STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Currituck Health & Rehab Center	**3907 Caratoke Highway , Barco, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/1/2025 through 12/4/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1DC92B-H1.	E0000		12/16/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/1/2025 through 12/4/2025. Event ID# 1DC92B-H1. The following intakes were investigated: NC875507, NC875509, NC2582012, and NC2626168. 1 of the 8 complaint allegations resulted in a deficiency.	F0000		12/19/2025
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Responsible Party, Law Enforcement and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of property when a staff member (Nurse Aide #1) took checks from Resident #92 without her knowledge, cashed one of the checks for $1000.00, and attempted to cash additional checks. The deficient practice was for 1 of 1 resident reviewed for misappropriation of resident property (Resident #92). Findings included:	F0602	Deficiency Statement: Resident had checks stolen by an agency CNA. 1) Corrective Action Accomplished for the Resident(s) Affected: Resident no longer resides at facility as of 3/2/25. 2) How the Facility Identified Other Residents Having the Potential to Be Affected and the Actions Taken: Initiated a building wide audit of resident valuables and financial documents (including checkbooks) within 24 hours of the incident. 100% audit was completed of all staff to ensure background checks were current. All residents with a Brief Interview for Mental Status (BIMS) score of 13 or higher were interviewed to ensure that no other concerns were identified with finances or money. For residents with a BIMS score of 12 or less, family or responsible parties were called to ensure that they had no concerns with finances or missing money. Interviews were conducted by the Nurse management team and Department heads and completion date was October 25, 2024 with no other concerns identified.	12/19/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0602 SS = D	Continued from page 1 Resident #92 was admitted to the facility on 8/28/23. An initial allegation report dated 10/25/24 completed by the Former Administrator showed that she (the Former Administrator) received an email from the Responsible Party of Resident #92, who also had Power of Attorney, on 10/25/24. The Responsible Party of Resident #92 made the Former Administrator aware that someone had forged and cashed multiple checks from Resident #92's bank account. The report stated that the Responsible Party of Resident #92 did not accuse any one person and was working with the local police department who had initiated an investigation. A review of the 5-day investigation report dated 11/1/24 completed by the Former Administrator revealed that on 10/24/24 two officers from the local police department came to the building looking for a staff person. The investigation report stated that the staff person was Nurse Aide #1 who was not in the building at the time. The investigation report revealed that on 10/25/24 the Former Administrator received an email from the Responsible Party and Power of Attorney for Resident #92. The Responsible Party revealed in the email that Resident #92's checks had been taken and attempted to be cashed. The Responsible Party had notified the local police department, who had initiated an investigation and was working with the bank as well. The incident report stated that the Responsible Party of Resident #92 followed up with the Former Administrator in a phone call and revealed that Resident #92 had approximately five single checks with her at the facility. The Responsible Party informed the Former Administrator that Resident #92's bank account had been closed, and she was working with the bank and Currituck Sheriff Department regarding fraudulent charges. The incident report stated Nurse Aide (NA) #1 who was an agency staff, was suspended. Attempts made to contact NA #1 by phone on 12/3/25 and 12/4/25 were unsuccessful. A review of Resident #92's medical record revealed the resident expired at the facility on 3/2/25.	F0602	Continued from page 1 3) Education and Training: Facility reported the incident to local law enforcement, the State Survey Agency, and other applicable authorities in accordance with mandatory reporting requirements. Nurse Aide #1 was an agency Certified Nursing Assistant (CNA) and was no longer scheduled at the facility. Nurse Aide #1's agency was contacted and her services were terminated. Nurse Aide #1 was reported to the North Carolina Health registry and the misappropriation of property allegation against her was substantiated. All staff members were educated on facility abuse policy, misappropriation, and reporting procedures. In addition, an audit of 100% of employee files was conducted to ensure all background checks were completed. Education and audit was completed by October 28, 2024 by Nurse managers and Human Resources Director. All new hires will receive the Abuse (including misappropriation) education during new hire orientation going forward. If any agency staff are used going forward, facility will ensure completion of background checks for those agency staff members and will conduct additional abuse and misappropriation training. 4) Monitoring and Quality Assurance: Administrator or designee will conduct weekly random audits of resident property security x 12 weeks. QA Committee will review audit results monthly x 3 months and corrective actions will be documented and trended. Compliance date: December 19,2025.	

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F0602 SS = D	Continued from page 2 In an interview on 12/4/25 at 10:09 a.m. with Resident #92's Responsible Party, she revealed that 5 checks belonging to Resident #92 had been presented to the bank on various dates. She further revealed that the bank contacted her after one check for $1000.00 had been cashed and 4 more checks were awaiting clearance. Resident #92's Responsible Party stated that she stopped the rest of the checks and the bank refunded the money that had been lost. She stated she reported the matter to the local police department and was not sure what happened thereafter. During an interview on 12/4/25 at 9:15 a.m. with Law Enforcement Officer #1, he revealed Nurse Aide #1 was arrested and charged in connection with the fraudulent checks presented to the bank. Law Enforcement Officer #1 stated that the case was still active and that he could not provide further information at this time. During an interview with the Business Office Manager (BOM) on 12/3/25 at 11:02 a.m. she revealed that she was not aware Resident #92 had checks with her at the facility. She revealed they discourage residents from having cash, checks, or credit cards on their person. During an interview on 12/3/25 at 11:50 a.m. with the Regional Director of Clinical Services, she revealed that Resident #92's Responsible Party had reached out to the facility on 10/25/24 around 10:00 a.m. and stated that somebody was attempting to cash checks belonging to Resident #92. She disclosed that Resident #92's Responsible Party immediately sent the facility copies of the checks, and it was discovered it was Nurse Aide #1 who was involved with the misappropriation. She stated that Nurse Aide #1's agency was contacted and her services were terminated. She further revealed Nurse Aide #1 was reported to the North Carolina Health Registry and the misappropriation of property allegation against her was substantiated. During a telephone interview with the Former Administrator on 12/4/25 at 9:29 a.m. she revealed she was contacted by Resident #92's Responsible Party on 10/25/24 about checks that had been cashed belonging to Resident #92. The Former Administrator stated that the Responsible Party had already contacted the local police department about the suspected fraud. She stated that Resident #92's Responsible Party sent her copies of the checks and that's when she noticed that Nurse	F0602		

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F0602 SS = D	Continued from page 3 Aide #1 was involved. She disclosed that the nurse aide was terminated, and the police advised the facility not to interview the nurse aide involved. The Former Administrator stated that the Responsible Party informed her that Resident #92's bank paid back all monies taken from her account. She stated that the facility completed an internal investigation after making a report to the Division of Health Service Regulation. The facility submitted a corrective action plan that was not acceptable to the State Agency. The plan did not include how providing staff re-education on the abuse policy, misappropriation, and reporting procedures was going to prevent future misappropriation of property. Staff had been educated on these topics previously and misappropriation occurred. Additionally, the facility's monitoring plan did not address how the facility was going to prevent future misappropriation property.	F0602		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment (SCSA) after enrollment in a hospice program for 1 of 3 residents reviewed for death in the facility (Resident #6). Findings included: Resident #6 was admitted to the facility on 5/6/25 with a diagnosis of heart failure. A Long-Term Care Status Form dated 9/5/25 revealed Resident #6 was admitted to the hospice program at the	F0637	Statement of Deficiency The facility failed to complete a Significant Change in Status Assessment (SCSA) when a resident experienced a significant change in condition and was placed on hospice services. This omission resulted in noncompliance with CMS requirements and risked inaccurate care planning and assessment data. 1)Corrective Action for the Identified Resident Resident #6 is no longer a resident as of September 20, 2025. 2)Identification of Other Residents with Potential to Be Affected Conducted an audit of all residents currently receiving hospice services to verify that a Significant Change in Status Assessment was completed. No other concerns were identified. Completion Date: December 3, 2025. Responsible Party: Regional MDS Coordinator 3)Systemic Changes to Prevent Recurrence	12/19/2025

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F0637 SS = D	Continued from page 4 facility on 9/5/25. His level of hospice care was routine hospice. No SCSA was found in Resident #6's medical record. In an interview on 12/2/25 at 3:51 PM MDS Nurse #1 stated Resident #6 was admitted to hospice services at the facility on 9/5/25. She reported she would have been responsible for completing an MDS SCSA for Resident #6 when he began receiving hospice services. She indicated she had missed this. MDS Nurse #1 stated she could not say why this had been missed. On 12/2/25 at 3:57 PM an interview with the Administrator indicated if Resident #6 had a significant change in status, an MDS SCSA should have been completed.	F0637	Continued from page 4 Provided staff education on CMS requirements for SCSA, including triggers such as hospice enrollment. Completion Date: December 4, 2025. Responsible Party: Regional Director of Clinical Services 4)Monitoring to Ensure Ongoing Compliance Weekly audits of all residents admitted to hospice for four (4) weeks, then monthly audits for two (2) months. Audit results reviewed by the QAPI Committee and documented in meeting minutes. Responsible Party: MDS Coordinator / Designee Compliance Date: December 19, 2025	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty	F0641	Statement of Deficiency The facility failed to ensure the Resident Assessment accurately reflected the resident's PASRR status. Specifically, the Level II PASRR determination was not recorded in the Minimum Data Set (MDS)/RAI for Resident #40, resulting in noncompliance with CMS requirements. 1)Corrective Action for the Identified Resident Immediately obtained and verified the resident's Level II PASRR determination from the State PASRR authority. Updated the resident's MDS/RAI and EHR to include the Level II PASRR information and any associated recommendations. Completion Date: December 2, 2025. Responsible Party: MDS Coordinator 2)Identification of Other Residents with Potential to Be Affected Conducted a 100% audit of all current residents to verify PASRR documentation (Level II) in the EHR and MDS/RAI. No other discrepancies were noted.	12/19/2025

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F0641 SS = D	Continued from page 5 of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident (Resident #40) reviewed for PASRR. Findings included: Resident #40 was admitted to the facility on 3/1/21 with diagnoses including bipolar disorder and schizophrenia. Resident #40's PASRR Level II determination notice dated 3/12/21 revealed nursing home placement was appropriate. It included the specialized service determination of follow-up psychiatric services by a psychiatrist. This PASRR Level II determination notice had no expiration date. Resident #40's annual MDS assessment dated 2/28/25 revealed he was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. On 12/2/25 at 12:23 PM an interview with MDS Nurse #2 indicated she coded the PASRR section of Resident #40's MDS assessment dated 2/28/25. She stated Resident #40's PASRR status was Level II and she should have coded his annual MDS assessment to reflect his status, but she had not. She stated she had not coded Resident #40's annual MDS assessment dated 2/28/25 accurately. In an interview on 12/2/25 at 12:40 PM the Administrator stated Resident #40's MDS assessment should have been accurately coded.	F0641	Continued from page 5 Completion Date: December 2, 2025. Responsible Party: Regional MDS Coordinator 3)Systemic Changes to Prevent Recurrence Staff Education: Provided targeted training for MDS staff on PASRR requirements and documentation standards. Completion Date: December 4, 2025 Responsible Party: Regional Director of Clinical Services 4)Monitoring to Ensure Ongoing Compliance Weekly audits of all new admissions for PASRR compliance for four (4) weeks, followed by 5 random monthly audits for two (2) months. Results of Audit tool will be reported to the QAPI Committee x 3 months. Responsible Party: Regional MDS Coordinator / Designee Compliance date: December 19, 2025	
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails.	F0700	Statement of Deficiency The facility failed to document alternative interventions prior to the use of grab bars for a Resident #67. This omission does not comply with CMS requirements for assessing risks and considering less	12/19/2025

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F0700 SS = D	Continued from page 6 The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to attempt alternatives prior to the installation and use of bed rails and did not assess for risk of entrapment when completing assessments for 1 of 2 residents reviewed for bed rails (Resident #67). Findings included: Resident #67 was admitted to the facility on 5/28/22 with a diagnosis of hypertension. Resident #67's current comprehensive care plan revealed a focus area dated as initiated on 3/8/25 and last reviewed on 9/11/25 for bilateral quarter bed rails (bed rails which extend from the head of the bed to a quarter of the way down the bed) to promote bed mobility. The goal was for Resident #67 to not demonstrate a decline in bed mobility through the next review. An intervention was for staff to assist with bed mobility as needed. Resident #67's Minimum Data Set (MDS) assessment dated 7/16/25 revealed he was cognitively intact. He had no behaviors or rejection of care. He was independent with all bed mobility and transfers. He had no falls since his prior MDS assessment. Bed rails were not used as a	F0700	Continued from page 6 restrictive measures before implementing bed rails. 1)Corrective Action for the Identified Resident Reviewed the resident's care plan and documented all alternative interventions considered prior to grab bar use. Completion Date: December 4, 2025. Responsible Party: Director of Nursing (DON) 2)Identification of Other Residents with Potential to Be Affected Conducted an audit of all residents using bed rails to verify documentation of alternative interventions and risk assessments. Corrected any missing documentation immediately and updated care plans accordingly. Completion Date: December 12, 2025. Responsible Party: DON / Designee 3)Systemic Changes to Prevent Recurrence Provided mandatory training for nursing staff on CMS bed rail requirements and documentation standards. Completion Date: December 12, 2025. Responsible Party: DON / Designee 4)Monitoring to Ensure Ongoing Compliance Weekly audits of bed rail documentation for four (4) weeks, then monthly for two (2) months. Report findings to QAPI Committee and document in meeting minutes. Responsible Party: DON / Designee Compliance Date: December 19, 2025	

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F0700 SS = D	Continued from page 7 restraint. A physician's order for Resident #67 dated 7/31/25 was for quarter bed rails bilaterally to the head of his bed. An Observation Detail List Report for Resident #67 dated 8/13/25 at 11:31 AM titled "Enabler-Restraint Observation 2" completed by the Director of Nursing (DON) revealed the reason for bed rail use was that Resident #67 had a physician's order for quarter bed rails bilaterally due to weakness, had a medical condition, and they promoted independence. A list of potential negative outcomes including the potential for accidents related to bed rail use had been discussed with Resident #67. A list of potential benefits related to the use of bed rails including an increased feeling of safety and security had been discussed with Resident #67. The bilateral quarter bed rails did not restrict or prevent Resident #67's movement. Resident #67 was his own Responsible Party (RP) and had given verbal consent for the use of the quarter bilateral bed rails. There was no indication in the assessment that any alternatives to bed rail use had been attempted with Resident #67 and there was not an assessment for risk of entrapment included in this Enabler-Restraint Observation. Resident #67's quarterly Minimum Data Set (MDS) assessment dated 10/16/25 revealed he was cognitively intact. He had no behaviors or rejection of care. He had no functional limitation of range of motion in his upper or lower extremities. He was independent with all bed mobility and transfers. He had no falls since his prior MDS assessment. Bed rails were not used as a restraint. On 12/3/25 at 8:21 AM Resident #67 was observed asleep in his bed. Bilateral bed rails measuring approximately 12 inches tall and 24 inches long, made of metal and attached to Resident #67's bedframe were in the raised position at the head of his bed. On 12/4/25 at 12:12 PM Resident #67 was observed in his room his wheelchair. Bilateral quarter bed rails were observed in the raised position at the head of his bed. In an interview conducted at that time, Resident #67 stated he used bed rails to assist himself with turning and repositioning in bed, and for transfers when he got in and out of the bed. He reported he had the bed rails since he was admitted to the facility, and he had not tried any alternatives to bed rails. 12/03/2025 at 3:00 PM an interview with the Maintenance	F0700		

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F0700 SS = D	Continued from page 8 Director he recalled Resident #67 getting his bed rails about a year and a half ago. He stated he would have gotten the assessment from either therapy or nursing that let him know Resident #67 needed bed rails and was appropriate for bed rails and then he would have installed them. He reported he no longer had the work order for the bed rails. The Maintenance Director indicated he no longer had the nursing or therapy assessment, but he was sure either nursing or therapy would have this. He reported the bed rails on Resident #67's bed had been specifically designed by the manufacturer for that bed. He stated when he installed bed rails, he assessed for entrapment risk including making sure that the mattress had no gaps between the rails and the mattress, and at the foot or head of the rails. He reported he also conducted safety inspections of all bed rails monthly. On 12/3/25 at 2:37 PM an interview with the DON indicated she was not certain why Resident #67 had bed rails. She stated a lot of times, residents had these at the hospital and would then request them when the entered the facility. She reported if this had been the case with Resident #67, then he would have been given the bed rails. The DON stated she had not attempted any alternatives to bed rail use with Resident #67 when she completed his bed rail assessment dated 8/13/25. She reported bed rail assessments were conducted initially when the decision was made for bed rail use, and then at least quarterly. She further stated she did not see anywhere in Resident #67's record that alternatives to bed rail use had been attempted and had not met his needs. She reported maybe the therapy department had that information. On 12/3/25 at 2:33 PM an interview with the Therapy Director indicated nursing could do a bed rail assessment or the therapy could do a bed rail assessment and if bed rails were needed, the maintenance department would install the bed rails. She stated she was not able to find any bed rail assessment from the therapy department indicating the reason Resident #67 would benefit from bed rails or that any alternatives were attempted and failed to meet Resident #67's needs. On 12/4/25 at 12:25 PM an interview with the Administrator indicated the alternatives that had been attempted and how these had failed to meet Resident #67's needs prior to the use of bed rails should be available. She indicated nursing or the therapy department should have this. She reported if it was not, she wouldn't have any additional information.	F0700		