablet once a day, which she was to stop taking on 8/16/2024. The resident also took Eliquis (a blood thinner) 5 mg twice a day, and a medication for her immune system once a day.

Resident #277's Transition of Care/Discharge Summary dated 8/01/2024 and signed by the resident revealed the resident was discharged 8/01/2024 with the destination to home with spouse. The summary noted the resident's goal was to discharge home with help from Family Member #6. The summary documented that all education was given to the resident. The summary did not indicate who picked up the resident at discharge.

Resident #277's Transition of Care/Discharge Summary dated 8/01/2024 and signed by the resident revealed the resident was discharging home with help from another family member, Family Member #6. The summary noted Resident #277 was frequently incontinent of bowel and bladder and needed assistance with eating, oral hygiene, toileting hygiene, personal hygiene, to shower and bathe self, with upper and lower body dressing, and with putting on and taking off her footwear. The summary noted that she needed assistance physically with rolling left and right in her bed, with moving from sitting to lying; with moving from lying to sitting on side of bed, with sitting to standing, transfers from chair or bed to another chair and transfers to the tub or shower,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 50	F 660		

to wheel herself 50 feet with two turns and with wheeling herself 150 feet. The summary included contact information for Home Health Company #2 but did not include contact information for the medical equipment company the SW used to order her wheelchair, did not mention the need for a front wheeled walker, an elevated toilet seat or commode, or grab bars, and did not include the scheduled Primary Care Physician (PCP).

In an interview on 8/13/24 at 1:01 PM, Nurse #6, who completed the discharge with Resident #277, said she provided education to the resident about her medications and provided the resident with the discharge summary. She did not have any concerns about the discharge, and thought the resident's family would be assisting her at home. She said the facility did not normally provide medications to the residents when they discharge and their prescriptions were electronically sent to the resident's community pharmacy.

In an interview on 8/5/24 at 3:57 PM, Resident #277's Family Member #1 said the resident's spouse, who was her caregiver prior to the resident's hospitalization, had suffered a stroke and was at another skilled nursing facility approximately one week prior to Resident #277's hospitalization on 7/11/2024. Family Member #1 became the resident's primary caregiver and said that a week prior to the resident's hospitalization, she went to stay with Family Member #1 at her home. She said the resident needed more assistance with ADL than the family could provide. Family Member #1 said there was no one at the resident's home to provide care for the resident. Family Member #1 said she called the facility and spoke with the Social Worker (SW) on 7/24/24, prior to the resident's discharge, letting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 660	Continued From page 51	F 660		

her know the resident's spouse had suffered a stroke and there was no one home to care for Resident #277 and that Family Member #1 would be going out of the country the next day. The SW told Family Member #1 that the resident was able to walk 125 feet with a rolling walker, that the facility had ordered home health therapy to continue the resident's rehabilitation care, and that the facility had ordered a wheelchair for the resident to use at home. Family Member #1 said Family Member #4 had visited the resident on 8/3/24 and the resident was sitting in a chair in a soiled brief because she was not able to get out of her chair to go to the bathroom or walk throughout the home. Family Member #1 said another family member, Family Member #2, was staying at the home in the evenings to assist the resident, but the resident was alone during the day with no caregiver. The resident did not receive her wheelchair until 8/5/24, and there had been no contact from a home health agency to provide continued care. Family Member #1 said the resident had been without her medications since she discharged from the facility. The resident did not receive any medications and Family Member #1 was unsure what the facility did to ensure the resident had medications at home. A member of the family notified Adult Protective Services (APS), who visited the resident at her home on 8/5/24. Family Member #1 said the facility did not notify her when the resident was discharged, though Family Member #1 was on the contact list. Family Member #1 found out while she was out of the country that the resident had discharged from the facility when she spoke with Family Member #6, who also told her that the resident discharged with a family friend. Family Member #1 spoke with the family friend on 8/4/2024, who said he did not receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 52	F 660		

any information or education from the facility at discharge and all the information was given to the resident. All he did was drive her home. The resident did not have any information about a follow up doctor's appointment and the resident did not have a PCP in the community that she had seen. Family Member #1 said the resident had a cell phone she could use in case of an emergency to call 911, but would not answer the phone when someone called. Family Member #1 did not provide the number to the resident's cell phone.

Attempts to interview Resident #277 were unsuccessful due to the only phone number available was for Family Member #1.

In an interview on 8/05/24 at 4:33 PM, the SW said Resident #277 requested to discharge home after her insurance company issued a Notice of Medicare Non-Coverage and discharge planning was initiated due to the resident being cognitively intact and her own responsible party. The SW said she was not aware that the resident's spouse was at a skilled nursing facility until 8/4/24 when she spoke with Family Member #1, who told the SW the resident should have stayed in the facility for long term care due to not having a caregiver. The SW said she referred Resident #277 to 3 different home health agencies and 2 of them, Home Health Agency #1 and #2, would not accept the resident's insurance but Home Health Agency #3 had accepted the referral to provide care for the resident. The SW said she ordered a wheelchair for the resident and the resident's medications were called into the resident's pharmacy.

In an interview on 8/5/2024 at 3:40 PM, the Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 53	F 660		

Manager and the Clinical Supervisor at Home Health #2, whose contact information was listed on the discharge summary as being responsible for providing continued care while at home, said Resident #277 was not a patient of the agency. The Office Manager said the resident was not listed in their system.

In an interview on 8/05/2024 at 4:51 PM, a customer representative for Home Health #3 said Resident #277 was not a patient in their system, that she did not see a referral from the facility for services, and she did not see that Home Health #3 provided services in the city the resident lived. The agency Branch Manager confirmed the agency does not provide services to the city where Resident #277 lived and did not have government approval to provide services there.

In an interview on 8/6/24 at 8:23 AM, the APS caseworker said she visited Resident #277 at her home on 8/5/24. She said the resident was unable to get out of her chair and walk when requested. Resident #277 attempted to get up but was unable to. The APS caseworker said she called the facility and spoke with the SW. The SW told the APS caseworker that the resident could walk 150 feet with a rolling walker, which the APS caseworker said did not match what she observed. When the APS caseworker asked the resident why she was unable to walk, the resident told her that Family Member #2, who cared for her at night, told her not to walk due to her risk of falling while no one was home. When the APS caseworker spoke with Family Member #2, he said he did not tell the resident not to walk but she was unable to walk. Family Member #2 said he did not stay in the home with the resident but would stop by regularly to provide assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 54	F 660		

The APS caseworker said there were no medications in the home, including no medications for continued preventative treatment for blood clots and her impaired immune system. Resident #277 said she did not know where her medicines from before her hospitalization were and said her family had moved things around while she was in the facility. The APS caseworker said the SW told her during the conversation on 8/5/24 that she was still trying to find a home health agency for the resident, that Home Health Agency #1 refused to take her insurance and the SW was going to call Home Health Agency #2. SW said she will check on why the resident did not have her medications and that it may have been a computer problem due to the prescription transmission process to the pharmacy. The APS caseworker said while she visited with the resident, she was clean, groomed, and not soiled because Family Member #2 cleaned her up prior to going to work. Family Member #2 also made breakfast for the resident, but she would have to get up to make lunch, which she was unable to do. The APS caseworker noted the resident had 3 stair steps from the yard to the front door and she was worried the resident was unable to climb up or down them, especially in an emergency. The APS caseworker said the resident's back door led to a porch and deck, but it could not be used safely due to the back door not working and the very worn wood on the deck. The APS caseworker said the resident was going to remain in her home per her choice because she was cognitively intact and could make her own decisions, even if others didn't agree with the decisions she made.

In a joint interview on 8/5/24 at 4:40 PM, the SW and the Director of Rehabilitation (DOR) said they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 55	F 660		

did not feel Resident #277's discharge home was unsafe and therefore did not contact APS. The SW said the resident had food in the home and she had made the appropriate referrals. The DOR said the resident could cook and do other ADL independently with activity modifications. The SW and the DOR said the resident could walk 150 feet. The DOR re-read the therapy progress notes and corrected herself. She said the resident could propel herself 150 feet in her wheelchair, not walking with a rolling walker. Resident #277 could walk 10-20 feet with rolling walker. She said the resident's progress was limited due to the resident's fatigue. The DOR said when the resident was in the facility, she would transfer and toilet herself independently and would propel herself around the halls in her wheelchair visiting other residents. The SW said the resident was discharged from the hospital with a community PCP appointment with the health department on 9/6/24 at 12:30 PM. The SW said the facility did not normally have meetings or care conferences at discharge with residents and caregivers to ensure all parties were aware of discharge plans.

In an interview on 8/12/2024 at 3:00 PM, the SW said she spoke with Resident #277 on 8/11/2024. The resident confirmed that she went to pick up her medications at her community pharmacy on 8/6/24, but left her purse there with all of her medications in it. When the resident returned to the pharmacy, her purse and medications were gone. The SW said the facility will hold on to a supply of the resident's Eliquis that she used while in the facility so the resident can come and pick it up. The SW did not know Home Health Agency #3 did not provide services to the resident's home and said she had faxed a referral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 56	F 660		

to them but had never heard anything back, so she assumed they were going to provide home health services. The SW said she did not know another home health company she could contact to provide services but said she will talk with the resident's insurance for any available options.

In a joint interview on 8/06/2024 at 9:35 AM, the Administrator and Director of Nurses (DON) said Resident #277 was in the facility for a short-term rehabilitation stay. Resident #277 was her own responsible party. Both were aware Family Member #1 had told the nurses and SW that they were worried about the resident's safety at home. The DON said the resident propelled herself in her wheelchair throughout the facility and had improved in what she was able to do since was at facility. The DON said residents who were in the facility under Medicare Part A services did not receive their medications at discharge because the facility had paid for the medications and that the electronic medical record automatically sent the discharge prescriptions electronically to the resident's community pharmacy. Both the Administrator and the DON did not have concerns about the resident's discharge or that she would be unsafe at home because of what she was able to do in the facility.

In an interview on 8/20/2024 at 1:00 PM, Resident #277's facility physician said he was not aware the resident went home without a caregiver, home health, a wheelchair, or medications. He said the SW usually took care of the arrangements and the facility had standing orders related to discharge. He did not remember the resident's specific functional abilities at discharge, so he could not say it was necessarily an unsafe discharge, but said that since Family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 57 Member #1 called the day before discharge, her concerns should have been addressed at discharge, as well as ensuring the resident had a wheelchair in the home. He said the nurse or SW should have been confirmed that the resident had enough medications at discharge, especially the medications for the resident's immune system and for prevention of blood clots. The physician did not provide any further information.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up	F 661		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 58 care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and a Family Member and staff interview, the facility failed to provide a complete discharge summary for 1 of 1 resident (Resident #277) reviewed for discharge to the community. Findings included: Resident #277 was admitted to the facility on 7/17/24 with diagnoses including a urinary tract infection (UTI) with extended-spectrum beta-lactamase (ESBL, an enzyme produced by some bacteria that makes them resistant to many antibiotics), sepsis (a life-threatening emergency to the body's response to an infection), a chronic disease of the immune system, and a history of deep vein thrombosis in both legs (blood clots). She discharged home to the community on 8/1/24. An admission Minimum Data Set Assessment (MDS) dated 7/23/24 indicated Resident #277 was cognitively intact and required extensive/maximum assistance (caregiver does more than half of the effort) for toileting, upper and lower body dressing, personal hygiene, and transfers. Review of Resident #277's Physical Therapy (PT) Discharge Evaluation dated 7/31/2024 revealed recommendations for home health services, an assistive device for safe functional mobility, and a wheelchair. Review of Resident #277's Occupational Therapy	F 661	Regarding F0661: 1. Resident #277 no longer resides in the facility. 2. All residents who discharged to home are at risk for this deficient practice therefore a seven day look back for 9/1/2024 to 9/7/2024 was reviewed by the director of nursing/designee and any areas of concern were addressed. Completed 9/12/2024. 3. To prevent this from reoccurring, by 9/12/2024, the administrator educated the interdisciplinary team responsible for the discharge summary process. The director of nursing/designee educated all licensed nursing staff on discharge summary process. The interdisciplinary team will review any planned discharges in the morning clinical meeting and review the discharge summary to ensure it is complete. Any identified gaps in information will be followed up on immediately in collaboration with the resident or resident representative. Any new employees or agency staff hired after 9/12/2024, who are responsible for this compliance, will receive the same education. 4. Ongoing compliance monitoring: Beginning the week of 9/9/2024, an audit of each discharge/transfer summary will occur for weekly for the next twelve weeks by the administrator/designee to ensure the summary is complete. Any identified problems will be followed up on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 59 (OT) Discharge Evaluation dated 7/31/2024 revealed recommendations for home health services, an assistive device for safe functional mobility, an elevated toilet seat or a commode, grab bars, and assistance with her ADLs. Review of Resident #277's SW progress notes dated 7/31/2024 noted she sent referrals for home health care and ordered the resident a wheelchair for home use. Review of Resident #277's Transition of Care/Discharge Summary dated 8/01/2024 and signed by the resident revealed the resident was discharging home with help from another family member. The summary included contact information for Home Health Company #2 but did not include contact information for the medical equipment company the SW used to order her a wheelchair, did not mention the need for a front wheeled walker, an elevated toilet seat, a commode or grab bars, and did not include information of scheduled follow-up appointments with her community Primary Care Physician. The discharge summary did not include information about how and where to obtain medications the resident needed at home. In an interview on 8/5/24 at 3:57 PM, Resident #277's Family Member #1 said the discharge summary did not include information about the need for a follow up doctor's appointment and the resident did not have a primary care physician (PCP) in the community that she had seen routinely. In an interview on 8/05/24 at 4:33 PM, the SW confirmed the discharge summary did not include information of the wheelchair provider and that it	F 661	immediately. Results will be reported in quality assurance performance improvement committee for three months by the administrator/designee. 5. The administrator is responsible for compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 60 did not list the correct contact information for the home health provider. She indicated the Interdisciplinary Team completed the discharge summary information. In an interview on 8/5/24 at 4:40 PM, the SW said she had spoken with Family Member #1 that day (8/5/24) and provided information about the home health agency, how to obtain the resident's medications, and about her upcoming doctor's appointment. In a joint interview on 8/06/2024 at 9:35 AM, the Administrator and Director of Nurses (DON) said Resident #277 was in the facility for a short-term rehabilitation stay. The DON said the arrangements for follow-up care and information on how to obtain medications from her community pharmacy should have been included in the discharge paperwork.	F 661		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with Division of Health Service Regulation (DHSR) Life Safety Surveyor, resident, physician and staff, the facility failed to provide the necessary supervision to ensure	F 689	Regarding F0689: 1. Resident #31 no longer resides in the facility. 2. All residents who smoke are at risk for deficient practice. All current residents as	9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 61 residents were safe while smoking when Resident #31 was found smoking in the presence of a supplemental oxygen device, to implement their smoking policy and effective interventions to address the resident's repeated non-compliance with safe smoking practices both inside and outside of the facility, and to monitor the resident to prevent further incidents of unsafe smoking. Resident #31 was assessed on admission as a non-smoker at the facility. On 1/31/24 Resident #31 was observed smoking outside in the designated smoking area and he had smoking materials in his possession in violation of the smoking policy. On 6/27/24 Resident #31 was observed smoking outside in a non-designated smoking area with his portable oxygen tank on his wheelchair. On 7/9/24 Resident #31 was observed lying in bed smoking a cigar with oxygen on via nasal cannula. On 7/20/24 staff found a cigarette in Resident #31's toilet in his bathroom, ashes on the floor, and in the trash can. Resident #31 admitted to smoking a cigarette in his bathroom. An oxygen concentrator was present in his room. On 8/4/24 Resident #31 was observed in the designated smoking area with a portable oxygen tank on his wheelchair smoking a cigarette. He remained an unsupervised/independent smoker until 8/5/24 at which time he refused to sign his updated smoking contract and indicated he would quit smoking. On 8/14/24 Resident #31 was observed in the designated smoking area smoking without supervision. Supplemental oxygen devices produce enriched oxygen which accelerates combustion. Smoking near oxygen devices, even when turned off, is a fire hazard and has a high likelihood of resulting in serious harm to all residents nearby from fire and/or an explosion. This deficient practice was for 1 of 6	F 689	of 9/12/2024 who reside in the community had their most recent smoking assessment reviewed to ensure accuracy. Care plans were reviewed to ensure accuracy. All resident who smoke were reeducated by the administrator and regional director of clinical services on the facility smoking policy including the designated smoking area, risks of smoking in the presence of oxygen or other flammables, and repercussions of non-compliance. Observations were performed by the regional director of clinical services with no identified concerns. Completed 9/12/2024. 3. To ensure this deficient practice does not reoccur, the administrator and director of nursing/designee completed education with all staff on the smoking policy. The education included risks associated with non-compliance, guidance for smoking residents and reporting on non-compliance. The interdisciplinary team will review in the morning clinical meeting for any change of condition of current smokers to identify any need to change their plan of care. 4. Ongoing compliance monitoring: Beginning 9/9/2024, the administrator/designee will observe all current smokers weekly for twelve weeks for compliance of smoking policy. Any new admission's smoking assessment will be reviewed weekly for twelve weeks to ensure accuracy. Results to be reported in quality assurance performance improvement committee for three months by the administrator/designee. 5. The administrator is responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 62 residents reviewed for smoking. Immediate jeopardy began on 6/27/24 when nursing did not extinguish the cigarette when Resident # 31 was observed with his oxygen tubing in his lap, nursing was unaware of the hazard and did not do a new smoking assessment. The immediate jeopardy was removed on 8/15/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level E (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: Review of the user's manual intended use for Resident #31's portable oxygen tank revealed the portable oxygen tank supplied a high concentration of oxygen and is used with a nasal cannula to channel oxygen from the concentrator to the patient. General precautions included a warning which stated this device produces enriched oxygen gas which accelerates combustion. Do not allow smoking or open flames within 10 feet of this device while in use. Review of the facility smoking policy last revised 12/20/2022 titled, "Resident Smoking Policy" revealed the following: Residents who smoke or desire to smoke will be required to sign a "Safe Smoking Contract" and agree to abide by the rules regarding safe smoking or they will forfeit their smoking privileges. Residents may only smoke on premises in designated location(s). Those requiring supervision will only smoke at	F 689	compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 63	F 689		

designated times. Independent smokers may smoke in designated location(s) at any time but need to sign out so that the staff know where the resident is. No resident will maintain or store smoking materials on their person or in their rooms. Resident smoking materials will be retained by the facility staff and distributed to the residents or supervising staff at designated smoking times. No smoking may occur near oxygen or other combustible materials. Failure to adhere to the provisions outlined in this smoking protocol (such as resident having smoking materials in his/her possession; found smoking in his/her room or any non-designated area, or smoking at any non-designated time) will result in:

a. A reassessment of the resident utilizing the smoking safety assessment.

b. Counseling of the resident by Social Services/designee using the Behavior Contract for Smoking Violations.

c. Notification of the resident representative and/or guardian or POA of the incident by Social Services/designee.

Depending on the severity of the violation, the following may occur at the discretion of the Administrator or his/her designee:

a. Social Services/designee will notify resident due to violation he/she will forfeit smoking privileges for a period to be determined.

b. A resident room search for smoking and lighting materials.

c. Issuance of a discharge notice.

Resident #31 was admitted to the facility on 1/27/24 with diagnosis which included chronic obstructive pulmonary disease (COPD).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 64	F 689		

Review of Resident #31's physician's order dated 1/27/24 included an order for continuous oxygen at 3 LPM (liters per minute) via nasal canula.

Resident #31's Smoking Assessment dated 1/27/24 indicated he was non-smoker or intended not to smoke.

a) The nursing progress note dated 1/31/24 documented by Nurse #2 stated Resident #31 was going outside to smoke and taking his nasal cannula off before lighting the cigarette.

In an interview with Nurse #2 on 8/5/24 at 3:24 pm, she stated Resident #31 traveled outside to smoke via his motorized wheelchair. Nurse #2 stated she observed Resident #31 take his oxygen tubing off and place it in his lap before lighting the cigarette on 1/31/24. She further stated Resident #31's portable oxygen tank was not on his wheelchair. Nurse #2 indicated Resident #31 was assessed as a non-smoker on 1/27/24 and was unaware he had his smoking materials in his room at the time of this incident. Nurse #2 indicated she did not complete a new smoking assessment on Resident #31 after she observed him smoking on 1/31/24. Nurse #2 stated she reported to the oncoming shift on 1/31/24 but was unable to recall exactly who she reported the incident to. The physician was made aware the next day when he came to the facility. Resident #31's smoking materials were taken away from him by Nurse #2 after this incident and stored on the nurses' medication cart. Resident #31 had to ask the nurse on the medication cart for his smoking materials when he wanted to go smoke.

Resident #31's Electronic Medical Record (EMR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 65	F 689		

revealed no evidence a smoking assessment was completed after the incident on 1/31/24. There was no documentation of counseling for the resident using the Behavior Contract for Smoking Violations for violating the smoking policy by having smoking materials in his possession as indicated in the smoking policy. No physician notes were documented related to the incident on 1/31/24.

Resident #31 did not sign the Safe Smoking Contract as stated in the facility's Smoking Policy.

Resident #31's Admission Minimum Data Set (MDS) dated 2/3/24 revealed he had moderate cognitive impairment and was on oxygen therapy. The Current Tobacco use section was marked "No". Resident #31 was independent with ambulation and transfers. Resident #31 had a walker and a motorized wheelchair for mobility.

Resident #31's care plan dated 2/3/24 revealed a focus for oxygen therapy with an intervention of a portable oxygen tank provided for ambulatory residents. Resident #31's care plan dated 2/3/24 did not address his smoking.

A nursing progress note completed by Nurse #8 on 3/15/24 stated Resident #31 asked for a nicotine patch to quit smoking. Physician notified and a new order for nicotine patches started on 3/16/24.

A phone interview on 8/9/24 at 4:05 pm with Nurse #8 revealed Resident #31 came to her on 3/15/24 and asked for the nicotine patch to quit smoking.

Resident #31's physician's order dated 3/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 66	F 689		

included an order for nicotine patch 21 milligrams (mg)/24 hour to be applied daily at 9:00 am.

Resident #31's March 2024 Medication Administration Record (MAR) revealed the nicotine patch was placed on 3/16/24, 3/17/24, 3/18/24 and refused on 3/19/24. The MAR further revealed this order was discontinued on 3/20/24.

Resident #31's physician's order dated 4/14/24 included an order for nicotine patch 21 mg/24 hour to be applied daily at 9:00 am. There was no documentation that corresponded to this 4/14/24 order for the nicotine patch.

Resident #31's quarterly Smoking Assessment completed by Nurse #14 on 4/18/24 indicated he was a safe smoker with a score of 1. The Smoking Assessment was a questionnaire, and the score was based on the answers to the questions for "Observation Details - Including Smokes in Unauthorized Areas, Careless with Smoking Materials (Drops cigarette/cigar butts or matches on floor, furniture, self, or others; burns finger tips; smokes near oxygen)" and for "Capability to Follow Facility Safe Smoking Policy". Scoring on the smoking assessment gave points for answers defined as: No Problem (0 points), Minimal Problem (1 point), Moderate Problem (2 points), and Severe Problem (3 points). Resident #31's smoking assessment scored revealed a minimal problem (1 point) for Careless with Smoking Materials. The Smoking Interpretation Risk is scored as follows:

- o Score 0 to 9 = Safe Smoker
- o Score 10 to 18 = Potentially Unsafe Smoker
- o Score 19 to 27 = Unsafe Smoker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 67	F 689		

Resident #31's April 2024 MAR indicated Resident #31 refused the nicotine patch on 4/14/24 and 4/19/24. The nicotine patch was discontinued on 4/28/24. There was no documentation that corresponded to this 4/28/24 discontinuation of the nicotine patch.

A discharge MDS dated 6/13/24 indicated Resident #31 was discharged to the hospital.

A hospital discharge summary dated 6/19/24 indicated Resident #31 was readmitted to the facility on 6/19/24. The expected medication list at discharge included the nicotine patch.

Resident #31's physician's order dated 6/20/24 included an order for nicotine patch 21 mg/24 hour to be applied daily at 11:00 am and to hold the patch if smoking.

Resident #31's June 2024 MAR indicated Resident #31 had the nicotine patch placed on 6/20/24 through 6/27/24.

b) A nursing progress note completed on 6/27/24 by Nurse #1 indicated Resident #31 was sitting outside of the 400-hall door. Resident #31 was wearing a nicotine patch and noted to be smoking in an area not designated for smoking. Resident #31's oxygen tubing was off and laying in his lap. Nurse #1 did not know if Resident #31's portable oxygen tank was on or off.

During an interview with Nurse #1 on 8/5/24 at 8:41 am, she stated on 6/27/24 it was brought to her attention, unable to recall by who, that Resident #31 was sitting outside of the facility in his motorized wheelchair at the 400-hall exit door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 68	F 689		

and was observed through the window on the door to be smoking. Nurse #1 stated she walked down the 400 hall to the exit door and observed Resident #31 smoking. Resident #31's oxygen tubing with nasal cannula was off and laying in his lap. His portable oxygen tank was sitting in his lap. She was unsure if it was on or off. Nurse #1 did not ask Resident #31 to extinguish the cigarette but immediately reported this to Nurse #6 who was the charge nurse on 6/27/24. She was not aware of where he got the smoking materials. Nurse #1 also stated Resident #31 had been smoking for years. Nurse #1 indicated Resident #31 was not a supervised smoker. She did not complete a new smoking assessment on 6/27/24. Nurse #1 was not sure if the physician was made aware of this incident.

In an interview with Nurse #6 on 8/5/24 at 9:09 am, she stated Nurse #1 reported to her on 6/27/24 that Resident #31 was outside smoking at the end of the 400-hall exit door in his motorized wheelchair. Nurse #6 went outside where Resident #31 was and educated him on the dangers of smoking with oxygen and wearing a nicotine patch. Resident #31 was observed by Nurse #6 to have his portable oxygen tank on his motorized wheelchair, but she was unsure if it was on or off. Resident #31 stated "man you caught me". Nurse #6 explained to Resident #31 he could not smoke and wear a nicotine patch. She stated she removed the nicotine patch. Nurse #6 explained Resident #31 was hiding and smoking because this area was not designated for smoking. No education was reported related to the fire hazards of smoking in the presence of a supplemental O2 device even when the device was turned off. Nurse #6 was not aware this was a fire hazard. Nurse #6 stated Resident #31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 69	F 689		

obtained the smoking materials from another resident's family member. Nurse #6 did not know the resident's or family member's name. Resident #31's family told her this information. Nurse #6 reported this to the Director of Nursing (DON) the same day. The physician was made aware and recommended to remove the nicotine patch. Nurse #6 removed the nicotine patch on Resident #31 and discontinued the nicotine patch on 6/27/24 due to Resident #31 was caught smoking with the nicotine patch. Nurse #6 did not complete a new smoking assessment on Resident #31 on this date.

During a phone interview with the NC DHSR Life Safety Surveyor on 8/12/24 at 3:46 pm, he stated smoking within 10 feet of a portable oxygen tank was a fire hazard. He further stated it did not matter if the portable oxygen tank was on or off, it still was a risk for fire and/or an explosion.

Resident #31's physician's order initiated on 6/20/24 included an order for nicotine patch 21 mg/24 hour to be applied daily at 11:00 am and to hold the patch if smoking was discontinued on 6/27/24 due to Resident #31 was caught smoking with the nicotine patch.

A nursing progress note completed by Nurse #6 dated 6/27/24 revealed Resident #31 was upset the nicotine patch was taken away. Nurse #6 explained to Resident #31 if he gave up his cigarettes, he could have the patch restarted. Resident #31 gave up his cigarettes. Resident #31's responsible party (RP) was notified by Nurse #6 not to provide Resident #31 with cigarettes. Nurse #6 made the physician aware, and the nicotine patch was restarted on 6/27/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 70	F 689		

During an interview with Nurse #6 on 8/5/24 at 9:09 am she stated Resident #31 was upset because his nicotine patch was discontinued after being caught smoking a cigarette on 6/27/24. Nurse #8 further stated she explained to Resident #31 he could not smoke and wear a nicotine patch at the same time. Nurse #6 told Resident #31 if he gave up his cigarettes, he could have the patch restarted. Resident #31 gave up his cigarettes. Nurse #6 notified Resident #31's RP and asked RP not to provide Resident #31 with cigarettes. Nurse #6 made the physician aware, and the nicotine patch was restarted on 6/27/24.

Resident #31's physician's order dated 6/27/24 included an order for nicotine patch 21 mg/24 hour to be applied daily at 11:00 am and to hold the patch if smoking.

Resident #31's June 2024 MAR indicated Resident #31 had the nicotine patch placed on 6/28/24 and 6/29/24

A discharge MDS dated 6/29/24 indicated Resident #31 was discharged to the hospital.

A hospital discharge summary dated 7/2/24 indicated Resident #31 was readmitted to the facility on 7/2/24.

Resident #31's previous order for the nicotine patch (initiated on 6/27/24) was discontinued on 7/1/24 and a new order was written on 7/2/24 for nicotine patch 21 mg/24 hour to be applied daily at 9:00 am.

Resident #31's July 2024 MAR indicated he had the nicotine patch placed on 7/3/24, 7/5/24, 7/6/24, and 7/7/24. Resident #31's July MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 71	F 689		

revealed documented refusals of the nicotine patch on 7/4/24, 7/8/24, and 7/9/24.

c) A nursing progress note completed by Nurse #2 on 7/9/24 documented Resident #31 was lying in his bed smoking a cigar with his oxygen tubing on via nasal cannula. Resident #31 was advised to put cigar out and Resident #31 refused to allow the nurse to extinguish his cigar. Resident #31 was advised either to extinguish the cigar or go outside with the lit cigar. Resident #31 was advised he could not smoke in the facility. Resident #31 stated "he did not care if we kicked him out", he was not going to allow Nurse #2 to have the cigar.

During an interview with Nurse #2 on 8/5/24 at 8:35 am, she stated Resident #31 was caught smoking a cigar in his bed on 7/9/24 with his oxygen tubing in place via nasal cannula. Resident #31's oxygen concentrator was on and was located beside his bed. Resident #31 refused to allow Nurse #2 to extinguish the cigar. Nurse #2 obtained the help of the Director of Nursing (DON) for Resident #31 to extinguish the cigar. Nurse #2 educated him (Resident #31) about the dangers of smoking with oxygen and how this was a fire hazard. She also educated him about the danger to the other residents in the facility. Nurse #2 did not know where Resident #31 got the cigar. Nurse #2 stated the facility was going to issue Resident #31 a 30-day discharge notice for continued violations of the smoking policy, evidenced by previous documented smoking incidents, but his family member did not return the phone calls. Resident #31 had been smoking since admission at the facility and did not require supervision to smoke. She was unable to explain why Resident #31 was an unsupervised smoker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 72	F 689		

when he had a previous incident of violating the smoking policy. Nurse #2 did not complete a new smoking assessment after the 7/9/24.

The medical record revealed no evidence a smoking assessment was completed after the incident on 7/9/24. There was no documentation of counseling for the resident using the Behavior Contract for Smoking Violations as indicated in the smoking policy.

There was no care plan update related to smoking made to Resident #31's care plan after the 7/9/24 smoking incident.

Resident #31's July 2024 MAR indicated he had the nicotine patch placed on 7/14/24 and refusals on 7/11/24, 7/12/24, 7/13/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, and 7/20/24. The 7/12/24 entry documented by Nurse #12 indicated Resident #31 continued to smoke.

An attempt was made to contact Nurse #12 via phone with a message left on 8/13/24 at 11:12 am with no return call received.

d) A nursing progress completed by Nurse #5 on 7/20/24 revealed a Nursing Assistant (NA) found a cigarette in Resident #31's toilet in his bathroom, ashes on the floor, and in the trash can. Resident #31 admitted "yes I did have a cigarette early this morning in my bathroom".

In an interview with NA #1 on 8/4/24 at 2:00 pm, she stated Resident #31 was non-compliant with the smoking policy. NA #1 indicated Resident #31 had a motorized wheelchair and was able to travel throughout the facility. NA #1 reported she did not know when Resident #31 was going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 73	F 689		

outside to smoke due to his mobility in his motorized wheelchair. NA #1 indicated Resident #31 was an unsupervised smoker. She was unable to explain why Resident #31 was an unsupervised smoker when he had previous incidents of violations with the smoking policy. NA #1 recalled the incident with Resident #31 smoking a cigar in his bed 7/9/24. She also recalled the incident where a cigarette was found in Resident #31's toilet in his bathroom (7/20/24). NA #1 explained she was aware of the dangers of smoking with his oxygen tank/concentrator present. No education to the resident was reported related to the fire hazards of smoking in the presence of a supplemental oxygen device even when the device was turned off. NA #1 stated she reported any violations by Resident #31 to the nurse working on the hall. NA #1 further stated she knew Resident #31 was counseled about his non-compliance several times by the staff and administration.

During an interview with Nurse #5 at 8/5/24 at 8:58 am, she stated she was informed by a NA #1 on 7/20/24 that a cigarette was found in Resident #31's bathroom toilet along with ashes on the floor and in the trash can. Nurse #5 indicated she went outside and talked to Resident #31 who was in the designated smoking area on 7/20/24. Resident #31 stated "Yes, I did have a cigarette early this morning in my bathroom." Nurse #5 indicated she educated him about the dangers of smoking with oxygen and the danger to the other residents. Nurse #5 notified the Administrator and DON of this incident on 7/20/24. The Administrator came to the facility and confiscated his smoking materials and put them in a lockbox. Nurse #5 did not know who had the lockbox key. Nurse #5 indicated Resident #31 continued to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 74	F 689		

violate the smoking policy with this incident and prior incidents. She was unable to explain why Resident #31 was an unsupervised smoker when he had previous incidents of violations with the smoking policy. Nurse #5 completed a smoking assessment on 7/20/24 after the incident and documented Resident #31 was a "potentially unsafe smoker". Nurse #5 explained Resident #31 was a potentially unsafe smoker because he continued to violate the smoking policy and ignored the education provided. Nurse #5 could not explain the difference between a potentially unsafe smoker, unsupervised smoker, or a supervised smoker. Nurse #5 stated she thought Resident #31 kept his smoking materials in his room.

Resident #31's Smoking Assessment completed by Nurse #5 on 7/20/24 indicated he was a potentially unsafe smoker with a score of 11. Resident #31's smoking assessment scored revealed a moderate problem (2 points) for Careless with Smoking Materials (smokes near oxygen), a moderate problem (2 points) for Begs or Steals Smoking Materials from Others, a moderate problem (2 points) for Ability to Understand the Facility Safe Smoking Policy, and a severe problem (3 points) for Capability to Following Facility Safe Smoking Policy.

The medical record revealed no evidence of counseling for the resident using the Behavior Contract for Smoking Violations as indicated in the smoking policy was provided after the 7/20/24 incident.

There was no care plan update related to smoking made to Resident #31's care plan after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 75	F 689		

the 7/20/24 smoking incident.

During an interview with the Administrator on 8/4/24 at 2:21 pm she indicated that Resident #31 was non-compliant with the smoking policy and safe smoking practices. She indicated she had talked to him multiple times regarding violating the facility's smoking policy. The Administrator stated she had confiscated his smoking materials after the incident on 7/20/24. She explained she ordered lockboxes to be placed in the lobby. She further explained the reason for the lockboxes was to keep the smoking materials out of the residents' room. All the smokers were listed as independent (unsupervised) smokers and kept the key to their lockbox. The Administrator did not have an explanation as to how the lockbox was supposed to help Resident #31 not violate the smoking policy when he had access to it and could retrieve the smoking materials without staff assistance.

During a follow up phone interview with the Administrator on 8/22/24 at 1:18 pm she stated it was around the second or third week of July when she ordered lockboxes for the residents who smoked to retain their smoking materials. The lockboxes were installed and implemented around 7/29/24. It was at that time that she met with each resident who smoked and had them sign new smoking contracts. The Administrator stated Resident #31 signed a new Behavior contract at that time.

The lockboxes were observed in the front lobby on 8/4/24. There were 6 lockboxes against the wall in the front lobby. On the front of each lockbox was the name of the resident who smoked. Resident #31 had a lockbox with his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 76	F 689		

name on it.

Resident #31's July 2024 MAR indicated he refused the nicotine patch on 7/21/24 and 7/22/24. The nicotine patch was discontinued on 7/23/24.

Resident #31's record revealed no documentation for why the nicotine patch was discontinued on 7/23/24.

Resident #31's care plan was revised by the Administrator on 7/29/24. A category of behavioral symptoms was created to reflect Resident #31 was a smoker. The goal created was Resident #31 would follow policies and procedures regarding smoking. The approach was Resident #31 would adhere to policies and procedures regarding smoking and would be accepting of staff redirection as indicated. Resident #31 would verbalize understanding of the risks associated with continued smoking.

After surveyor entry to the facility for the recertification survey on 8/4/24, a list of residents who smoked was provided. Resident #31 was on the list, and he was identified as an independent (unsupervised) smoker. There were 5 additional residents on the list, and all were identified as independent smokers.

e) On 8/4/24 at 2:15 pm an observation of residents in the designated smoking area revealed Resident #31 was sitting on the seat of his motorized wheelchair smoking a lit cigarette with a portable oxygen tank hanging on the back of his wheelchair. His oxygen tubing and nasal cannula was lying across his lap. There were 2 other residents in the designated smoking area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 77	F 689		

were within 5 feet of Resident #31. No staff were observed in the designated smoking area. The designated smoking area was located at the end of the concrete sidewalk outside the front of the facility near the corner of the facility. No fire blanket, no fire extinguisher, and no sign to warn against having oxygen in the designated smoking area was observed. The designated smoking area had a self-extinguishing cigarette butt receptacle (a cylindrical container made of flame-retardant polyethylene material approximately 11 inches in diameter and 30 inches in height)

On 8/4/24 at 2:21 pm this surveyor went to the Administrator's office and notified the Administrator, Director of Nursing (DON), and the Assistant Director of Nursing (ADON) of the observation of Resident #31 smoking in the designated smoking area with his portable oxygen tank in his motorized wheel chair. The ADON immediately went outside to the designated smoking area and brought the portable oxygen tank in the facility. Resident #31's portable oxygen tank was off.

In an interview with Nurse #4 on 8/5/24 at 8:35 am, she stated she has been employed at the facility for approximately 6 to 7 months. She indicated Resident #31 had smoked since his admission to the facility. Nurse #4 stated she had been re-educating Resident #31 about the dangers of smoking with oxygen for months. She explained Resident #31 was fully aware that he continued to violate the smoking policy. Nurse #4 stated she would remove his portable oxygen tank from him when he went to smoke and that he smoked without supervision. Nurse #4 was unaware Resident #31 was not allowed to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 78	F 689		

smoking materials in his possession per the smoking policy. After the incidents on 7/9/24 and 7/20/24 his smoking materials were kept on the nurses' medication cart. The Administrator purchased lock boxes around the end of July and placed them in the front lobby of the facility. Resident #31's smoking materials were in the lockbox. Resident #31 had the lockbox key on a chain around his neck. She was unable to explain how the lockbox would be effective for Resident #31 if he still had access to his smoking materials. Nurse #4 stated Resident #31 had been caught many times violating the smoking policy and was re-educated every time about the dangers of smoking with his portable oxygen tank and/or while on a nicotine patch. She was unable to explain why Resident #31 was an unsupervised smoker when he had previous incidents of violations with the smoking policy.

On 8/5/24 at 9:01 am, an observation was made of the lockbox key on a chain around Resident #31's neck.

During an interview with Resident #31 on 8/5/24 at 9:01 am, he stated he had been smoking since he was 15 years old. He further stated he had smoked since his admission at the facility. He indicated he kept his smoking materials when he was first admitted. He then explained his smoking materials were kept by the nursing staff because he was caught smoking a cigar in his bed on 7/9/24 and the staff had found a cigarette butt in his bathroom toilet on 7/20/24. He stated currently his smoking materials were in a lockbox located in the front lobby instead of his room. He had the key on a necklace around his neck. He indicated he went out to smoke whenever he wanted. He was told by the nursing staff not to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 79	F 689		

take his portable oxygen tank when he went out to smoke. Resident #31 stated the nursing staff had educated him on the dangers of smoking with oxygen.

During an interview with Nurse #2 on 8/5/24 at 3:24 pm, she revealed she was not aware that smoking with the oxygen tank present was a fire hazard even when the tank was off.

A Smoking Assessment completed by the Clinical Unit Manager on 8/5/24 indicated Resident #31's score increased to 15 due to increased points on the assessment questions for "General Awareness and Orientation - Including Ability to Understand the Facility Safe Smoking Policy" and for "Capability to Follow Facility Safe Smoking Policy". He required supervision to smoke.

During an interview with the Social Worker on 8/6/24 at 1:26 pm, she indicated she had discussions with Resident #31 about the facility's smoking policy and discussed the dangers of smoking with oxygen. There was no documentation of these discussions with Resident #31. The smoking materials for Resident #31 were kept on the nurses' medication cart after 7/9/24. She verified the resident was an unsupervised smoker through 8/4/24 and was unable to explain why Resident #31 was an unsupervised smoker after multiple incidents of violations with the smoking policy.

In an interview with the DON on 8/6/24 at 9:09 am, she stated she was made aware of each incident involving Resident #31's violation of the smoking policy on 1/31/24, 6/27/24, 7/9/24, 7/20/24 and 8/4/24. The DON explained she assisted the nurse on 7/9/24 to get the cigar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 80	F 689		

extinguished. She further stated she had educated Resident #31 about the dangers of smoking with oxygen and smoking with a nicotine patch after each of the incidents. The dangers of smoking with a nicotine patch can include nicotine poisoning and fast, irregular, or pounding heartbeat. The DON stated she placed a call to his family member/representative on 7/10/24 to discuss Resident #31's non-compliance with the facility smoking policy and was unable to leave a voice message. The DON explained the facility had 5 residents that smoked along with Resident #31. The smoking materials were kept by the residents who smoked. She was she aware of the smoking policy that stated no residents were supposed to retain their smoking material and was unable to explain why any residents had been allowed to retain their smoking materials. Resident #31's smoking materials were located on the nurses' medication cart due to the previous incidents (7/9/24 and 7/20/24) of violating the smoking policy and non-compliance. The DON explained the Administrator purchased lockboxes in July 2024 to keep the smoking materials out of the residents' rooms. The DON stated each smoker had the key to their lockbox. She was unable to explain how the lockbox would be effective for Resident #31 if he still had access to his smoking materials. She was aware the smoking assessment completed on 7/20/24 for Resident #31 indicated he was a potentially unsafe smoker. She was unable to explain why Resident #31 was an unsupervised smoker until 8/5/24 when he had previous incidents of violations with the smoking policy. She stated the smoking assessments should have been completed upon admission, quarterly, and after violations of the smoking policy. The floor nurses were responsible for completing the smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 81	F 689		

assessments.

During an interview with the Administrator on 8/6/24 at 10:30 am, she stated she began in the position of Administrator on 5/24/24. Upon her arrival at the facility the residents who smoked had their cigarettes and lighters on their person and in their rooms. She indicated after she assumed the position in May as Administrator, the facility was identified as non-smoking for newly admitted residents. The current smoking residents were grandfathered in. She was aware of the smoking policy and that no residents were supposed to retain their smoking materials. The Administrator indicated Resident #31 was assessed as a non-smoker upon admission. She was made aware of several incidents of Resident #31 smoking with his portable oxygen tank on his motorized wheelchair and smoking in his room. He had been educated by her and the staff about the dangers of smoking in the facility and smoking with his portable oxygen tank but was unsure if the education included that smoking in the presence of a supplemental oxygen device was a fire hazard even when the device was turned off. She verified Resident #31 was independent (unsupervised) smoker until 8/5/24.

f) A progress note completed by the Administrator as a late entry note on 8/15/24 indicated she was made aware that Resident #31 was found outside with a cigarette. Resident #31 had lost his smoking privileges due to non-compliance with the facility smoking policy. The Administrator spoke with Resident #31 about his continued behaviors of non-compliance. She also notified and discussed with the resident's representative (RP) the risks and safety concerns of Resident #31's non-compliant behavior.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 82	F 689		

In a phone interview with the Human Resource Director on 8/22/24 at 1:50 pm, she stated on 8/14/24 she observed Resident #31 light and smoke a cigarette in the designated smoking area. She reported this to the Administrator. The Human Resource Director further stated Resident #31 did not have his portable oxygen tank or oxygen tubing on his wheelchair.

During a follow-up phone interview with the Administrator on 8/22/24 at 1:18 pm, she was notified by the Human Resource Director that Resident #31 was outside smoking a cigarette. The Administrator went outside and informed Resident #31 he was not allowed to smoke. The Administrator stated she did not know where Resident #31 got the cigarette. Resident #31 stated he had found the cigarette on the ground. He extinguished the cigarette in front of the Administrator. She indicated Resident #31 did not have his portable oxygen tank or oxygen tubing on his wheelchair. The Administrator further indicated another resident was in the designated smoking area. The Administrator immediately placed Resident #31 on one-to-one (1:1) observation.

A phone interview was conducted with the Physician on 8/22/24 at 3:13 pm and he stated he was made aware of each of the smoking incidents (1/31/24, 6/27/24, 7/9/24, 7/20/24, and 8/14/24) for Resident #31. The Physician explained the goal of the nicotine patch was smoking cessation. He described the nicotine from the patch was absorbed through the skin and was considered less harmful than a cigarette. The Physician stated the side effect from smoking and wearing a nicotine patch could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 83	F 689		

make Resident #31 "jittery" as he was receiving nicotine from the patch and from smoking a cigarette. He further stated to his knowledge Resident #31 had not exhibited this side effect.

In a follow-up phone interview with the Administrator on 8/22/24 at 1:18 pm, she stated after she started as the Administrator (5/24/24) she began the process of transferring the smoking materials from the residents who smoked to the nurses' medication carts. She indicated she had nursing huddles (a meeting with the nursing staff who were working) to inform them of where the smoking materials were supposed to be kept for each resident who smoked and if any changes had occurred. The Administration stated she held the nursing huddles several times but did not document these meetings.

The Administrator was notified of immediate jeopardy on 8/5/24 at 1:05 pm.

The facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
The facility failed to provide the necessary supervision to ensure residents were safe while smoking and to implement effective interventions to address a resident (Resident #31) who was non-compliant with safe smoking practices and the smoking policy on multiple occasions.
The admission smoking assessment for Resident #31 completed on 1/27/24 indicated he intended not to smoke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 84	F 689		

On 1/31/24 staff found Resident #31 smoking in the designated smoking area.

On 6/27/24 staff found Resident #31 outside of the 400 hall exit door smoking with his portable tank on his wheelchair. Nurse went out to resident and educated him that he could not smoke while on a nicotine patch. Resident gave up his cigarettes and continued on the patch. MD made aware.

On 7/9/24 staff found Resident #31 lying in his bed smoking a cigar with oxygen on via nasal cannula. Resident #31 refused to allow the nurse to extinguish the cigar, and the nurse had to obtain assistance from the Director of Nursing (DON) to extinguish the cigar. Resident #31 was again educated on not smoking in the facility, not with his oxygen and not with the patch on. The DON and the Social Worker placed a call to the emergency contact on 7/10/24 to inform him of the safety concern of resident smoking in facility and while on oxygen and a nicotine patch.

On 7/20/24 staff found a cigarette in Resident #31's toilet in his bathroom, ashes on the floor, and in the trash can. Resident #31 admitted "yes, I did have a cigarette early this morning in my bathroom". On 7/21/24 the Administrator came into the building and confiscated Resident #31's smoking materials. The smoking materials were locked in the nurse's cart. Resident #31 would have to get cigarette from the nurse prior to smoking. Resident #31 was again educated by the Administrator on the risks associated with non-compliance with the smoking policy and guidelines to include the dangers of smoking while his oxygen tank was present.

On 8/4/24 Resident #31 was observed in the designated smoking area with a portable oxygen tank on his wheelchair. Two other residents were present in the courtyard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 85	F 689		

8/5/24 Smoking Assessment completed by Clinical Unit Manager. Score increased to 15 at this time due to increased points on the assessment questions for "General Awareness and Orientation - Including Ability to Understand the Facility Safe Smoking Policy" and for "Capability to Follow Facility Safe Smoking Policy". Scoring on the smoking assessment gives points for answers defined as: No Problem (0 points), Minimal Problem (1 point), Moderate Problem (2 points), and Severe Problem (3 points). The Smoking Assessment is scored as follows:

- o Score 0 to 9 = Safe Smoker
- o Score 10 to 18 = Potentially Unsafe Smoker
- o Score 19 to 27 = Unsafe Smoker

8/5/24: Resident #31's smoking materials was confiscated by the Administrator. Resident gave Administrator and Director of Nursing verbal permission to search his room for additional lighters or smoking items. The Social Worker completed a room sweep. Resident #31 did not have any additional smoking materials in his room.

8/5/24: Resident #31's care plan was updated by Regional Director of Clinical Services to show resident will no longer be able to smoke independently.

8/5/24: Resident #31 will require supervision for safety. Resident #31 was presented with updated smoking contract to include designated smoking times and supervision requirements for the remainder of the resident's stay in this community. The Administrator and Regional Director of Clinical Services presented the updated contract to the Resident. Resident #31, when offered the updated contract, chose to quit smoking and requested to obtain a nicotine patch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

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F 689	Continued From page 86	F 689		

8/5/24: The Medical Director was notified of this incident by Director of Nursing and Resident's request for a nicotine patch via phone and the physician gave telephone orders for resident to have a nicotine patch. The order was transcribed as appropriate.

8/5/24 The Administrator attempted to contact resident's emergency contact via phone multiple times during the day to inform of incident. Phone would not accept messages-mailbox full with each attempt. Resident #31 is their own responsible party

All residents had the potential to be affected if there was an adverse outcome as a result of this noncompliance. All smokers had a smoking assessment completed 8/5/24 by the Assistant Director of Nursing and Clinical Unit Manager. Medical records of all smokers were reviewed by the Director of Nursing and Regional Clinical Director for any incidence of non-compliance in the last 90 days. No other incidents of non-compliance were found.

8/5/24: The Quality Assurance and Performance Improvement (QAPI) team was pulled together to discuss the incident and initiate a plan of correction. QAPI members included: the Administrator, Director of Nursing, Regional Director of Clinical Services, Human Resources Director, Director of Social Services, and Medical Records. The Root Cause of the system analysis revealed a failure to recognize resident's change in condition and smoking abilities. Recent hospitalizations had shown a decrease in his alertness as evidenced by his Brief Interview for Mental Status (BIMS) on 7/3/24 with a score of 7 which indicates severe impairment. He had previously scored the maximum points of 15 on this assessment.

On 8/14/24: Resident #31 was found outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 87	F 689		

smoking without supervision.

The Director of Human Resources notified the Administrator who immediately approached the resident, and the cigarette was extinguished. The Administrator reminded Resident #31 that his privileges had been taken because of his non-compliance.

The staff working that shift were made aware of the non-compliance by Resident #31 and the Resident was put on one-to-one monitoring. Physician and resident's responsible party was made aware. One to ones will continue until the resident's discharge.

Due to continued non-compliance and the risk of safety for other residents a 30-day notice of discharge has been issued to Resident #31 and the facility is working with his son to identify appropriate placement likely at an assisted living because of his high functionability.

Specify the action the entity will take to alter the process or system failure to prevent a serious outcome from occurring or recurring, and when the action will be complete:

8/5/24: All smoking residents were assessed by Clinical Unit Managers using the Smoking Assessment Tool. The Smoking Assessment Tool is used by the facility to identify a resident's intent to smoke, the physical ability to smoke and hold smoking materials, and the resident's ability to understand smoking policies and safe smoking practices.

8/5/24-8/6/24: Regional Director of Clinical Services performed smoking observations of all current smokers to validate smoking assessment tools.

Five remaining current smokers are safe to smoke independently based upon their assessments. All smoking residents score between 13-15 out of 15 on their BIMS cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 689	Continued From page 88	F 689		

screens.

8/5/24: All residents who smoke were re-educated by the Administrator and Regional Director of Clinical Services on the facility smoking policy, including designated smoking area, risks of smoking in the presence of oxygen or other flammables, and repercussions of non-compliance.

8/5/24: Administrator, Director of Nursing and Human Resources initiated education with all staff on the facility smoking policy including the dangers of smoking with concentrated oxygen present (even when off), smoking assessments, unsafe smoking, designated smoking areas and lock boxes for smoking materials, protocols and where to find the master list of supervised smokers.

8/5/24: The Administrator and Director of Nursing completed education with all staff currently in the facility.

8/5/24: All staff received broadcast text communication through the time and attendance system from Human Resources with Smoking Policy Education. The Education included risks associated with non-compliance, guidance for smoking residents and reporting of non-compliance.

8/5/24: Staff began receiving one-to-one or small group education from the Director of Nursing, Assistant Director of Nursing and Clinical Unit Managers. Education regarding Smoking policies and procedures including identification of residents requiring supervision will continue until all staff have received the education. Beginning 8/8/24 if staff have not completed the education they cannot work their scheduled shift.

Human Resources in collaboration with the Administrator will ensure all staff have received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 689	Continued From page 89	F 689		

education.

Any staff who are not part of the initial education will be required to complete education prior to the start of their next shift at the facility. (those who work PRN, or on vacation, etc.)

Human Resources and Department Managers will be responsible for educating new hires during their facility and department orientation process.

As of 8/6/24 the designated smoking area is equipped with a mounted fire extinguisher and appropriate signs- Designated Smoking Area and No Oxygen Use in this Area. An emergency blanket to extinguish fire is available just inside the front doors closest to the designated smoking area. The emergency blanket will be replaced with a wall mounted version at the designated area as soon as it arrives from the vendor.

Alleged date of immediate jeopardy removal is 8/15/24.

A validation of immediate jeopardy was completed on 8/6/24 as evidenced by the following: New smoking assessments were completed on all smoking residents on 8/5/24 by the Assistant Director of Nursing and the Clinical Unit Manager. Resident #31 was identified as a potentially unsafe smoker with a score of 15 and all smoking materials were confiscated. He would require supervision to smoke. Resident #31's room was searched by the Social Worker on 8/5/24. Resident #31's care plan was updated to reflect he was no longer able to smoke independently. A new smoking contract was presented to Resident #31 with designated smoking times and supervision requirements. Resident #31 did not sign the updated smoking contract. Resident #31 chose to quit smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 689	Continued From page 90	F 689		

and requested the nicotine patch. The Medical Director was made aware of Resident #31's request for a nicotine patch. The order was completed on 8/5/24. The remaining 5 smokers were assessed by the Clinical Unit Managers to identify the resident's intent to smoke, the physical ability to smoke and hold smoking materials, and their ability to understand smoking policies and safe smoking practices. All residents who smoke were re-educated by the Administrator and Regional Director of Clinical Services on the facility smoking policy including the risks of smoking in the presence of oxygen and other flammables. The Administrator, Director of Nursing and Human Resources initiated education on 8/5/24 with all the staff on the facility smoking policy including the dangers of smoking with concentrated oxygen present and that even when the concentrator was turned off it was dangerous, smoking assessments, unsafe smoking, designated smoking areas, and lock boxes for storing the smoking materials, and where to find the master list of supervised smokers. All the staff received communication through the attendance system from Human Resources with Smoking Policy education. Human Resources will educate new hires during their facility and department orientation process. The designated smoking area was observed and equipped with a mounted fire extinguisher and appropriate signs - Designated Smoking Area and No Oxygen Use in this Area .

Interviews were conducted on 8/29/24 with the staff that worked the shift when the non-compliance by Resident #31 happened. All staff were notified and received an in-service immediately. Resident #31 was placed on one to one from 8/14/24 until 8/27/24 when resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 91 discharged to an assisted living facility. The Medical Director and resident's responsible party were made aware. Due to continued non-compliance and the risk of safety for other residents a 30-day notice of discharge was issued to Resident #31 on 8/15/24 and the facility worked with his son to identify appropriate placement at an assisted living facility. Resident #31 was discharged on 8/27/24. On 8/29/24 an observation verified the designated smoking area was equipped with a mounted fire extinguisher and appropriate signs- Designated Smoking Area and No Oxygen Use in this Area. A wall mounted emergency blanket to extinguish fire was available in the designated smoking area. Immediate jeopardy removal date of 8/15/24 was validated.	F 689		
F 690 SS=J	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 690	Continued From page 92 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff and the physician, the facility failed to ensure Resident #6 received necessary care and services for a urinary tract infection (UTI) when she experienced signs and symptoms of a change in condition. The facility failed to follow up on results of urinalysis, failed to effectively respond to a positive urinalysis (UA) report, failed to follow up on results of urine culture and sensitivity, effectively respond to urine culture and sensitivity results (C&S), and administer an antibiotic that was sensitive to the microorganism listed on the C&S report. These deficient practices affected 1 of 4 residents reviewed for UTI (Resident #6). Resident #6 was sent to the emergency department on 6/22/24 due to being found with seizure-like symptoms, requiring hospital admission for acute metabolic encephalopathy (an alteration in consciousness caused by large-scale brain dysfunction from impaired cerebral metabolism) due to a UTI with	F 690	Regarding F0690: 1. Resident #6 remains in the facility. This urinary tract infection resolved and she has had no further urinalysis culture and sensitivity test or urinary tract infection since survey exit. The regional director of clinical services reviewed the medical chart to ensure no other labs or diagnostics had been missed Completed 8/8/2024. 2. The director of nursing/designee reviewed all resident's urinalysis culture and sensitivity test results obtained since June 10, 2024 to ensure results were communicated to the provider and appropriate antibiotic was ordered. Completed 8/14/2024. 3. On 8/13/2024 the implementation of integrated laboratory services was completed which enhances staff and physician's ability to access lab results 24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 93 extended-spectrum beta-lactamase (ESBL, an enzyme produced by some bacteria that makes them resistant to many antibiotics). The resident's antibiotics were changed due to the results of the C&S, noting the antibiotic started in the facility was ineffective, and the resident began to improve. The immediate jeopardy began on 6/10/24 when the facility did not effectively respond to the results of the C&S. The immediate jeopardy was removed on 8/15/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "D" (no actual harm with potential for more than minimal harm) to ensure monitoring systems are put into place are effective. The findings included: Resident #6 was admitted to the facility on 5/7/24 with diagnoses including renal (kidney) insufficiency and congestive heart failure (CHF). Resident #6's Minimum Data Set (MDS) assessment dated 5/13/24 revealed she had moderate cognitive impairment, had not displayed any combative or aggressive behaviors, was always incontinent of bowel and bladder, was dependent on staff for assistance with activities of daily living (ADL). The assessment indicated the resident did not have a UTI and was not taking antibiotics in the past 7 days. Resident #6's comprehensive care plan dated 5/30/24 revealed the resident was incontinent, needed assistance with toileting and had CHF. Interventions included to monitor and report to	F 690	hours a day for timely communications ad treatment plans. On 8/13/2024, the director of nursing/designee initiated education for all nurses on the process for obtaining lab results and communicating to the physician. Additional education was completed 9/12/2024. Any staff who did not receive the education will complete the education prior to their next working shift. All new employees and agency staff responsible for this compliance who are hired after 9/12/2024 will receive this education as a part of orientation. 4. Ongoing compliance monitoring: Beginning the week of 9/9/2024, the director of nursing/designee will audit all urinalysis culture and sensitivity lab results weekly for twelve weeks to ensure timely physician notification was completed. Results will be reported in quality assurance performance improvement committee for three months by the director of nursing/designee. 5. The director of nursing is responsible for compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 690	Continued From page 94	F 690		

physician changes in mental condition like lethargy, confusion, disorientation, and anxiety.

Review of Resident #6 nursing progress notes dated 06/06/2024 written by the Assistant Director of Nursing (ADON) revealed it was reported from the floor nurses and nursing aides (NA) resident had become increasingly more agitated and combative with staff. The ADON assessed the resident and noted that resident was not acting as she normally did. The ADON contacted the physician, who ordered laboratory tests including a UA and C&S.

Review of preliminary laboratory results dated 6/8/24 revealed Resident #6's urine sample was collected on 6/7/24 and the results were positive for 1+ bacteria (normal range was none). The preliminary report indicated identification of the bacteria and sensitivity results would be on a following report. The physician reviewed and signed the results on 6/12/24.

Review of Resident #6's C&S results dated 6/10/24 revealed the bacteria identified was Escherichia coli (E. coli) which was positive for ESBL. Continued review of Resident #6's C&S results dated 6/10/24 revealed the bacteria was resistant to the effects of the antibiotic levofloxacin. The physician reviewed and signed the results on 6/19/24.

In an interview on 8/12/24 at 3:53 pm, Nurse #13 said laboratory results would be in the communication portal in the computer or come via fax. The laboratory would call the facility directly only if there are critical results to follow up on immediately. He said the nurse managers check the laboratory results, so he didn't usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 95	F 690		

check the portal.

In an interview on 8/12/24 at 6:03 pm, the customer representative for the facility contracted laboratory stated the final results of Resident #6's UA were uploaded to the communication portal on 6/7/24 and the finalized C&S results were uploaded to the portal on 6/10/24 at 10:38 am and would have been available to the facility at those times. The facility used the communication portal to obtain results directly instead of waiting for a faxed copy.

Review of Resident #6's nursing progress notes dated 06/11/2024 written by Nurse #12 revealed the resident's UA results were received. The physician was notified and said to wait for the C&S report. There was no indication the C&S results were reviewed with the physician at this time.

In an interview on 8/13/24 at 10:04 am, Nurse #12 said she did not remember any additional information about Resident #6's UTI or reporting the results to the physician.

Review of Resident #6's nursing progress notes dated 6/17/2024 by the ADON revealed the C&S results were reviewed with the physician, who ordered the antibiotic levofloxacin 500 milligrams (mg) every day for 7 days.

Review of Resident #6's physician order dated 6/17/24 revealed the physician ordered levofloxacin 500 mg every day for 7 days for a UTI to start on 6/18/24. The order was entered into the record by the ADON.

Review of Resident #6's Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 690	Continued From page 96	F 690		

Administration Record for June 2024 indicated she received the medication daily from 6/18/24 through 6/21/24.

In an interview on 8/12/24 at 2:45 pm, the ADON said she went out of town the week of 6/11-6/17/24. When she came back to work, she saw the C&S had not been reported to the physician, so she called him with the results. She was not sure why the results had not been reported to the physician earlier. She said she was the unit manager on that hallway and would normally check the results of the laboratory tests, but it appeared to her that no one had done so while she was out.

In an interview on 8/12/24 at 4:20 pm, the ADON said she didn't know how she didn't see that the bacteria was resistant to the antibiotic ordered for Resident #6. She said she reviewed the results with the physician by phone and the physician reviewed and signed the order on his subsequent facility visit. She did not know why neither of them caught the error. She said that giving an antibiotic that the bacteria was resistant to delayed the effective treatment of the UTI.

In an interview on 8/13/24 at 10:01 am, Nurse #4 said she was passing breakfast trays on 6/22/24 on Resident #6's hallway but didn't normally work on that hall. She brought Resident #6 her breakfast tray and set it up. Resident #6 began eating and then her roommate requested assistance with being moved in bed. While Nurse #4 was assisting Resident #6's roommate, she heard Resident #6 make an unusual noise. Nurse #4 said she turned and saw the resident was having a seizure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 690	Continued From page 97	F 690		

Review of the EMS Patient Care Record dated 6/22/24 revealed EMS was called to the facility for Resident #6. When they arrived, they found Resident #6 sitting upright in bed with an oxygen mask on. The oxygen was set at 15 liters per minute (lpm). Staff reported to EMS that Resident #6 was eating breakfast and started to seize. Her body went rigid. EMS noted she was awake but not oriented to person, place, or time. She was breathing on her own and started to try to verbalize and move extremities. She had a weak pulse in both wrists. EMS transferred her to the hospital.

Review of Resident #6's hospital ER evaluation dated 6/22/24 revealed her symptoms were consistent with acute UTI complicated by acute metabolic encephalopathy. The ER provider indicated resident's symptoms did not indicate sepsis at that time. Resident was given intravenous (IV) fluids due to a low blood pressure of 80/40 and the resident responded well. The ER provider initiated IV ceftriaxone (an antibiotic). The provider did not believe the resident suffered a seizure but instead experienced rigors (sweats and uncontrollable shivering attacks due to a severe infection). The provider noted the resident's family stated she had no history of seizures but would have episodes of involuntary shaking at times. The provider noted the resident's laboratory results related to her diagnosis of chronic kidney disease (CKD) were "very elevated." The provider noted that the appearance of her urine indicated Keflex (another name for the antibiotic levofloxacin) was not treating UTI adequately and the UTI had progressed causing encephalitis. Resident #6's vital signs did not indicate she had a fever when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 98	F 690		

she arrived at the ER. The hospital C&S results confirmed resistance to levofloxacin, as well as the ceftriaxone started in the ER.

Review of Resident #6's hospital discharge summary dated 6/26/24 revealed her antibiotics were changed due to the C&S results in the hospital to meropenem through an IV. The resident was noted to be alert, eating, drinking, voiding, improved, and stable at discharge. Resident #6 discharged with orders for meropenem 1 gram in 100 milliliters of normal saline IV every 12 hours until 6/29/24.

In an interview on 8/12/24 at 3:22 PM, the Director of Nurses (DON) said Resident #6's UA and C&S results should have been reported to the physician sooner. The DON reviewed Resident #6's C&S results and confirmed the bacteria was resistant to the ordered antibiotic. The DON said the expected procedures were for the charge nurses to check the laboratory portal and report the results to the physician that shift. The DON said she knew of several instances when the procedures weren't followed because they were used to the nurse managers reviewing them. The nurse managers would then review the laboratory results the next day. She said when obtaining an order for an antibiotic, the nurse was responsible to compare the C&S results and the antibiotic ordered and to get clarification from the physician if microorganism was resistant to the ordered antibiotic. If the resident received the wrong antibiotic, the UTI would not be treated and resolved, causing further complications.

In an interview on 8/20/24 at 1:00 pm, Resident #6's physician said he expected to be notified of UA and C&S results the same day they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 99	F 690		

reported from the laboratory. He expected the nurse to review the C&S and what antibiotics the C&S indicated would be effective with him so he could make an informed decision since he would only review the results on his next visit to the facility. If he ordered an antibiotic that was noted in the C&S to be resistant and ineffective, he expected the nurse to let him know and review options of what antibiotic would be effective so the UTI could be effectively treated. If a UTI was not treated, the resident could develop sepsis, which may cause further inflammation, metabolic encephalopathy, seizures, and other complications.

The Administrator was notified of an immediate jeopardy on 8/13/24 at 2:09 pm.

The facility provided the following credible allegation of immediate jeopardy removal plan.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

6/6/24: A UA C & S was ordered by nursing for Resident #6 with the UA results received on 6/7/24 positive for a Urinary Tract Infection (UTI).

6/10/24: C & S results were received for Resident #6.

6/11/24: Positive results for the Urinalysis (UA) were reported to the physician. Nursing staff did not identify that the Culture & Sensitivity test (C & S) results had also been received with the UA. Nursing staff did not communicate the C & S results to the physician. The physician indicated waiting for the C & S results before initiating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 100	F 690		

treatment orders.

6/17/24: The Assistant Director of Nursing (ADON) identified that the physician had not been made aware of the C & S results and communicated with the physician the lab results. The physician ordered an antibiotic that the organism was resistant to.

6/22/24: Nursing staff noted Resident #6 with seizure-like activity and she was sent to the hospital for further evaluation. The hospital record indicates that Resident #6 was bradycardic and tachypneic upon arrival. The hospital record indicates that the antibiotic was not treating the UTI causing encephalopathy. Resident #6 was transitioned to a new type of antibiotic via intravenous (IV).

6/26/24: Resident #6 returned to the facility. Readmission diagnoses included acute metabolic encephalopathy and UTI secondary to Escherichia coli (ESBL E. coli).

8/13/24: The Director of Nursing (DON) and ADON began reviewing all resident's UA C&S results obtained since June 10, 2024 to ensure results were communicated to the provider and an appropriate antibiotic was ordered. Completed by 8/14/24. Any identified problems will be addressed immediately by the DON/ADON to include communication with the physician.

All residents had the potential to be affected as a result of noncompliance with provision of necessary care and services to treat infection.

Specify the action the entity will take to alter the process or system failure to prevent a serious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 101	F 690		

adverse outcome from occurring or recurring, and when the action will be complete.

8/13/24: The Quality Assurance and Performance Improvement team met to discuss the failure and initiate a plan of correction.

8/13/24: Implementation of integrated laboratory services was completed. With the integration services, all licensed nursing staff will have the ability to transcribe laboratory test orders and have the ability to view test results from the electronic medical record.

8/13/24: The Assistant Director of Nursing/ Human Resources Director initiated education for all licensed nurses on the process for obtaining and following up on test results. Charge Nurses will be responsible for communication of all test results to the physician. Nursing staff will be notified of lab results on the electronic medical record dashboard alert screen which is the first screen nurses see upon logging into the medical record. Education included how to transcribe laboratory orders correctly to utilize the integration system effectively, the process for obtaining results, as well as reporting procedures including provider notification and required documentation of physician and responsible party notification of test results. The Human Resources Director provided education to all licensed nursing via the facility broadcast text communication through the time and attendance system. The Assistant Director of Nursing initiated education for all licensed nurses in house, including completion of Lab and Diagnostic Results Reporting Competency. All licensed nurses will complete education on the test results reporting procedures prior to the start of their next shift. Nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 102	F 690		

was reeducated as a part of the new integrated system that it is their responsibility to address lab results as results come in during their work shift and to ensure the appropriate treatment is started for the identified diagnosis. The ADON is leading the education and will be tracking for competency and completion on 8/14/24.

8/13/24: The DON provided education to the ADON and Unit Managers on the process for reviewing UA C&S test results and verifying an appropriate antibiotic including organism susceptibility to the medication being ordered during the morning clinical meeting. The medication is reviewed for appropriateness by the Charge Nurse when received, 7 days a week. The DON, ADON and Unit Managers will audit antibiotic orders Monday through Friday during the morning clinical meeting. Completed 8/13/24.

All new hires will be educated on the process for lab results and physician communication during the department orientation led by the ADON.

Alleged date of immediate jeopardy removal is 8/15/24.

The validation process for the IJ removal plan was completed on 8/15/2024. Licensed nursing staff who worked different shifts were interviewed and verified receiving training on entering laboratory test and reviewing laboratory results in the facility's electric health record system and documenting in the progress notes notification of the physician of laboratory test results. The licensed nursing staff also demonstrated using the facility's electronic health record system to enter and review laboratory test ordered. The facility provided a list of all licensed nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 103 and in-service training sheets that included verbalization and demonstration on entering, reviewing and documenting notification of the physician of laboratory tests were reviewed for all licensed staff randomly interviewed. There were no new hired licensed nursing staff and licensed nursing staff (medical leave, vacation) will not be able to work until receiving the education training on entering, reviewing and documenting notification of the physician of laboratory test in the facility's electronic health record system. The immediate jeopardy removal date of 08/15/24 was validated.	F 690		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 104 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Physician, and Pharmacy Consultant interviews, the Pharmacy Consultant failed to identify on a drug regimen review a resident was prescribed and received an antibiotic that was not effective to treat a urinary tract infection (UTI) for 1 of 6 residents reviewed for pharmacy reviews (Resident #6) received an antibiotic). Findings included: Resident #6 was admitted to the facility on 5/7/24 with diagnoses including renal (kidney) insufficiency and congestive heart failure (CHF). Review of Resident #6's urinalysis culture and sensitivity (C&S) results dated 6/10/24 revealed she had a UTI and the bacteria identified was Escherichia coli (E. coli) which was positive for ESBL. Continued review of Resident #6's C&S results dated 6/10/24 revealed the bacteria was	F 756	Regarding F 0756: 1. Resident #6 remains in the facility and has recovered from the urinary tract infection and has completed her course of antibiotic. 2. All current residents on antibiotics for urinary tract infection has the potential to be affected. The pharmacist and director of nursing reviewed these residents on 9/12/2024 to ensure appropriate antibiotic. 3. On 8/13/2024 lab integration was activated in the electronic medical record and access has been given to the pharmacist to promote lab result reviews. The director of nursing has educated the pharmacist on how to access lab results in the medical record and on communicating with the provider of any noted concerns during the medication regimen review. The pharmacists will contact the director of nursing if he is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 105 resistant to the effects of the antibiotic levofloxacin. Review of Resident #6's nursing progress notes dated 6/17/2024 by the ADON revealed the C&S results were reviewed with the physician, who ordered the antibiotic levofloxacin 500 milligrams (mg) every day for 7 days. Review of Resident #6's physician order dated 6/17/24 revealed the physician ordered levofloxacin 500 mg every day for 7 days for a UTI to start on 6/18/24. The order was entered into the record by the ADON. Review of Resident #6's Medication Administration Record for June 2024 indicated she received the medication daily from 6/18/24-6/21/24. Review of Resident #6's pharmacy review notes dated 6/19/24 revealed the Pharmacy Consultant did not identify any irregularities in the resident's medication regimen. In an interview on 8/22/24 at 4:54 PM, the facility''s Pharmacy Consultant said he normally reviewed and compared an ordered antibiotic and the C&S to ensure the bacteria was not resistant to the medication. He said he was not able to compare the results of Resident #6's C&S with the levofloxacin due to not having access to the C&S report in the chart. He said he did the medication review on 6/19/24 and the C&S results were not uploaded to the electronic medical record until 6/20/24. He said at that time, he did not have access to the laboratory portal directly and had to rely on the information that was in the medical record when he did his review.	F 756	unable to access results during his reviews. Completed 9/12/2024. 4. Ongoing compliance monitoring: The director of nursing/designee will audit all urinalysis culture and sensitivity results to ensure appropriate antibiotic in collaboration with the pharmacist is ordered based upon the urinalysis culture and sensitivity test each week for the next twelve weeks. Results will be reported in quality assurance performance improvement committee for three months by the director of nursing/designee. 5. The director of nursing is responsible for compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 106 In an interview on 8/12/24 at 3:22 PM, the Director of Nurses (DON) said the C&S results and the antibiotic ordered should have been compared to ensure the bacteria was not resistant to the ordered antibiotic. If the resident received the wrong antibiotic, the UTI would not be treated and resolved, causing further complications. In an interview on 8/20/24 at 1:00 pm, Resident #6's physician said he expected the C&S and what antibiotics the C&S indicated would be effective to be reviewed. If he ordered an antibiotic that was noted in the C&S to be resistant and ineffective, he expected the facility to let him know and review options of what antibiotic would be effective so the UTI could be effectively treated. If a UTI was not treated, the resident could develop sepsis, which may cause further inflammation, metabolic encephalopathy, seizures, and other complications.	F 756		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident, staff, Pharmacy Consultant and Medical Director interviews, the facility failed to have a medication error rate less than five percent as evidenced by 4 medication errors out of 33 opportunities, resulting in a medication error rate	F 759	Regarding F0759: 1. Resident #71 no longer resides in the facility. Resident #18 remains in the facility and has had no negative outcome because of this deficient practice. Physician and responsible party were	9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 107 of 12.12% for 2 of 4 residents observed during the medication administration observations (Resident #18 and Resident #71). Findings included: 1. Resident #18 was admitted to the facility on 7/7/2023 with diagnoses including chronic obstructive pulmonary disease, acute bronchitis, congestive heart failure and hypertension. Physician orders for Resident #18 included the following medications: - On 3/5/2024, Klor-Con 10 (Potassium Chloride) Extended Release 10 milliequivalent (meq) two tablets once a day. - On 3/7/2024, Fluticasone propionate spray 50 micrograms (mcg) suspension 1 spray alternating nostrils once a day for allergies. - On 7/3/2024, Polyethylene glycol 3350 powder 17 grams per dose mixed in 4-8 ounces of fluid. The quarterly Minimal Data Set (MDS) assessment dated 7/14/2024 indicated Resident #18 was cognitively intact. On 8/6/2024 in a continuous observation at 8:36 am, Nurse #3 was observed preparing Resident #18's medications scheduled for 8:00 am and 9:00 am. At 8:47 am, Nurse #3 was observed entering Resident #18's room and administering the medications (Pregabalin, Aspirin, Lactobacillus Rhamnosus gg [a Culturelle probiotic], Docusate Sodium, Duloxetine, Hydrochlorothiazide [a diuretic medication that reduces excess fluid in the body], Loratadine and Magnesium Oxide) prepared for Resident #18. Nurse #3 was not observed offering or	F 759	notified and no harm occurred as a result of the deficient practice. 2. All residents are at risk for this deficient practice. All current residents had a medication pass observation completed by a clinical manager to ensure medications were offered as ordered and documented accurately in the medical record. Education was provided with the nurse that missed the medication to include a medication pass observation. Completed 9/12/2024. 3. Education was provided to all licensed nursing staff regarding accurate medication and documentation by the director of nursing/designee. Random medication pass observations will be completed by the director of nursing/designee to ensure medications are offered as ordered and documented accurately. Any new employees or agency staff hired after 9/12/2024, who are responsible for this compliance will receive this same education. Completed 9/12/2024. 4. Ongoing compliance monitoring: Beginning 9/9/2024, one medication pass observation will occur weekly for twelve weeks by the director of nursing/designee. Results will be reported to quality assurance performance improvement committee for three months by the director of nursing/designee. 5. The director of nursing is responsible for compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 108	F 759		

administering Resident #18 the following medications: Klor-Con 10 Extended Release, Fluticasone Propionate nasal spray and Polyethylene glycol 3350 powder 17 grams per dose mixed in 4-8 ounces of fluid.

A review of the August 2024 Medication Administration Record (MAR) recorded Klor-Con Extended Release two tablets scheduled for administration at 9:00am were administered to Resident #18 on 8/6/2024, and Resident #18 refused the medications, Fluticasone Propionate nasal spray and Polyethylene Glycol 3350 powder 17 grams scheduled for 9:00am on 8/6/2024. The August 2024 MAR further indicated nursing staff had initialed Resident #18 was administered the medications as ordered from 8/1/2024 and 8/5/2024.

In an interview with Resident #18 on 8/6/2024 at 9:57 am, Resident #18 stated Nurse #3 had not offered her the following medication: Klor-Con Extended-Release tablets, Fluticasone Propionate nasal spray and Polyethylene Glycol 3350 powder 17 grams on 8/6/2024 prior to the observation for the 9:00am medication pass. Resident #18 explained she did not think she had received Klor-Con Extended-Release tablets since December 2023 and was taking Fluticasone Propionate nasal sprays and Polyethylene Glycol 3350 powder 17 grams when offered by the nurses.

In an interview with Nurse #3 on 8/6/2024 at 10:06 am, she stated Fluticasone Propionate nasal spray, Polyethylene Glycol 3350 powder 17 grams and Klor-Con Extended Release tablets were not offered to Resident #18 for the 9:00am medication pass observed on 8/6/2024. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 109	F 759		

explained she had not offered Resident #18 the medications because Resident #18 would refuse the medications. She further explained Klor-Con Extended-Release tablets was still ordered due to Resident #18 continuing to receive a diuretic, Hydrochlorothiazide.

In a phone interview with Nurse #6 on 8/14/2024 at 12:01 pm, she stated when assigned to Resident #18, she was able to administer Resident #18 all her medications as ordered and stated Resident #18 did not usually refuse her medications.

In a phone interview with Pharmacy Consultant #1 on 8/14/2024 at 1:28 pm, he stated since Resident #18's last potassium level was in the normal range, Resident #18 missing a dose of Klor-Con Extended Release would not be considered a significant medication error and Hydrochlorothiazide did not deplete potassium from the body like other diuretics.

In an interview with the Medical Director on 8/15/2024 at 11:35 am, he stated Resident #18 not receiving Klor-Con Extended Released as ordered on 8/6/2024 was a medication error but not a significant medication error. He explained Resident #18 was on Hydrochlorothiazide as a blood pressure and diuretic medication and he was not concerned with depletion of Resident #18's potassium levels.

In an interview with the Director of Nursing (DON) on 8/15/2024 at 2:55 pm, she stated since there was an order for the medications on the MAR, Resident #18 should have been offered and administered the medications as ordered. She further said if Resident #18 was refusing her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 110	F 759		

medications, the physician should be notified to determine if the medication needed to be continued. The DON explained documentation of administration of medications on the MAR should be accurate.

In an interview with the Administrator on 8/15/2024 at 4:25 pm, she stated Resident #18 should have been offered and received her medications as ordered and documentation should had reflected what occurred with the medication administration.

2. Resident #71 was admitted to the facility on 6/20/2024 with diagnoses including diverticulitis (inflammation of irregular pouches in the wall of the large intestines).

Physician orders for Resident #71 dated 6/21/2024 included Polyethylene glycol 3350 powder (a laxative that increases the amount of water in the intestinal tract to stimulate bowel movements) 17 grams per dose one a day mixed in 4-8 ounces of fluid.

The admission Minimal Data Set (MDS) assessment dated 6/24/2024 indicated Resident #71 was severely cognitively impaired.

On 8/6/2024 at 8:50 am in a continuous observation, Nurse #3 was observed preparing Resident #71's medications: Buspirone, Famotidine, Spironolactone and Torsemide. At 8:57 am, Nurse #3 was observed entering Resident #71's room and administering Resident # 71 the following scheduled 9:00 am medications: Buspirone, Famotidine, Spironolactone and Torsemide. During the medication administration, Nurse #3 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

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F 759	Continued From page 111 observed offering or administering Resident #71 the medication, Polyethylene glycol 3350 powder 17 grams mixed in 4-8 ounces of fluid. A review of the August 2024 Medication Administration Record (MAR) for Resident #71 recorded the medication, Polyethylene glycol 3350 powder 17 grams, was administered by Nurse #3 at 9:00 am on 8/6/2024 as scheduled. In an interview with Nurse #3 on 8/6/2024 at 10:10 am, she stated the medication, Polyethylene glycol 3350 powder was not offered to Resident #71 on 8/6/2024 at 8:57 am because she thought the medication had been discontinued. In an interview with Resident #71 on 8/6/2024 at 10:13 am, Resident #71 admitted to having a problem with constipation and drank a clear liquid to help prevent constipation. When Resident #71 was asked if he was offered a clear liquid to drink on 8/6/2024 to help with constipation, Resident #71 answered, "No". In an interview with the Director of Nursing on 8/15/2024 at 2:55 pm, she stated the Polyethylene glycol 3350 powder medication should have been offered and administered to Resident #71 as ordered by the physician. In an interview with the Administrator on 8/15/2024 at 4:25 pm, she stated Resident #71 medication, Polyethylene glycol 3350 powder, should have been offered and administered as ordered unless Resident #71 refused the medication.	F 759		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 803	Continued From page 112 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on a dinner meal tray line observation, staff interviews and record review, the facility failed to follow the approved menu for pureed diets for 7 of 7 residents on a pureed diet. The findings included: Review of the facility's menu dated 8/6/24 revealed the meal was a chicken sandwich,	F 803	Regarding F0803: 1. The facility failed to follow the recipes and mix appropriate liquid with bread for a pureed meal, and to use the appropriate size scoop to assure adequate serving sizes. At the time of this survey there was no obvious negative outcomes related to this deficient practice. 2. All residents on pureed diets are at risk	

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	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 803	Continued From page 113 potatoes, vegetables, and baked beans. According to the menu residents on a pureed diet should have received one #10 scoop (3/8 cup or 3-4 ounces, an ivory colored handle) of pureed chicken and two #20 scoops (1.5 ounces, a yellow colored handle) of pureed bread. Observation of the dinner meal on 8/6/24 5:25 PM revealed Cook #1 used the one blue scoop of pureed chicken. There was no pureed bread on the serving line. In an interview on 8/6/24 at 5:33 PM, Cook #1 confirmed he used one blue scoop for the pureed chicken. He said he was not sure what size the blue scoop was and was unable to find the label with the number on the scoop. He said he did not add any bread to the pureed chicken or serve bread with the meal because the chicken patties were already breaded. He did not think there needed to be additional bread served. He provided the extended menu and confirmed the scoop sizes were specified, one #10 scoop of pureed chicken and two #20 scoops of pureed bread. In an interview on 8/6/24 at 5:40 PM, the Interim Dietary Manager, said the blue scoops used by Cook #1 were size #16 scoops (2 ounces or ¼ of a cup). She reviewed the menu and confirmed that menu called for one #10 scoop of chicken and two #20 scoops of bread for the bun. She confirmed the correct portions were not served to residents on a pureed diet. She said there were 7 residents in the facility on a pureed diet.	F 803	for this deficient practice. The cook who performed the deficient practice was educated by the assistant dietary manager on following food preparation and menu instructions as well as on appropriate scoop sizes on 8/7/2024.The administrator completed a meal observation on 8/7/2024 to ensure menus and recipes were followed and portions were correct. There were no other concerns identified. 3. The assistant dietary manager provided education to all dietary staff on the proper way to follow recipes including pureed prep and scoop sizes. Completed 8/7/2024.All new employees will be trained during department orientation going forward. 4. Ongoing compliance monitoring: Beginning 9/9/2024, the assistant dietary manager will observe preparation of three pureed meals, including appropriate portion size weekly for twelve weeks. Results will be reported in quality assurance performance improvement committee for three months by the assistant dietary manager/designee. 5. The administrator is responsible for compliance. Date of Compliance: 9/16/24	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 842	Continued From page 114	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 842	Continued From page 115 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews and staff interviews, the facility failed to maintain a complete and accurate medical record by failing to document the assessment and orders related to a resident's change in condition (Resident #6) and failed to maintain an accurate medical record for documentation of the administration of medications (Resident #6, Resident #18, Resident #71) for 3 of 33 residents whose medical records were reviewed.	F 842	Regarding F0842: 1. All residents remain in the facility and have not had any negative outcomes as a result of the deficient practice. 2. All residents are at risk for deficient practice. A medication pass observation was completed on all current residents by 9/9/2024 to ensure all residents were offered medications as ordered and accurate documentation was entered into the electronic medical record to document	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 842	Continued From page 116 Findings included: 1. Resident #6 was admitted to the facility on 5/7/24 with diagnoses including renal (kidney) insufficiency a. Review of Resident #6's nursing Situation, Background, Appearance, and Review (SBAR) Communication Form to the provider dated 6/22/24 completed by Nurse #12 noted Resident #6 was unresponsive after a seizure. There was no assessment information on the SBAR, including no vital signs or interventions used to assist the resident. Review of Resident #6's Transfer and Discharge Information form dated 6/22/24 indicated there was a physician's order to transfer the resident to the hospital. Review of Resident #6's physician's orders dated 6/22/24 did not reveal an order to send the resident to the hospital. Review of Resident #6's progress notes did not reveal any information related to the resident's change in condition on 6/22/24. Further review of Resident #6's electronic medical record did not reveal any additional information related to the resident's change of condition on 6/22/24. In an interview on 8/22/24 at 4:07 pm, Nurse #4 said Resident #6 was seizing for approximately 2-3 minutes at some time between 8:00-8:30 am on 6/22/24. She yelled out for help and the nurse assigned to the hall (Nurse #10) came into the resident's room. Nurse #4 took Resident's #6's	F 842	the change of condition. A review of the last 72 hours of change of condition documentation was completed on 9/12/2024 to ensure the medical record is complete and accurate. .Any negative findings were followed up on as needed. Completed by 9/12/2024. 3. Education was provided to all licensed nursing staff regarding proper medication documentation and complete and accurate documentation by the director of nursing/designee. Completed 9/12/2024. Any new employees or agency staff who are responsible for this compliance hired after 9/12/2024 will receive this education. 4. Ongoing compliance monitoring: Beginning 9/9/2024, one medication pass observation will occur weekly for twelve weeks by the director of nursing/designee to ensure all residents are offered medications as ordered and documentation in the medical record is accurate. Beginning the week of 9/9/2024, three resident charts will be reviewed weekly for twelve weeks by the director of nursing/designee to identify any change of condition to ensure the condition change is complete and accurate in the medical record. Results will be reported in quality assurance performance improvement for three months by the director of nursing/designee. 5. The director of nursing is responsible for compliance. Date of Compliance: 9/16/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 842	Continued From page 117	F 842		

vital signs while another nurse (Nurse #11), who was in the room, put oxygen on the resident for comfort, though the resident did not appear to be in respiratory distress. An unknown staff member called 911 and Emergency Medical Services (EMS) arrived at the facility approximately 15-20 minutes after the seizure. She did not document any information related to the seizure because she assumed the charge nurse would document an assessment.

In an interview on 8/22/24 at 4:14 pm, Nurse #10, Resident #6's charge nurse on 6/22/24, said she responded to Nurse #4's call for help and went to Resident #6's room. After the resident's seizure ended, the nurse said she assessed the resident and stayed with her until EMS arrived. She said she did not fill out the SBAR or the hospital transfer paperwork because she believed another nurse (name not recalled) had completed them.

In an interview on 8/22/24 at 4:50 pm, Nurse #12 said she was working on another hall and heard someone yelling. She went to see what was going on and saw Nurse #10, who told her Resident #6 was seizing and needed to go out to the hospital. Nurse #12 volunteered to do the transfer documentation and the Situation, Background, Appearance, and Review (SBAR) Communication Form to the provider. She had not gone into the room and did not see the resident at all during the seizure so she did not want to document an assessment because she didn't actually see the resident.

In an interview on 8/06/24 at 9:35 AM, the Director of Nurses (DON) said assessments and a note should have been completed by the nurse when a resident was transferred to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 118	F 842		

b. Review of Resident #6's readmission progress notes revealed she was readmitted to the facility on 6/26/24 after a hospitalization for acute metabolic encephalopathy (an alteration in consciousness caused by large-scale brain dysfunction) due to a urinary tract infection (UTI).

Review of Resident #6 physician's orders dated 6/26/24 revealed orders for meropenem (an antibiotic) 1 gram in 100 milliliters of normal saline intravenously (IV) every 12 hours until 6/29/24.

Review of Resident #6's June 2024 Medication Administration Record (MAR) revealed Nurse #4 indicated the resident did not receive the IV antibiotics on 6/27/24. The reason listed was the resident refused all medications taken by mouth.

Review of Resident #6's nursing progress notes dated 6/27/24 written by Nurse #4 revealed she placed the IV and began the dose of antibiotic with no difficulties.

In an interview on 8/23/24 at 1:55 PM, Nurse #4 said the documentation of refusal of the IV antibiotic was incorrect. She said Resident #6 had received the IV antibiotic with no concerns but had refused all of her medications by mouth.

2. Resident #18 was admitted to the facility on 7/7/2023 with diagnoses including chronic obstructive pulmonary disease.

Physician orders for Resident #18 included the following medications:

- On 3/5/2024, Klor-Con 10 (Potassium Chloride) Extended Release 10 milliequivalent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 119	F 842		

(meq) two tablets once a day.
- On 3/7/2024, Fluticasone propionate spray 50 micrograms (mcg) suspension 1 spray alternating nostrils once a day for allergies.
- On 7/3/2024, Polyethylene glycol 3350 powder 17 grams per dose mixed in 4-8 ounces of fluid.

The quarterly Minimal Data Set (MDS) assessment dated 7/14/2024 indicated Resident #18 was cognitively intact.

On 8/6/2024 in a continuous observation at 8:36 am, Nurse #3 was observed preparing Resident #18's medications scheduled for 8:00 am and 9:00 am. At 8:47 am, Nurse #3 was observed entering Resident #18's room and administering the medications. Nurse #3 was not observed offering or administering Resident #18 the following medications: Klor-Con 10 Extended Release, Fluticasone Propionate nasal spray and Polyethylene Glycol 3350 powder 17 grams per dose mixed in 4-8 ounces of fluid.

A review of the August 2024 Medication Administration Record (MAR) recorded Klor-Con Extended Release two tablets scheduled for administration at 9:00am were administered to Resident #18 on 8/6/2024, and Resident #18 refused the medications, Fluticasone Propionate nasal spray and Polyethylene Glycol 3350 powder 17 grams scheduled for 9:00am on 8/6/2024.

In an interview with Resident #18 on 8/6/2024 at 9:57 am, Resident #18 stated Nurse #3 had not offered her the following medication: Klor-Con Extended Release tablets, Fluticasone Propionate nasal spray and Polyethylene Glycol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 120	F 842		

3350 powder 17 grams on 8/6/2024 for the 9:00am medication pass. Resident #18 explained she did not think she had received Klor-Con Extended Release tablets since December 2023 and was taking Fluticasone Propionate nasal sprays and Polyethylene Glycol 3350 powder 17 grams when administered.

In an interview with Nurse #3 on 8/6/2024 at 10:06 am, she stated Fluticasone Propionate nasal spray, Polyethylene Glycol 3350 powder 17 grams and Klor-Con Extended Release tablets were not offered to Resident #18 for the 9:00am medication pass observed on 8/6/2024 because Resident #18 would refuse the medications.

In a follow up phone interview with Nurse #3 on 8/14/2024 at 11:15 am, she stated the documentation of Resident #18 refusing Fluticasone Propionate nasal spray and Polyethylene Glycol 3350 powder 17 grams and the administration of the Klor-Con Extended Release tablets on the MAR on 8/6/2024 for 9:00 am medication pass was incorrect. She stated Klor-Con Extended Release tablets were not given as documented. She stated documentation of medication administration should be accurate and usually Resident #18 refused the medications. Nurse #3 did not provide a reason why she documented the Klor-Con Extended Release was documented as administered.

In an interview with the Director of Nursing (DON) on 8/15/2024 at 2:55 pm, she explained documentation of administration of medications on the MAR should be recorded after administration and accurate.

In an interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HEALTH & REHAB CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 121	F 842		

8/15/2024 at 4:25 pm, she stated documentation on Resident #18's MAR should had reflected what occurred with the medication administration on 8/6/2024 at 9:00 am.

3. Resident #71 was admitted to the facility on 6/20/2024 with diagnoses including diverticulitis (inflammation of irregular pouches in the wall of the large intestines).

Physician orders for Resident #71 dated 6/21/2024 included Polyethylene glycol 3350 powder (a laxative that increases the amount of water in the intestinal tract to stimulate bowel movements) 17 grams per dose one a day mixed in 4-8 ounces of fluid.

The admission Minimal Data Set (MDS) assessment dated 6/24/2024 indicated Resident #71 was severely cognitively impaired.

On 8/6/2024 at 8:50 am in a continuous observation, Nurse #3 was observed preparing Resident #71's medications. At 8:57 am, Nurse #3 was observed entering Resident #71's room and administering the prepared medications. Nurse #3 was not observed offering or administering Resident #71 the medication, Polyethylene Glycol 3350 powder 17 grams mixed in 4-8 ounces of fluid.

A review of the August 2024 Medication Administration Record (MAR) for Resident #71 recorded the medication, Polyethylene glycol 3350 powder 17 grams, was administered by Nurse #3 at 9:00 am on 8/6/2024 as scheduled.

In an interview with Nurse #3 on 8/6/2024 at 10:10 am, she stated the medication,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 122	F 842		

Polyethylene glycol 3350 powder was not offered to Resident #71 on 8/6/2024 at 8:57 am because she thought the medication had been discontinued.

In a follow up phone interview with Nurse #3 on 8/14/2024 at 11:15 am, she stated the documentation on Resident #71's August MAR on 8/6/2024 for 9:00 am was incorrect. She stated Polyethylene glycol 3350 powder 17 grams was not administered as documented and stated documentation of medication administration should be accurate on Resident #71's MAR. Nurse #3 did not provide a reason why she documented the medication was given.

In an interview with Resident #71 on 8/6/2024 at 10:13 am, Resident #71 admitted to having a problem with constipation and drank a clear liquid to help prevent constipation. When Resident #71 was asked if he was offered a clear liquid to drink on 8/6/2024 to help with constipation, Resident #71 answered, "No".

In an interview with the Director of Nursing on 8/15/2024 at 2:55 pm, she stated documentation of medication administration should be accurate and recorded on the MAR after the administration of the medication. She stated when a medication was not administered to Resident #71, an explanation documenting why the medication was not administered should be entered on the MAR.

In an interview with the Administrator on 8/15/2024 at 4:25 pm, she stated Resident #71's MAR should reflect documentation of what occurred during medication administration on 8/6/2024 at 9:00 am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 123	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		9/16/24

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F 880	Continued From page 124 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to practice infection control measures when Nurse Aide (NA) #3 did not apply a gown and gloves before entering a resident's room on contact isolation to deliver a meal tray (Resident #177) and when Nurse #3 and NA #5 did not wear gowns when providing gastrostomy tube, urinary catheter and wound care to a resident on enhanced barrier precautions	F 880	Regarding F0880: 1. Resident #177 no longer resides in the facility. Resident #68 remains in the facility but had no adverse outcome from this deficient practice. Resident #68's room was restocked to include all appropriate personal protective equipment. 2. All residents on isolation precautions	

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F 880	Continued From page 125 (Resident #68) for 2 of 3 residents reviewed for infection control. Finding included: Th facility's "Transmission Based Precautions" policy dated 4/15/2024 stated contact precautions were intended to prevent transmission of infectious agents which were spread by direct or indirect contact with the patient or the patient's environment. Personal protective equipment (PPE) recommended for contact isolation included gloves whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident and gown whenever anticipating touching environmental surfaces or equipment in close proximity to the resident. The policy stated enhanced barrier precautions were intended to prevent transmission of multi-drug resistant organisms by contaminated hands and clothing of the health care workers to high risk residents and was indicated for high contact activities for residents with chronic wounds and indwelling catheters (central lines, urinary catheters). 1. a. On 8/4/2024 at 12:45 pm, a contact precautions sign was observed on Resident #177's door. The contact precautions sign stated providers and staff must put on gloves and a gown before entering the room. A container with gowns and gloves was observed hanging on the outside of Resident #177's door. On 8/4/2024 at 12:45 pm, NA #3 was observed delivering a meal tray to Resident #177's room wearing no gloves or gown. NA #3 was observed clearing Resident #177's bedside table of Resident #177's personal items wearing no	F 880	are at risk for deficient practice. The regional director of clinical services completed walking rounds of all residents that reside in the building with isolation precautions on 8/6/2024. 3. The director of nursing/designee educated all staff on proper personal protective equipment especially as related to guidelines for isolation precautions. Routine rounds will be completed by members of the interdisciplinary team and any concerns identified will be addressed immediately. Any new employees or agency hires after 9/12/2024 who are responsible for this compliance will receive this education. Completed on 9/12/2024. 4. Ongoing compliance monitoring: Beginning 9/9/2024, the director of nursing/designee will complete three observations of personal protective equipment and isolation practice weekly for twelve weeks. Results will be reported to quality assurance performance improvement committee for three months by the director of nursing/designee. 5. The director of nursing is responsible for compliance. Date of Compliance: 9/16/24	

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F 880	Continued From page 126	F 880		

gloves before placing the meal tray onto the bedside table. Resident #177 was observed sitting in her wheelchair along the opposite side of the bedside table from NA #3.

On 8/4/2024 at 12:48 pm in an interview with NA #3, she stated she did not put gloves and gown before entering Resident #177's room to deliver the meal tray because she did not touch Resident #177. She explained she placed Resident #177's meal tray on the mattress that had no linen covering while she removed Resident #177's personal items (lotion) from the bedside table to the bathroom. She stated for contact precautions PPE was only necessary when touching Resident #177.

On 8/14/2024 at 11:37 am in a following up phone interview with NA #3, she verified she had received training on transmission based precautions on 4/19/2024, and gown and gloves should be worn before entering Resident #177's room for contact isolation. She stated on 8/6/2024 when delivering Resident #177's meal tray she got contact precautions confused with enhanced barrier precautions.

On 8/4/2024 at 12:47 pm in an interview with Nurse #3 located outside Resident #177's door, she stated Resident #177 was on contact precautions for Extended Spectrum Beta-lactamases (ESBL), enzymes produced by certain bacteria that are resistant to common antibiotics, in urine. She said NA #3 did not need to wear a gown or gloves to deliver the meal tray into the room. When Nurse #3 was informed NA #3 was observed handling and moving Resident #177's personal items off the bedside table, she stated NA #3 should have put on gloves when

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F 880	Continued From page 127	F 880		

touching Resident #177's personal items.

b. On 8/6/2024 at 2:05 pm, an enhanced barrier precaution sign was observed on Resident #68's door. The enhanced barrier precautions sign stated providers and staff must wear gloves and a gown for the following activities: device care or use (urinary catheter and feeding tube) and wound care (any skin opening requiring a dressing). A tote was observed hanging in Resident #68's room behind the door. There was a box of gloves in the tote. There were no gowns observed in the tote.

On 8/6/2024 at 2:06 pm, Nurse #3 and Nurse Aide (NA) #5 were observed entering Resident #68's room and washing their hands before applying gloves. The following observations occurred while providing care to Resident #68:

- On 8/6/24 at 2:06 pm, NA #5 was observed not wearing a gown when emptying the urinary catheter bag.
- On 8/6/2024 at 2:09 pm, Nurse #3 was observed not wearing a gown when providing gastrostomy tube care.
- On 8/6/2024 at 2:12 pm, Nurse #3 and NA #5 (who was assisting in holding Resident #68 on his side) were observed not wearing gowns when changing a sacral wound dressing.
- On 8/6/2024 at 2:20 pm, NA #5 was observed not wearing a gown when providing urinary catheter care to Resident #68.

On 8/6/2024 at 2:45 pm in an interview with NA #5, she stated she understood that she needed to wear gloves only with enhanced barrier precautions. She explained the facility had PPE for use, and the nursing staff were responsible to restock the containers/totes.

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F 880	Continued From page 128 On 8/14/2024 at 12:29 pm in a follow up phone interview, NA #5 stated she had received educational training on 4/19/2024 for enhanced barrier precautions and should had worn a gown along with the gloves on 8/6/2024 when providing Resident #68's urinary catheter care and assisting Nurse #3 with the wound care. She said there was no reason why she did not wear a gown and recalled not seeing any PPE in the PPE tote in Resident #68's room on 8/6/2024 to apply. She explained it was the nurse aides and nurses responsibility to refill the containers/totes when empty and did not know why the tote in Resident #68's room was without PPE (gowns). On 8/6/2024 at 2:43 pm in an interview with Nurse #3, she explained that Resident #68 was on enhanced barrier precautions due to having a wound and the urinary catheter. She stated she had never been told to wear a gown for enhanced barrier precautions, just gloves. Nurse #3 stated the PPE including gowns were available in the facility. On 8/14/2024 at 11:15 am in a follow up phone interview with Nurse #3, she stated she had been trained on 4/19/2024 for enhanced barrier precautions and should had applied a gown with the gloves before performing Resident #68's gastrostomy care and wound care. Nurse #3 was unable to provide a reason for not wearing the gown. She said she didn't think about wearing the gown to provide Resident #68's care and there were no gowns in the PPE tote behind the door in Resident #68's room on 8/6/2024. Nurse #3 stated Resident #68's tote did not include gowns on 8/6/2024 because she missed restocking the tote.	F 880		

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F 880	Continued From page 129 On 8/6/2024 at 5:09 pm in an interview with the Infection Preventionist, she explained Nurse #3, NA #5 and NA #3 had received educational training on contact precautions and enhanced barrier precautions. She stated gown and gloves was required before entering Resident #177's room who was on contact precautions and a gown and glove was required when conducting patient care for Resident #68 on enhanced barrier precautions. She stated the facility had PPE available for the nursing staff, and it was the nursing staff's responsibility to restock PPE daily as needed for residents on contact precautions and enhanced barrier precautions. On 8/15/2024 at 3:13 pm in an interview with the Director of Nursing, she stated NA #3 should had applied a gown and gloves prior to entering Resident #177's room, who was on contact precautions, when delivering the meal tray. She also stated due to Resident #68 being on enhanced barrier precautions, Nurse #3 and NA #5 should have worn a gown when providing gastrostomy care, urinary catheter care and wound care to Resident #68. She explained the facility used container outside the door to store PPE for contact precautions and there were totes inside the rooms to store PPE for the residents on enhanced barrier precautions. She stated the facility had a plentiful supply of PPE and the nursing staff had access to PPE storage room to restock the PPE for residents on contact precautions and enhanced barrier precautions as needed. On 8/15/2024 at 4:16 pm in an interview with the Administrator, she stated there was PPE available for the nursing staff to use as needed	F 880		

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F 880	Continued From page 130 and the nursing staff should use PPE based on the directive on the signage for contact precautions and enhanced barrier precautions.	F 880		