PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONS	COMPLETED			
		345491	B. WING _			02	C 2/07/2025
	NAME OF PROVIDER OR SUPPLIER CROATAN RIDGE NURSING AND REHABILITATION CENTER			210 FOX	ADDRESS, CITY, STATE, ZIP CODE CHALL ROAD DRT, NC 28570	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	investigation survey 02/04/2025 through found in compliance	02/07/2025. The facility was with the requirement CFR Preparedness. Event ID	F(000			
	survey was conducto 02/07/2025. Event I intake was investiga						
F 580 SS=D	deficiency.	allegations resulted in njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 5	580			3/10/25
	consult with the resic consistent with his of representative(s) who (A) An accident involved results in injury and physician intervention (B) A significant characteristic of mental, or psychosologications deterioration in health status in either life-thal clinical complications (C) A need to alter to a need to discontinual treatment due to advancemence a new for	nediately inform the resident; dent's physician; and notify, r her authority, the resident en there is- lving the resident which has the potential for requiring in; nge in the resident's physical, cial status (that is, a ch, mental, or psychosocial intereatening conditions or s); reatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or insfer or discharge the					
I ABORATORY I		IIITY as specified in /SUPPLIER REPRESENTATIVE'S SIGNATUI	RF		TITLE		(X6) DATE

Electronically Signed 02/27/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
345491			B. WING _		02/07/2025		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570	1 02/01/2020		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLET		
F 580	(14)(i) of this section all pertinent informa is available and proviphysician. (iii) The facility must resident and the resident in §483 (B) A change in resistate law or regulati (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a composite of §483.5) must disclosits physical configurations that composite of §483.5) must disclosits physical configurations that composite of physical configurations that composite of physical configurations that composite of the physical configuration of the nurse of the physician dose of insulin due to unavailable for admitted insulin from the nurse not obtain administer insulin from the deficient practice affiliation.	tification under paragraph (g) a, the facility must ensure that tion specified in §483.15(c)(2) vided upon request to the also promptly notify the ident representative, if any, or or roommate assignment alo(e)(6); or dent rights under Federal or ons as specified in paragraph on. record and periodically (mailing and email) and e resident cosite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various ise the composite distinct ify the policies that apply to seen its different locations T is not met as evidenced view, and staff and Nurse erviews, the facility failed to when a resident missed a to the medication being nistration. This resulted in	F 5	On 2/5/25, the Director of Nursin notified the physician that residen not receive the scheduled dose of on 2/4/25 due to the medication in available in the facility. The residuance assessed with no negative finding new order was obtained for a one dose of an alternate insulin and to Toujeo on 2/6/25. Toujeo was	t #28 did f Toujeo ot ent was js. A -time		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
						С					
		345491	B. WING _			02	/07/2025				
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE						
0004744	I DIDOE NUIDOINO A	ND DELLA DIL ITATION CENTED		2	210 FOXHALL ROAD						
CROAIAN	I RIDGE NURSING A	ND REHABILITATION CENTER		N	NEWPORT, NC 28570						
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI)		FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 580	Continued From p	page 2	F 5	580							
	#28).		' '	500							
	#20).				administered per physician order on 2/6/25.						
	The findings inclu	ded:			2/0/25.						
	The infairigs inclu	ueu.			On 2/5/25, the DON educated Nurse #	3					
	Resident #28 was	admitted to the facility on			regarding 1) the rights of Medication	3					
		oses that included diabetes.			Administration with emphasis on ensur	rina					
	O/1/24 With diagno			the right medication is administered at	•						
	A review of the ph			right time and 2) Following Physician							
		t #28 was prescribed Toujeo			Orders with emphasis on obtaining						
		neous Solution Pen-injector 300			medications via eKit, back up pharmac	v					
		(insulin glargine)-inject 25 units			or notification of the physician for further						
		under the skin) at bedtime for			recommendations when medications						
	diabetes.	,			cannot be obtained/administered per						
					physician order.						
	The quarterly Min	imum Data Set (MDS)									
		d 2/4/25 revealed Resident #28			On 2/5/25, the Social Services Director	r					
	was cognitively in	tact and was coded for receiving			initiated resident questionnaires regard						
	insulin.				medication concerns to include any						
					incidents of not receiving medications	that					
	Resident #28's M	edication Administration Record			had not previously been addressed. T	he					
	(MAR) dated 2/4/2	25 signed off by Nurse #3,			DON wil laddress all concerns identifie	:d					
	revealed Residen	t #28 did not receive the			during the audit to include assessment	i of					
	scheduled dose o	f insulin at 8:00 p.m. because			the residents, notification of the physic	ian					
	the medication wa	as not available.			when indicated for further						
					recommendations and/or education of						
	During a telephon	e interview with Nurse #3 on			staff. The audit will be completed by						
	2/5/25 at 2:06 p.m	n. she revealed that Resident			3/10/25.						
	#28 did not receiv	e his insulin on 2/4/25 because									
		le. She revealed she should			On 2/7/25, the administrative nurses to						
		P, left her a voice message, and			include the Quality Assurance (QA) Nu						
		essage for authorization to			Staff Development Coordinator (SDC)						
		from the backup kit. She further			Minimmum Data (MDS) Nurse, audited	l all					
		the NP by phone once on 2/4/25			medication carts to ensure all						
		did not receive a response, and			medications, to include insulins, were						
	_	again, leave a voice message or			available to administer per physician						
		ndicated she should have left a			order. The QA Nurse, SDC and MDS						
	message or texte	d the NP.			Nurse will address all concerns identifi	ed					
					during the audit to include obtaining						
	In an interview with	th the NP on 2/5/25 at 1:56 p.m.			medications from the eKit/back up						

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		345491	B. WING _	B. WING		C 02/07/2025		
NAME OF P	ROVIDER OR SUPPLIER	1	<u>l</u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE		02020	
				2	210 FOXHALL ROAD			
CROATAN	RIDGE NURSING AND	REHABILITATION CENTER			NEWPORT, NC 28570			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
F 580	Continued From page	e 3	F 5	580				
	she revealed she wa	s not contacted on 2/4/25			pharmacy when indicated, notification	of		
	about Resident #28 r	missing his insulin on 2/4/25.			the physician for further recommendati			
		as available by phone and via			if the medication cannot be obtained ar			
		the day and night. She			education of staff. The audit will be			
		een informed about the			completed by 3/10/25.			
	•	oday (2/5/25) by Nurse #2.			completed 2) of to/20.			
		y would need authorization			On 2/6/25, the QA Nurse, SDS and MD)S		
		cian to administer any other			Nurse initiated Medication Pass Audits			
		e backup kit at the facility.			with all nurses and Medication Aides.			
modiff that was in the bi		o backap itt at the radiity.			This audit is to ensure the nurse and /c)r		
	During an interview v	with the Director of Nursing			Medication Aides administered			
		:46 p.m. she stated Nurse			medications per the physician			
	, ,	have contacted the NP by			orders/Rights of Medication Administat	ion		
	phone call and a text	_			or the physician was notified for further			
	-	inister insulin in the backup			recommendations when medication was			
		d that all nurses will be			not available to administer, with	13		
		the NP to avoid any lapses						
	in administration of m	•			corresponding documentation in the			
	iii auriiiiistiation oi n	nedications.			electronic record. The QA Nurse, SDC and MDS Nurse will address all concer			
	In an interview with t	he Administrator on 2/7/25 at				115		
					identified during the audit of include	. of		
		she was unaware that Nurse			assessment of the resident, notification			
		NP of Resident #28 missing			the physician for further recommendati			
		a result of the medication			when indicated and/or education of sta			
	_	administration. She further			The audit will be completed by 3/10/25	•		
		responsibility of nurses to			After 3/10/25 any nurse or medication			
		ext or phone call to receive			aide who has not worked or completed			
		inister medications in the			the education will complete prior to the			
	facility's backup kit.				next scheduled work shift. All newly hi	red		
					nurses and medication aides will be			
					inserviced by the SDC during orientation	n l		
					regarding Rights of Medicaiton			
					Administration and Following Physician	1		
					Orders.	ĺ		
					The Quality Assumes as (QA) No.	\		
					The Quality Assurance (QA) Nurse, SE	<i>,</i> C		
					and MDS Nurse will complete 10			
					Medication Pass Audits with all nurses			
					and medication aides across all shifts a			
					days of the week, weekly x 4 weeks; the	en		

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		345491	B. WING _			C 02/07/2025	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY	. STATE, ZIP CODE	02/01/2023	
				210 FOXHALL ROAD	, , , , , , , , , , , , , , , , , , , ,		
CROATAN RIDGE NURSING AND REHABILITATION CENTER			NEWPORT, NC 2857	0			
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F 580	Continued From page	4	F	monthly x one mensure the nurse administered me orders, Rights or Administration or notified for further when a medicati administer, with documentation in The QA Nurse, address all concaudit to include a resident, obtainifindicated, administration order of physician order of physician when obtained/administration of the QA Nadits weekly x month, to ensure addreassed. The Interdiscipitrinclude the QA Nadits weeks then we audit is to ensure available to be a orders or that the for further recommedications were administer, with electronic record Nurse and SDC identified during assessment of the medications when administers when a medications when administers when a medications when a medication and a medicati	or that the physician wa er recommendations ion was not available to	s vill he er g of ss c 1 for sian d	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345491	B. WING		C 02/07/2025	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570	02/07/2025	
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F 602 SS=D	Free from Misapprop CFR(s): 483.12		F 58	the medication cannot be obtained a retraining of staff. The DON will revi the Medications Not Administered Refive times a week x 8 weeks then we 4 weeks, to ensure all concerns are addressed. The Administrator/DON will forward to results of the Medication Pass Audits Medications Not Administered Report the Quality Assurance Performance Improvement (QAPI) Committee more x 1 month for review and to determine trends and/or issues that may need further interventions put in place and determine the need for further and/or change in frequency of monitoring.	ew eport ekly x he and t to hthly e to	
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m This REQUIREMENT by: Based on record rev staff interviews, the fa- resident's right to be a of property when a st took a cell phone from practice was reviewed	involuntary seclusion and ical restraint not required to		Past noncompliance: no plan of correction required.		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345491	B. WING			C 02/07/2025		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 210 FOXHALL ROAD NEWPORT, NC 28570	CODE	02/07/2023		
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F 602	Continued From pag	ge 6	F 6	502				
	The finding included	:						
	Resident #12 was ac 10/13/22.	dmitted to the facility on						
		um Data Set (MDS) 0/29/2024 had Resident #12 cognitively impaired.						
	at 2:11 p.m. he state last year but was late further described the #1 who had taken hi	with Resident #12 on 2/4/25 and his phone went missing er found. Resident #12 be perpetrator as Nurse Aide s cell phone, and he could gave it to her or she took it on.						
	· -	ontact Nurse Aide #1 by d 2/7/25 were unsuccessful.						
	Nurse #4 was not av	vailable for the interview.						
	2/6/25 at 2:16 p.m. s #12 had complained stated she asked Nu taking the phone. Sh helped in looking for outside the facility. S members of Resider they determined thro that the missing pho the left side of the but they had searched for contacted the police that the police arrive phone. She revealed	nterview with Nurse #3 on she revealed the Resident I his phone was missing. She are Aide #1 who denied he revealed Nurse Aide #1 the missing phone in and She revealed the family hat #12 were contacted and bough a tracker on the phone he was in the parking lot on wilding. She further revealed for the phone for 4 hours and at 9:15 p.m. She revealed as they searched for the di Nurse Aide #1, went to her essing phone, and handed it to						

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		345491	B. WING				07/2025	
	ROVIDER OR SUPPLIER RIDGE NURSING AND	REHABILITATION CENTER		STREET ADDRESS, C 210 FOXHALL ROAL NEWPORT, NC 2		1 02	0172020	
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F 602	the phone was becautracker was leading to revealed the phone wand Nurse Aide #1 was tated that she will not Resident #12 did not Nurse #3 revealed the was unlocked, and Naseveral calls from the During an interview was unlocked, and Naseveral calls from the During an interview was unlocked, and Naseveral calls from the During an interview was unlocked, and Naseveral calls from the Pouring of 6/19/2 phone saying Reside phone. She stated the Resident #12 had state asked to use his cell directed the nurse are the building and not until the phone was I proceeded to the builthe police and Resides on had arrived at the revealed that Reside able to locate the phefacility using a tracker retrieved her pockette phone out and gave Resident #12 was alle to press charges. The company policy to use DON stated that she	at Nurse Aide #1 knew where use the phone location of her car. She further was returned to Resident #12 has sent away after the police of be charged because want to press charges. Hat Resident #12's cell phone lurse Aide #1 had made be phone. With the Director of Nursing 2:28 p.m. she stated that on each #12's was missing his cell hat Nurse #3 called her on each #12's was missing his cell hat Nurse #3 had told her that hated that Nurse Aide #1 had phone. She revealed she had all staff to do a search in rash should be thrown out ocated. She stated she lding at about 9:50 p.m. after each #12's granddaughter and	F	502				
	was terminated. The training on misappro for all staff and an au	DON revealed that Inservice priation of property was done dit completed for all alert ts for any missing property.						

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		345491	B. WING _			C 2/07/2025	
NAME OF PROVIDER OR SUPPLIER CROATAN RIDGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570		210112023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 602	12:43 p.m. she reveal phone went missing p.m., and Nurse Aide stated that the family to track the location of #1's car. She reveale that Resident #12 all but Resident #12 had phone. The Administ was terminated immediate borrowed and to used it. She stated it company policy. She received Inservice traproperty. The facility provided action plan with a condition plan with a	the Administrator on 2/5/25 at alled that Resident #12's on 6/19/24 at about 7:15 at 11 had it in her car. She of Resident #12 were able of the phone to Nurse Aide at that Nurse Aide #1 told her owed her to use the phone at denied giving her the rator stated Nurse Aide #1 ediately after establishing ok Resident #12 phone and was a violation of the revealed that all staff aining on misappropriation of the following corrective mpletion date of 6/23/24. The were put in place to practice will not recur: The was contacted by Nurse of p.m. Adult Protective Services by 6/20/24. The deal of the protective services by 6/20/24.	F 6	02			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345491	B. WING _				07/ 2025
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		210	REET ADDRESS, CITY, STATE, ZIP CODE D FOXHALL ROAD EWPORT, NC 28570	1 027	0172023
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F 602	oriented residents re- 100% in-service of a departments regardin resident property cor- Time stamps per resident property cor- Time stamps per resident property company policy regalor resident's property- Audits of private proforiented residents Indicate how the faciliperformance to make sustained. Include: -From 6/20/24 through DON/Designee to more questionnaire every without a their review Performance Improved- An Ad Hoc Quality A Improvement (QAPI) interdisciplinary on 6 borrowing residents of correction that was designed. The facility's QAPI of POC for the next 3 metalor. The Administrator statis POC. Corrective action corrective action corrections.	ed/terminated by the DON of alert and garding any missing items. All employees in all ang misappropriation pf appleted by the DON. Sident's cell phone are Aides use of the resident's any time which is a violation of arding unauthorized borrowing are perty for non-alert and ality plans to monitor its as sure that the solutions are are unauthorized borrowing are and ality plans to monitor its as sure that the solutions are are unauthorized borrowing are and ality plans to monitor its as sure that the solutions are are unauthorized borrowing are unauthorized borrowing and ality plans to monitor its as sure that the solutions are and Performance ement (QAPI). Assurance and Performance meeting was held by the are ality plan of eveloped and implemented. Below the DON. Sident's cell phone and this plan of eveloped and implemented.	F	602			

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(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION		
departments in the freceived in-service to resident property and of the audit tool was of the resident questoriented residents contented residents and the reviewed at licensed pharmacists §483.45(c)(1) The distribution of the resident's medical directories and these reports more services and these reports more services and the residents reports of the contented reports of the contented reports of the resident of the re	raining on Misappropriation of d exploitation policy. A review conducted including a review tionnaires for all alert and ompleted on 8/19/24. e of 6/23/24 for the corrective dated. ew, Report Irregular, Act On (2)(4)(5) gimen Review. rug regimen of each resident teleast once a month by a dical chart. harmacist must report any attending physician and the ector and director of nursing, sust be acted upon. ude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. noted by the pharmacist sust be documented on a coort that is sent to the and the facility's medical of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. The proposed of the pharmacist identified. The pharmacist identified of the pharmacist identified. The pharmacist identified of the pharmacist identified of the pharmacist identified. The pharmacist identified of the pharmacist id			3/10/25		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page departments in the freceived in-service tresident property an of the audit tool was of the resident questoriented residents contented residents may be a service of the resident's medical directors and these reports may be a service of the resident's medical director and the service of the resident's medical director and the irregularity to the resident's medical resident resident resident resident resident resident resident resid	TORRECTION IDENTIFICATION NUMBER: 345491 ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 departments in the facility confirmed they received in-service training on Misappropriation of resident property and exploitation policy. A review of the audit tool was conducted including a review of the resident questionnaires for all alert and oriented residents completed on 8/19/24. The compliance date of 6/23/24 for the corrective action plan was validated. 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)(2) This review must include a review of the resident's medical chart. \$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, 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,	ROWIDER OR SUPPLIER RIDGE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEPOLED PROJUCES (EACH DEPOLE MINET) BE PROCEEDED BY TULL REGULATORY ORLSO (DENTIFYMO INFORMATION) Continued From page 10 departments in the facility confirmed they received in-service training on Misappropriation of resident property and exploitation policy. A review of the resident questionnaires for all alert and oriented residents completed on 87:19/24. The compliance date of 6//23/24 for the corrective action plan was validated. Drug Regimen Review, Report Irregular, Act On CFF(s): 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)(2) This review must include a review of the resident's medical chart. (i) Irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (ii) 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. (iii) 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, and the regularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified. (iii) The attending physician must document in the resident's medical record that the identified. (iii) The attending physician must document in the resident's medical record that the identified. (iii) The attending physician must document in the resident's medical record that the identified to the pharmacist identified.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345491	B. WING		C 02/07/2025			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION			
F 756	be no change in the rephysician should doc the resident's medical §483.45(c)(5) The fact maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action. This REQUIREMENT by: Based on record rev. Consultant and staff in Consultant and staff in Consultant failed to rea physicians order for psychotropic medical used to treat anxiety) rationale for extended duration for 2 of 5 resumnecessary medical (Resident #22 and R. The findings included 1. Resident #22 was 06/26/2021 with diagramith anxiety. A review of the physical of the physic	medication, the attending ument his or her rationale in I record. cility must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take office an irregularity that in to protect the resident. It is not met as evidenced item and Pharmacy interviews, the Pharmacy interviews, and the Pharmacy interviews, the Pharmacy interviews, and the Pharmacy interviews in the Pharmacy	F 75	On 2/6/25, the Quality Assurance (QA nurse clarified with the physician the ofor as needed (PRN) antianxiety medication stop date. The PRN medication was discontinued per the physician order. On 2/6/25, the Quality Assurance (QA nurse clarified with the physician the ofor PRN antianxiety medication stop date. The PRN medication was discontinued per the physician order. On 2/11/25, the pharmacy supervisor educated the pharmacy consultant regarding PRN Psychoactive Medicati Monitoring with emphasis on limiting the duration of PRN psychotropic medicate to a duration of 14 days unless the attending physician or prescribing practitioner documents the rational for extended time in the medical record an indicates the specific duration. The in-service also included that PRN antipsychotics require a physician visit prior to renewal of medication. On 2/12/25, the pharmacy supervisor audited the monthly Medication Regim	rider) rder ate. d on ne ion the			

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345491	B. WING _				07/ 2025
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0172025
	10115211 011 001 1 2.2.1				10 FOXHALL ROAD		
CROATAN	RIDGE NURSING AND	REHABILITATION CENTER	NEWPORT, NC 28570				
				r	NEWPORT, NC 20570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 12	F7	756			
	Review by the Pharm	acy Consultant dated			Review for February 2025 to ensure th	e	
		medication regimen review			pharmacy consultant had addressed al		
	completed. No recom	_			psychotropic medications that require a		
					stop date or rational for extended use h		
	The admission Minim	ium Data Set (MDS) dated			been addressed. There were no addition	onal	
	01/23/2025 coded as				concerns identified.		
		ntianxiety medication seven			On 2/27/25, the facility consultant initia	ted	
	out of seven days of	the look back period.			an audit of all PRN psychotropic		
					medications. This audit is to ensure PF	₹N	
	An interview was con	ducted with the Pharmacy			psychotropic medications for all resider	nts	
	Consultant on 02/06/2	2025 at 09:48 AM. The			to ensure PRN psychotropic medication	ns	
	Consultant stated she	e performed monthly			were limited to a duration of 14 days		
		n Resident #22 and was			unless the attending physician or		
	aware of the Ativan 0				prescribing practitioner documented the	е	
		ne also stated she did not			rational for the extended time in the		
		ion questioning the rationale			medical record and indicated the speci		
	of the PRN Ativan me				duration. The Quality Assurance Nurse	<i>'</i>	
		aware a physician needed			(QA), Staff Development Coordinator		
		nt for the rationale prior to			(SDC), and/or Minimum Data Set Nurs		
	the extended order.				(MDS) will address all areas of concer	n	
					identified during the audit to include		
		ducted with the Director of			notification of the attending physician of	r	
		/06/2025 at 12:47 PM. The			prescribing practitioner for appropriate		
		macy Consultant was			stop date or rationale for extended use The audit will be completed by 3/10/25		
		ny irregularities from the eviews. She did not receive			On 2/7/25, the SDC initiated in-service		
		cerning the PRN medication			with all nurses/medication aides (MA) a		
	•	22. The DON also stated			providers regarding PRN Psychoactive		
	she expected her to a				Medication Monitoring with emphasis of		
		monthly during her reviews.			limiting the duration of PRN psychoacti		
	in egalanties nom nei	monthly during her reviews.			medication to a duration of 14 days unl		
	An interview with the	Administrator was			the attending physician or prescribing	230	
		2025 at 12:53 PM. The			practitioner documents the rational for	the	
		she expected the Pharmacy			extended time period in the medical		
		tely report irregularities from			record and indicates the specific durati	on.	
	the monthly medication				The in-service also included that PRN		
	and modele				antipsychotics require a physician visit	ĺ	
	2. Resident #47 was	admitted to the facility on			prior to renewal of medication and limit		
		noses including dementia			to 14 days for each renewal. The	-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		(X3) DATE SURVEY COMPLETED					
		345491	B. WING				0 7/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0112025
				2.	10 FOXHALL ROAD		
CROATAN	RIDGE NURSING AND I	REHABILITATION CENTER		N	EWPORT, NC 28570		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 756	Continued From page	÷ 13	F	756			
	with mood disturbanc	es.			In-service will be completed by 3/10/25 After 3/10/25, any nurse, MA or provide		
		um Data Set (MDS) dated dent #47 coded as severely			who has not worked or received the education will complete it upon the nex schedule work shift. All newly hired nurses, MAs and/or providers will be		
	dated 12/27/2024 rev (mg) as needed every	ce physicians order (PO) ealed Ativan 1 milligrams / 4 hours for 0 days end of life care. The			in-serviced by the SDC during orientation regarding PRN Psychoactive Medicatic Monitoring. The Pharmacy Supervisor will audit the	on	
	medical record did no for the medication.	t contain a 14-day stop date			pharmacy monthly Medication Regimer Review for PRN psychoactive medicati monthly x 3 months and provide a writt	n ons en	
	A review of the summary of Medication Regimen Review by the Pharmacy Consultant dated 01/02/2025 lacked a recommendation for the Ativan.				review to the Director of Nursing and/or Administrator. This audit is to ensure al PRN psychoactive medications have appropriate stop states of 14 days unle the attending physician or prescribing	II	
	Consultant on 02/06/2 stated she performed on Resident #47 but of	ducted with the Pharmacy 2025 at 09:48 AM. She monthly medication reviews did not send a he Ativan PRN medication			practitioner documented the rational for the extended time in the medical record and that all antipsychotics are limited to 14-day renewal following an in person by the physician. The Pharmacy	ds o	
	know they could not h	nospice resident and did not nave an extended order. ducted with the Director of			Supervisor will address all concerns identified during the audit to include notification of the facility and/or physicis for recommended stop date and	an	
	Nursing (DON) on 02 DON stated the Phari supposed to report ar monthly medication re a report from the Con	/06/2025 at 12:47 PM. The macy Consultant was by irregularities from the eviews. She did not receive sultant concerning the PRN			re-training of the consultant and/or nurs The Quality Assurance Nurse (QA), Sta Development Coordinator (SDC), and/o Minimum Data Set Nurse (MDS) will review all new orders for PRN	aff or	
	also stated she exped	ely report all irregularities			psychotropic medications 5 times a we x 4 weeks then weekly x 4 weeks to ensure PRN psychotropic medications were limited to a duration of 14 days unless the attending physician or	ek	
	An interview with the conducted on 02/06/2	Administrator was 2025 at 12:53 PM. The			prescribing practitioner documented the rational for the extended time in the	е	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345491	B. WING _				C 07/2025
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0112025
				210	FOXHALL ROAD		
CROATAN	RIDGE NURSING AND	REHABILITATION CENTER		NEV	NPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 14	F 7	'56			
		she expected the Pharmacy rely report irregularities from on reviews.			medical record and indicated the speci duration. The Quality Assurance Nurse (QA), Staff Development Coordinator (SDC), and/or Minimum Data Set Nurs (MDS) will address all areas of concerridentified during the audit to include notification of the attending physician of prescribing practitioner for appropriate stop date or rationale for extended use The DON will review the audits to 5 times a week x 4 weeks then weekly x 4 week to ensure all concerns are addressed. The DON and/or Administrator will prest the findings of the Medication Regimer Review and the Orders Audit for psychotropic medications to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 month for review and to determine trends and issues that may need further interventic put into place and to determine the need for further frequency of monitoring.	e n	
F 758 SS=D	S483.45(e) Psychotro §483.45(c)(3) A psychaffects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	opic Drugs. hotropic drug is any drug that associated with mental rior. These drugs include, drugs in the following	F 7				3/10/25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345491	B. WING		C 02/07/2025	
	ROVIDER OR SUPPLIER RIDGE NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570	02/01/2023	
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLÉTION	
F 758	Continued From pag	e 15	F 75	58		
	psychotropic drugs a unless the medicatio specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradua	ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically				
	behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and					
	are limited to 14 days §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he	RN order to be extended or she should document their ent's medical record and				
	drugs are limited to a renewed unless the a prescribing practition the appropriateness This REQUIREMENty:	orders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. Γ is not met as evidenced		On 2/6/25, the Quality Assurance (0	QA)	
		d Medical Director (MD) failed to ensure the		nurse clarified with the physician the for as needed (PRN) antianxiety medication stop date. The PRN		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345491	B. WING _				C 07/2025
NAME OF PR	ROVIDER OR SUPPLIER	1		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0172020
CDOATAN	DIDGE NUBSING AND	DELIA DII ITATIONI CENTED		21	0 FOXHALL ROAD		
CRUAIAN	RIDGE NURSING AND	REHABILITATION CENTER		Ni	EWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758		e 16 tion, Ativan, (a medication i included a rationale for	F	758	medication was discontinued per the physician order.		
	2 of 5 residents revie	as time limited in duration for wed for unnecessary ant #22 and Resident #47).			On 2/6/25, the Quality Assurance (QA) nurse clarified with the physician the or for PRN antianxiety medication stop da The PRN medication was discontinued	der ite.	
	The findings included	l: admitted to the facility on			per the physician order. On 2/27/25, the facility consultant initia an audit of all PRN psychotropic	ted	
		noses including dementia			medications. This audit is to ensure PR psychotropic medications for all resider to ensure PRN psychotropic medication	nts	
	01/23/2025 coded as	intianxiety medication seven			were limited to a duration of 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time in the		
	A review of the physi 0.5 milligrams (mg) e anxiety dated 08/09/2	cian's order revealed Ativan every 6 hours as needed for 2024 to 08/23/2024 and a			medical record and indicated the speci- duration. The Quality Assurance Nurse (QA), Staff Development Coordinator (SDC), and/or Minimum Data Set Nurse	e	
	for Ativan 0.5 milligraneeded for anxiety for	ed 08/23/2024 to 09/22/2024 ms (mg) every 6 hours as or 30 days. The medical or a documented rationale for			(MDS) will address all areas of concerr identified during the audit to include notification of the attending physician of prescribing practitioner for appropriate stop date or rationale for extended use	r	
	The August 2024 Me	dication Administration v revealed an order for			The audit will be completed by 3/10/25 On 2/7/25, the SDC initiated in-service with all nurses/medication aides (MA) a		
	Ativan 0.5 mg every 0 anxiety for 30 days 0 09/22/2024. The med	6 hours as needed for 8/23/2024 and discontinue dication was administered on			providers regarding PRN Psychoactive Medication Monitoring with emphasis o limiting the duration of PRN psychoacti	n ve	
	and 08/30/2024.	924, 08/28/2024, 08/29/2024 • MAR review revealed an			medication to a duration of 14 days unl the attending physician or prescribing practitioner documents the rational for extended time period in the medical		
	order for Ativan 0.5 n for anxiety for 30 day discontinue 09/22/20	ng every 6 hours as needed rs. 08/23/2024 and 24. The medication was			record and indicates the specific duration. The in-service also included that PRN antipsychotics require a physician visit		
	administered on 09/0	11/2024, 09/02/2024,	1		prior to renewal of medication and limit	ea	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345491	B. WING				C	
NAME OF D	DOVIDED OD CLIDDLIED	343431	B: Willo		TREET ADDRESS CITY STATE ZID CODE	02/	07/2025	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CROATAN	RIDGE NURSING AN	D REHABILITATION CENTER			10 FOXHALL ROAD			
		-		N	IEWPORT, NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 758	Continued From pa	age 17	, F 7	758				
	_	2024, 09/14/2024, 09/16/2024			to 14 days for each renewal. The			
	and 09/19/2024.	2024, 03/14/2024, 03/10/2024			In-service will be completed by 3/10/25	5		
	4114 00/10/2021.				After 3/10/25, any nurse, MA or provide			
	The care plan date	d 01/27/2025 included			who has not worked or received the	J1		
	•	aluate and effectiveness of			education will complete it upon the nex	αt		
	psychotropics.				schedule work shift. All newly hired			
					nurses, MAs and/or providers will be			
	An interview was c	onducted with the Director of			in-serviced by the SDC during orientati	on		
	Nursing (DON) on	02/06/2025 at 10:49 AM. The			regarding PRN Psychoactive Medication	nc		
	DON stated there v	was no rationale for the new			Monitoring.			
		mg PRN on 08/23/2024 and			The Quality Assurance Nurse (QA), Sta			
	_	extended automatically after			Development Coordinator (SDC), and/	or		
	the initial 14-day or	der.			Minimum Data Set Nurse (MDS) will			
					review all new orders for PRN			
	•	ew with Nurse Practitioner			psychotropic medications 5 times a we	ek		
	` '	ed on 02/07/2025 at 11:42 AM.			x 4 weeks then weekly x 4 weeks to			
		did write the PRN Ativan order			ensure PRN psychotropic medications			
		f 30 days and was not aware to be a rationale after the initial			were limited to a duration of 14 days			
		n the future, it will include the			unless the attending physician or prescribing practitioner documented the	0		
	rationale prior to ar				rational for the extended time in the	<u> </u>		
	Tationale prior to ai	r exteriaca oraci.			medical record and indicated the speci	fic		
	An interview with the	ne Administrator was			duration. The Quality Assurance Nurse			
		6/2025 at 12:53 PM. The			(QA), Staff Development Coordinator			
		d she was made aware that			(SDC), and/or Minimum Data Set Nurs	e		
	Resident #22 had a	a PRN medication without a			(MDS) will address all areas of concern			
	rationale for use af	ter the initial 14-day order and			identified during the audit to include			
	wanted her staff to	follow the regulations and			notification of the attending physician of	or		
	make sure the PRI	N medication had a rationale			prescribing practitioner for appropriate			
	prior to extension of	of the medication.			stop date or rationale for extended use	:-		
					The DON will review the audits to 5 times			
		as admitted to the facility on			a week x 4 weeks then weekly x 4 wee	ks		
		agnoses including dementia			to ensure all concerns are addressed.			
	with mood disturba	nces.			DON will present the findings of the			
					Psychoactive Audit Tool to the Quality			
		imum Data Set (MDS) dated			Assurance Performance Improvement			
		esident #47 coded as severely			(QAPI) committee monthly for 2 month			
	cognitively impaire	d			for review and to determine trends and			
					issues that may need further intervention	ons		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345491	B. WING _			02/0	07/ 2025
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		···=•=•
CROATAN	RIDGE NURSING AND	REHABILITATION CENTER			10 FOXHALL ROAD EWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	e 18	F 7	758			
		2024 had focus of use of ith the potential for side			put into place and to determine the nee for further frequency of monitoring.	ed .	
	12/27/2024 revealed needed for anxiety/ag	ce physicians order dated Ativan 1 milligrams (mg) as gitation for 90 days end of life cord did not contain a 14-day lication.					
	Record (MAR) review Ativan 1 mg as neede every 4 hours as nee 90 days end of life ca	Medication Administration variety revealed an order for ed. Give 1 tablet by mouth ded for anxiety/agitation for the medication was 8/2024, 12/29/2024 and					
	for Ativan 1 mg as ne mouth every 4 hours anxiety/agitation for 9	AR review revealed an order eded. Give 1 tablet by as needed for 00 days end of life care. The nistered 23 out of 31 days in					
	Nursing (DON) on 02 DON stated there wa PRN for Resident #4	ducted with the Director of /06/2025 at 10:49 AM. The s an order for Ativan 1 mg 7 on 12/27/2024 and it was ld have been an initial order					
	conducted on 02/06/2 stated she wrote the thought she could ex- psychotropic for more understands that it m	Medical Director (MD) was 2025 at 12:04 PM. The MD order for the PRN Ativan and tend an order for than 14 days. She now ust have an initial 14 days the resident with rationale and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345491	B. WING _			C 02/07/2025	
	ROVIDER OR SUPPLIER RIDGE NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 210 FOXHALL ROAD NEWPORT, NC 28570	ODE	V 2/0/12020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	MMARY STATEMENT OF DEFICIENCIES ID DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE		I	
F 758	Continued From page duration to extend ore will make sure it will be forward. An interview with the conducted on 02/06/2 Administrator stated It Resident #47 had a Finitial 14-day stop dat follow the regulations medication had an initial rationale and duration medication. Free of Medication Error of Medication Error of Medication Error of Medication The facility must ensure \$483.45(f)(1) Medication and the facility must	der. The MD also stated she be implemented going Administrator was 2025 at 12:53 PM. The ne was made aware that PRN medication without the e and wanted her staff to and make sure the PRN tial 14-day stop date and n prior to extension of the extension of the extension of the extension of the extension error rates are not 5 is not met as evidenced ens, record reviews, and staff failed to ensure it was free	F 7	758	lopment	3/10/25	
	of 6.9% for 2 of the 5 observed during med (Resident #44 and Re The findings included 1. Resident #44 was	g in a medication error rate sampled residents ication administration esident #45).		resident was provided with dose per physician orders. evening nurse applied the dosing card and instruction order. The On 2/7/24, the Staff Develor Coordinator (SDC) educate regarding validating order that does not clearly indica medication, dose/quantity, location to be applied, freq duration prior to administer	The assigned gel using the gel	ed e cian	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		345491	B. WING _			l	C /07/2025	
NAME OF PR	ROVIDER OR SUPPLIER	1	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		0112020	
					10 FOXHALL ROAD			
CROATAN	RIDGE NURSING AND	REHABILITATION CENTER			EWPORT, NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 759	Continued From page	e 20	F 7	759				
F 759	A review of Resident dated 02/07/2025 rev 1% Diclofenac Sodiu Apply to the left ankle pain/inflammation for 2.25 inches to site two An observation of Readministration on 300 02/07/2025 at 9:31 A medications for Residents room and bedside table on an observation of the Residents room and bedside table on an observation on her finger and approximation of the final f	#44s physician's orders vealed Voltaren external Gel m Topical (helps with pain). e two times a day for 10 days. Apply 2 grams or vice daily. esident #44s medication halls was conducted on M. Nurse #2 gathered dent #44 including Voltaren took medications in the sat the medications on the opened tissue. She ately a nickel amount of gel blied it to the Residents left not use the dosing card to	F 7	759	The in-service also included when a medication cream/gel has a dosing car the nurse should follow the instructions ensure appropriate dose is administered. The nurse verbalized understanding of education. On 2/6/25, the assigned nurse assisted resident #45 to rinse mouth per direction of the Director of Nursing. On 2/7/25 the Staff Development Coordinator (SDC) educated nurse #1 regarding Procedure for administering steroid inhalers with emphasis on ensuring residents who receive steroid inhalers are prompted to rinse mouth following administration of inhaler. The nurse verbalized understanding of the education. On 2/7/25, the DON, SDC, and Quality Assurance Nurse (QA) initiated an audiall current residents with orders for creams to ensure the order clearly indicates the medication, dose/quantity route or location to be applied, frequen and duration to be administered. The DON, SDC, and Quality Assurance Nur (QA) will address all concerns identified during the audit to include notification of the physician for clarification of the ord and updating the order when indicated The audit will be completed by 3/10/25 On 2/10/25, the DON, SDC, and Quality Assurance Nurse (QA) Medication Pas Audit with all nurses and medication aid to ensure (1) all medications were give per physician order and according to	it of it of cy, rse d of er		
	used every time the r	osing card needed to be medication was narmacist also stated there			established guidelines/procedures to include to prompting residents to rinse mouth following administration of stero	id		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345491	B. WING				07/2025	
NAME OF PE	ROVIDER OR SUPPLIER	0.0.0.	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	07/2025	
TAPAWIE OF TH	COVIDER OR GOLF EIER				10 FOXHALL ROAD			
CROATAN	RIDGE NURSING AND	REHABILITATION CENTER			EWPORT, NC 28570			
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F 759	Continued From pag	e 21	F 7	759				
	were no adverse effe	ects from the nickel size			inhaler and (2) the nurse/medication ai	de		
	amount of the medic	ation that was administered.			validates any order that does not clearl			
					indicate the medication, dose/quantity,			
	An interview with the	Director of Nursing (DON)			route or location to be applied, frequen	су,		
		2/07/2025 at 12:47 PM. The			or duration prior to administering			
		2 should have used the			medication (3) the nurse or medication			
	-	asured out the correct			aide utilized dosing cards when applyir	-		
	•	nistration. The DON also			creams/gels if indicated for correct dos	•		
		the nursing staff to follow the			per physician orders. The DON, SDC,	and		
		ere any concerns, then they			Quality Assurance Nurse (QA) will	areas of concern le assessment of		
	should have reported	il to ner.			immediately address all areas of conce			
	An interview with the	QI Nurse was conducted on			during the audit to include assessment resident when indicated, notification of			
		PM. The QI Nurse stated the			physician for any identified concerns,			
		ed and have checkoff skills			obtaining new orders when appropriate	ا		
		/ were supposed to use the			and education of staff. The audit will be			
	dosing card to meas				completed by 3/10/25.			
	· ·				On 2/7/25, the SDC an in-service with	all		
	An interview with the	Administrator was			nurses and medication aides regarding	j		
	conducted on 02/07/	2025 at 3:55 PM. The			Medication Administration to include the	е		
		she expected the nursing			six rights of a medication pass and			
		ers and measure the topical			administering medications according to	,		
		e dosing card that is included			established guidelines/procedures to			
	with the medication.				include prompting residents to rinse			
	0.0	1 20 10 0 6 22			mouth following administration of stero			
		admitted to the facility on			inhaler, validating order with physician			
	obstructive pulmonal	noses including chronic			does not clearly indicate the medication dose/quantity, route or location to be	1,		
	obstructive pulmonal	y disease (COPD).			applied, frequency, or duration prior to			
	Δ review of Resident	#45's physician's orders			administering medication. The in-service	`e		
		Advair 2 inhalation orally two			also included when a medication			
		D. Rinse the mouth with			cream/gel has a dosing card, the nurse	,		
	water after dose.				should follow the instructions to ensure			
					appropriate dose is administered.	ſ		
	An observation of Re	esident #45's medication			In-service will be completed by 3/10/25	i.		
	administration was c	onducted on 02/06/2025 at			After 3/10/25, any nurse or medication			
	9:36 AM. Nurse #1 g	athered medications and			aide who has not worked or received the	ne		
		e Advair and went into			education will receive it prior to the nex	t.		
	Resident #45's room	. The Nurse administered			scheduled work shift. All newly hired			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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		345491	B. WING _			02/07/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
CROATAN	I RIDGE NURSING AN	ID REHABILITATION CENTER		210 FOXHALL ROAD			
OKOAIAN	I KIDOL NOKOMO AK	D KENABIENATION SERVER		NEWPORT, NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 759	Continued From page	age 22	F 7	59			
F 759	the medications to assisted with the 2 Resident received signs or symptoms the room without a rinsing her mouth of the room without a rinsing her mouth of the room without a rinsing her mouth of the room with An interview with Resident was conducted on DON stated Nurse Resident #45 with after the use of Adshed in the room of the nursing staff to and if there were a report it to her. An interview with the old of the room o	the Resident and then inhalations of Advair. The the medications without any of distress and the nurse left ssisting the resident with with water. Surse#1 was conducted on AM. The Nurse stated she did dent with rinsing her mouth the there was no need to rinse vair. The Director of Nursing (DON) 02/07/2025 at 12:47 PM. The #1 should have assisted rinsing her mouth with water vair and could not explain why ON also stated she expected follow the physicians' orders my concerns, then they should the QI nurse was conducted on PM. The Nurse stated the ated and have checkoff skills ses were trained to assist with this mouths out after using the Administrator was 7/2025 at 3:55 PM. The ad she expected the nursing	F 7	nurses will be in-serviced by t during orientation regarding M Administration. The SDC and Quality Assurar (QA) will complete medication observations with 25% of all nurses/medication aides to ind #1 and nurse #2 utilizing the M Pass Audit Tool weekly x 4 we monthly x 1 month to ensure a medications were given per the of a medication pass, administ according to established guidelines/procedures to incluprompting residents to rinse in following administration of stethe nurse/medication aides varorder that does not clearly ind medication, dose/quantity, roulocation to be applied, frequer duration prior to administering and when a medication cream dosing card, the nurse follower instructions to ensure appropriadministered. The SDC and CAssurance Nurse will immedicated addressed all areas of concernaudit to include assessment of when indicated, notification of for any identified concerns, obsorders when appropriate and staff. The Director of Nursing review the Medication Pass A weekly x 4 weeks then month to ensure all areas of concerns.	Medication Ince Nurse In pass Iclude nurse Medication Iclude street Iclude nurse Medication Iclude street Iclude nurse Iclude nurse Iclude nurse Iclude nouth Iclude street Iclude Iclude nouth Iclude any Iclude any Iclude street Iclude or Incy, or Iclude medication Iclude street Icl		
				addressed. The DON will forward the result Medication Pass Audit Tool to Assurance Performance Impro	the Quality		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION 3	, ,	(X3) DATE SURVEY COMPLETED	
		345491	B. WING			C / 07/2025	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0112020	
CDOATAN	DIDGE NUDSING AND I	REHABILITATION CENTER		210 FOXHALL ROAD			
CROAIAN	RIDGE NORSING AND I	CHABILITATION CENTER		NEWPORT, NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 759	Continued From page	23	F 75	(QAPI) Committee monthly x 2 mor review and to determine trends and issues that may need further interve put into place and to determine the for further and / or frequency of monitoring.	l / or entions		
F 760 SS=D	Residents are Free of CFR(s): 483.45(f)(2)	Significant Med Errors	F 76	30		3/10/25	
	medication errors. This REQUIREMENT by: Based on record revi pharmacy staff intervi administer medication physician to meet res sampled residents rev services (Resident #2 The findings included	is not met as evidenced ew, resident, facility and ews, the facility failed to a as ordered by the ident's need of 1 of 5 viewed for pharmacy 8).		On 2/5/25, the Director of Nursing notified the physician that resident not receive scheduled Toujeo on 2/due to the medication not available facility. The resident was assessed no negative findings. A new order vobtained for a one-time dose of an alternative insulin and to restart Tou 2/6/25. Toujeo was administered pephysician order on 2/6/25. On 2/5/25, the DON educated nurs regarding the rights of Medication	#28 did 4/25 in the with vas ujeo on er		
	The quarterly Minimu assessment dated 2/4 was cognitively intact A review of the physic revealed Resident #2 Solostar Subcutaneous	A/25 revealed Resident #28 and coded for Insulin use. sian's orders dated 5/23/24 8 was prescribed Toujeo us Solution Pen-injector 300 Glargine) Inject 25 units dtime for diabetes.		Administration with emphasis on er the right medication is administered right time and Following Physician with emphasis on obtaining medica via eKit, back up pharmacy or notifi of the physician when meds cannot obtained/administered per physicia for further recommendations. On 2/5/25, the Social Worker initiat resident questionnaires regarding medication concerns to include not receiving medications that had not	I at the Orders tions cation be n order		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 02/07/2025	
		345491 B. V					
NAME OF PROVIDER OR SUPPLIER				STR	REET ADDRESS, CITY, STATE, ZIP CODE	02/	07/2025
NAME OF PROVIDER OR SUPPLIER							
CROATAN RIDGE NURSING AND REHABILITATION CENTER					FOXHALL ROAD WPORT, NC 28570		
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(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 760	Continued From page 24		F 7	60			
	Administration Recor	d (MAR) dated 2/4/25,			previously been addressed. The DON	will	
	revealed Resident #2	28 did not receive insulin			address all concerns identified during t	he	
	because the medicat	ion was not available.			audit to include assessment of the		
					residents, notification of the physician		
	In an interview with R	Resident #28 on 2/5/25 at			when indicated for further		
		ed he was concerned that he			recommendations and/or education of		
		on 2/4/25 at 8:00 p.m.			staff. The audit will be completed by		
		he was told by the nurse that			3/10/25.	_	
	the medication was n	ot available.			On 2/26/25, the DON initiated an audit	of	
	In an internal accordant N	#0 0/5/05 -+ 44.57			all current resident eMARs from		
	In an interview with Nurse #2 on 2/5/25 at 11:57 a.m. she stated she had just re-ordered Resident				2/1-2/26/25 to ensure medications to include insulin were available to be		
					administered per physician order or that	. +	
	#28s insulin and was not sure why the backup insulin was not administered on 2/4/25. During a telephone interview with Nurse #3 on 2/5/25 at 2:06 p.m. she revealed that Resident				the physician was notified when		
					medication was not available to		
					administer for further recommendation:	S.	
					The DON will address all concerns		
		empty when she was			identified during the audit to include		
	administering medica	itions on 2/4/25. She			assessment of the resident, notification	of	
	revealed she re-ordered the medication 2 nights prior but it had not been delivered by the pharmacy. She further stated she did not know she could use the backup kit medication because				the physician for further		
					recommendations, obtaining medicatio	ns	
					when indicated and education of staff.		
					The audit will be completed by 3/10/25		
	the medication was a				On 27/25, the administrative nurses to		
prescribed, Toujeo Solostar Pen-inje		olostar Pen-Injector.			include Quality Assurance (QA) nurse,	1	
	In an intension, with th	as Dharmasy Canaultant an			staff development coordinator (SDC) a	na	
		ne Pharmacy Consultant on ne revealed the facility made			minimum data set (MDS) audited all medications carts. This audit is to ensu	ro	
		the pharmacy on 2/4/25 at			medications to include insulins were	IE	
		e order was filled on 2/5/25			available to administer per physician		
		y on the same day in the			order. The Quality Assurance (QA) nur	se	
	evening.	, are carrie day in the			staff development coordinator (SDC) a		
	everining.				minimum data set (MDS) will address a		
	During an interview w	vith the Director of Nursing			concerns identified during the audit to		
	•	:46 p.m. she revealed			include obtaining medications from the		
	, ,	n had been re-ordered 2			eKit/back up pharmacy when indicated		
	days prior to 2/4/25 a			notification of the physician if medication			
	on back order. She s			cannot be obtained for further			
	Resident #28 missed his insulin. She further				recommendations and education of sta	ff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345491	345491 B. WING				C 02/07/2025	
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0172020	
				2	10 FOXHALL ROAD			
CROATAN	RIDGE NURSING AND I	REHABILITATION CENTER			NEWPORT, NC 28570			
(X4) ID PREFIX TAG	SUMMARY ST, (EACH DEFICIENC' REGULATORY OR L	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 760	Continued From page 25		F	760				
	stated the facility had	back up insulin available			The audit will be completed by 3/10/25			
	that the nurse could a	access to ensure there was			On 2/6/25, the Quality Assurance (QA)			
		stated that all nurses will be			nurse, staff development coordinator			
	retrained on re-orderi	ng medications timely.			(SDC) and minimum data set (MDS)			
		A			initiated Medication Pass Audits with al			
		ne Administrator on 2/7/25 at			nurses and medication aids. This audit	IS		
	•	she was unaware that			to ensure the nurse and/or medication aide (MA) administered medications pe	ar		
	Resident #28 did not receive his insulin on 2/4/25. She further stated that it was the responsibility of				the physician □s order/Rights of	71		
		DN if a resident has a lapse			Medication Administration or the physic	cian		
	in medication adminis				was notified when medication was not			
					available to administer for further			
					recommendation with documentation in	1		
					the electronic record. The Quality			
					Assurance (QA) nurse, staff developme			
					coordinator (SDC) and minimum data s			
					(MDS) will address all concerns identifi			
					during the audit to include assessment the resident, notification of the physicia			
					for further recommendations when	.11		
					indicated and/or education of staff. The	ا د		
					audit will be completed by 3/10/25. After			
				3/10/25, any nurse or medication aide				
					who has not worked or completed the			
					medication pass audit will complete it			
					upon the next scheduled work shift.			
					On 2/5/25, the SDC initiated an in-serv	ice		
					with all nurses and medication aides			
					regarding the (1) Rights of Medication Administration with emphasis			
					administration with emphasis administering the right medication at the	e		
					right time (2) Following Physician Orde			
					with emphasis on how to obtain	. =		
					medications from pharmacy, eKit or			
					backup pharmacy and notification of th	е		
					physician if medications cannot be			
					obtained to administer for further			
					recommendations. The in-services will			
					completed by 3/10/25. After 3/10/25, at	าy		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345491	B. WING			C 02/07/2025			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE	1 02/0	112025		
				210 FOXHALL ROAD					
CROATAN	I RIDGE NURSING AND	REHABILITATION CENTER		NEWPORT, NC 28570					
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE		
F 760	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26		F 7	PREFIX (EACH CORRECTIVE ACTION SHO			t vill work by the hts taff te 10 ifts d hen hsure on in ment a set tiffied ht of vhen per e of ass		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				С				
345491			B. WING _			02/	07/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STATE, ZIP CODE			
CROATAN	RIDGE NURSING AND I	REHABILITATION CENTER		210 FOXHALL	ROAD			
ONOAIAI	MIDGE NONGING AND	REHABIEHATION SERVER		NEWPORT, N	IC 28570			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 760	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F7	210 FOXHALL ROAD NEWPORT, NC 28570 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD		E COMPLETION DATE ator 8 De ne ot in ff all on ff. Not 8 e e e ind o in nly e to		