STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Rose Manor LLC	**4230 North Roxboro Street , Durham, North Carolina, 27704**

(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
F0000	INITIAL COMMENTS The survey team entered the facility on 12/8/25 to conduct a complaint investigation survey. The survey team was onsite on 12/8/25. Additional information was obtained offsite on 12/10/25 and 12/15/25. Therefore, the exit date was 12/15/25. Event ID# 1DDCD5-H1. The following intakes were investigated: NC002684775 and NC002684251. 2 of the 6 complaint allegations resulted in deficiency.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with residents, staff and Emergency Medical Technician (EMT), the facility failed to provide care in a safe manner when Resident #1 rolled off the bed to the floor while Nurse Aide #1 provided incontinence care for 1 of 3 residents reviewed for accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/3/25. Her current diagnoses included a wound on her left lower leg, anxiety disorder, and arthritis. Review of a social work progress note dated 12/3/25	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = D	Continued from page 1 indicated Resident #1 was cognitively intact. A nursing progress note dated 12/4/25 revealed while Nurse Aide (NA) #1 was changing Resident #1 she rolled out of bed, away from NA #1, and landed on the floor towards the wall. Resident #1 was lying on her left side. Staff were unable to get her off the floor because she was complaining of right knee pain. Emergency Medical Services (EMS) was called. The resident assisted with a lift to the stretcher and was transported to the local emergency department. Review of NA #1's written statement dated 12/4/25 revealed she had provided incontinence care to Resident #1. She reported she was going to assist Resident #1 after a countdown. NA #1 stated the resident pulled on the transfer bar prior to her getting to the window side of the bed. She stated Resident #1's legs went off the bed and then her body followed, with her face hitting the wall and she slid out of the bed. NA #1 stated the resident began yelling for help. She stated she then notified the nurse. A phone interview was conducted with NA #1 on 12/8/25 at 11:45 AM. She explained that when she assisted residents with turning, she would count backwards from three and then turn the resident (3,2, 1, then begin turning the resident). NA #1 stated she was going to assist Resident #1 with turning to provide incontinence care at the count of three. NA #1 stated on 12/4/25 she had not started the countdown from three when Resident #1 placed her left leg over her left foot and fell off the bed while holding the transfer bar. She reported she did not touch the sheet and had not attempted to turn the resident. NA #1 stated she planned to move from one side of the bed to the other prior to turning the resident. She reported she was on the door side of the bed and the resident fell towards the opposite side of the bed. NA #1 stated Nurse #1 came in and assessed the resident. She stated after Nurse #1 assessed Resident #1 she and another nurse aide (NA #2) were going to place the resident back in bed. NA #1 stated when they attempted to get the sling under her to use the lift, Resident #1 complained of knee pain. Nurse #1 then instructed the nurse aides to stop and contacted EMS. Attempts to contact NA #2 were unsuccessful. A statement written by Nurse #1 stated she was approached by NA #1 who stated Resident #1 was on the floor and had rolled off the bed. She assessed the resident who stated she had pain in her knees. She conducted neurological checks, and the resident did	F0689		

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F0689 SS = D	Continued from page 2 complain of pain in her knees of 7 out of 10. Nurse #1 stated she instructed NA #1 and NA #2 to place the resident back in bed. The resident complained of pain while the nurse aides were attempting to place her back in bed, so Nurse #1 decided to contact EMS. A telephone interview was conducted with Nurse #1 on 12/10/25 at 3:42 PM. She reported she assessed Resident #1 on 12/4/25, did not find any injury, and instructed NA #1 and NA #2 to place her back in bed afterwards. Nurse #1 stated Resident #1 began complaining of severe knee pain and she decided to contact 911 to transport Resident #1 to the hospital. Nurse #1 stated she could not comment on the incontinence care as she was unsure of what happened. A phone interview was conducted with Resident #1 on 12/8/25 at 11:32 AM who remained in the hospital. Resident #1 stated she was at the edge of the bed and rolled off when NA #1 pulled the sheet. Resident #1 reported NA #1 was nice the previous evening but appeared short and in a hurry the evening of 12/4/25. She reported she used the transfer bar (a sturdy mobility device designed to provide a secure handhold for individuals entering, exiting, or repositioning themselves in bed) on the side of bed and rolled away from NA #1. An Emergency Medical Technician (EMT) report dated 12/4/25 revealed Resident #1 stated she was dropped from her bed after requesting to do her rehabilitation exercises. She was on a lift mat when EMT staff arrived, and Resident #1 stated she had pain in her head and back. A telephone interview was conducted with Emergency Medical Technician (EMT) #1 on 12/10/25 at 3:00 PM. She stated Resident #1 complained of pain in her head and back. Review of emergency department admission record dated 12/4/25 revealed Resident #1 was evaluated for a fall. She complained upon admission of pain in her upper back, head and knees. A computed tomography scan of her head, an x-ray of her hip and laboratory testing was done for infection. All studies were negative. As of 12/11/25 hospital notes indicated Resident #1 refused to return to the facility and remained in the hospital awaiting an alternate placement An interview was conducted with the Director of Nursing on 12/8/25 at 3:05 PM. She stated NA #1 should have rolled Resident #1 towards her when providing incontinence care.	F0689		

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F0689 SS = D	Continued from page 3 During an interview with the Administrator on 12/8/25 at 2:05 PM he indicated NA #1 should have been at the correct side of the bed to roll Resident #1 towards her. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 12/4/25 Resident #1 experienced fall from a bed while Nurse Aide (NA) #1 was providing incontinence care. According to interviews conducted with Resident #1 and NA #1 Resident #1 was holding the grab bar when the fall occurred and NA #1 was on the opposite side of the bed at that time. NA #1 called for Nurse #1 and an assessment was completed. No gross injuries noted. Resident complained of generalized pain of a seven out of 10 in her knees. Neurological checks were within normal limits. When the nurse aides attempted to assist Resident #1 back to bed she complained of severe pain and Nurse #1 made the decision to call Emergency Medical Services. Nurse #1 remained with resident assessing and reassuring the resident. EMS transferred Resident #1 from floor to stretcher and Resident #1 then complained of pain of 10 of 10. Nurse #1 notified Resident #1's provider, resident representative, and Director of Nursing (DON). Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 12/4/25 the DON and Assistant Director of Nursing (ADON) reviewed the falls in the last six months. No other residents were identified as having experienced a fall from bed during care. The Nursing Home Administrator (NHA) reviewed the Grievance Log for the last six months with no concerns of accidents or injuries during care. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/4/25 the DON, ADON, and Unit Managers began education with the nursing staff (nurses and nurse aides) including agency staff on guiding the resident through provision of care before and as care was being provided and when turning the resident towards the staff member providing the care, turning towards	F0689		

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F0689 SS = D	Continued from page 4 oneself. Staff were educated to not to tilt resident more than 30 degrees if possible per policy and proper body alignment. Nursing staff was educated to kindly educate the resident not to assist during care unless and until instructed to do so. Nursing staff will not be permitted to work after 12/5/25 without having received the preceding education. Beginning 12/5/25 nursing orientation will be inclusive of the preceding education and will be educated by the DON or ADON prior to provision of care. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Observation audits began on 12/4/25 by DON/ADON and/or unit managers observing 15 nursing staff a week for 12 weeks on all shifts including agency staff. The staff will be observed to determine if when turning a resident to side lying position are staff tilting resident more than 30 degrees, turning the resident towards staff, was resident guided through provision of care and was resident educated not to assist during care unless instructed to do so. Results of the observation audits will be presented by the DON in the facility monthly Quality Assurance and Performance Improvement Committee Meeting monthly for three months. The Quality Assurance and Performance Improvement Committee will make recommendations, as needed, to assure compliance is sustained ongoing. Date of compliance:12/6/25 Validation was completed 12/8/25 and included staff interviews regarding the in-service training that was received to ensure understanding and knowledge of the training provided. Staff members interviewed stated they had received training. In-service training included turning and positioning policy and training on body alignment which consisted of turning the resident towards the staff member, guiding residents through care provision, and educating the resident to not assist until instructed. Inservice logs and the initial and ongoing audits were verified. There were no concerns identified. Observations of incontinence care revealed residents were instructed to roll towards the staff member assisting with incontinence care and to not assist with care until instructed to do so. The corrective action plan compliance date of 12/6/25 was validated.	F0689		