

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026
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NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids	STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870
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F0000	<p>INITIAL COMMENTS</p> <p>A complaint investigation was conducted on 03/10/26 through 03/11/26.</p> <p>The following intake was investigated: 2789474.</p> <p>1 of the 2 complaint allegations resulted in deficiency.</p>	F0000		04/02/2026
F0684 SS = D	<p>Quality of Care</p> <p>CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff, Resident Representative (RR), Nurse Practitioner (NP), and physician interviews, the facility failed to obtain a STAT (immediate or rapid response) mobile x-ray exam when Resident #1 fell and experienced left leg pain for 1 of 3 residents reviewed for falls.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility most recently on 02/03/26 with diagnoses that included, in part: End stage renal disease, primary pulmonary hypertension (admission diagnosis), chronic obstructive pulmonary disease, chronic respiratory failure, dependence on renal dialysis, congestive heart failure, paroxysmal atrial fibrillation, sick sinus syndrome, presence of cardiac pacemaker, essential primary hypertension, Type 2 Diabetes Mellitus, poly osteoarthritis, unsteadiness on feet, difficulty in walking, muscle weakness, and limitation of activities due to disability.</p>	F0684	<p>On 2/17/26 Resident #1 was immediately assessed after her return from dialysis by Director of Nursing. After assessment Director of Nursing informed Medical Director of residents left hip pain gave Director of Nursing an order to send resident to ECU Health North Emergency Department for further evaluation and immediate X ray for left leg pain. X ray results revealed a fracture of the left femoral neck/closed left hip fracture.</p> <p>On 3/11/26 the Regional Nurse Consultant reeducated the Director of Nursing on Radiology Services and timely follow up for routine and STAT X-Rays.</p> <p>On 3/20/26 the Director of Nursing identified all residents that have received a STAT chest Xray in the last 60 days have the potential to also be affected by the alleged deficient practice. The results included: 6 out of 16 residents received Stat Xray as ordered. On 3/20/26 the Director of Nursing implemented corrective action to ensure all Stat Xray orders were carried out timely. This was completed on 3/20/26.</p> <p>On 3/11/26, the Director of Nursing/Staff Development Coordinator started servicing all Licensed Nurses (including agency) on Timely processing of Stat X Rays. This training included all current Licensed Nurses including agency. This training included:</p> <p>Radiology Services Education – Radiology Orders, Routine Orders v/s Stat Xray orders (4-6 hours timeline).</p> <p>Required following-up timeline, documentation</p>	04/02/2026

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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F0684 SS = D	<p>Continued from page 1 Review of an admission Minimum Data Set assessment dated 11/19/25 revealed Resident #1 had severely impaired cognition. She could be understood and did understand others. She had no moods or behaviors. She had impairments to both upper extremities and no impairment to either lower extremity. She had no falls since admission. She received a mechanically altered, therapeutic diet. She had no pressure ulcers. Resident #1 had received anticoagulant medication. She denied pain at the time of the assessment. She received dialysis services. Resident #1 had received Speech Therapy, Occupational Therapy, and Physical Therapy during the assessment look back period. The family of Resident #1 provided the information for the assessment.</p> <p>Review of the care plan for Resident #1 last updated on 02/05/26 revealed the following problem: Resident at risk for falling related to debility and difficulty walking. The category was falls. The goal was for Resident #1 to remain free from falls with major injury with a target date of 05/05/26. Approaches included: 02/17/2026 actual fall, resident sent to emergency room for evaluation and treatment per physician order; therapy evaluation and treat as needed; staff to assist resident with transfers as needed; arrange for a clutter free environment as resident will allow; Keep personal items and frequently used items within reach; encourage and assist resident to assume a standing position slowly; and keep call light in reach.</p> <p>A progress note written by Nurse #2 on 02/16/26 at 7:20 AM was reviewed. Nurse #2 documented she was called to Resident #1's room by the nurse aide where she found Resident #1 laying on the floor. Nurse #2 documented that Resident #1 stated she slid off the bed while trying to sit on the edge. The Resident #1 denied hitting her head or hurting anywhere. The Resident #1 was assessed for any injuries and there were none. She was put back to bed by the nurse aides. Resident #1 was talking about going out to a store shopping during the assessment.</p> <p>An interview was conducted with Nurse #2 on 02/10/26 at 2:15 PM. Nurse #2 stated that she was the wound care nurse; however, staff had called her to Resident #1's room the morning of 02/16/26 because the other nurses were busy elsewhere. She explained Resident #1 was sitting on the floor when she arrived. She assessed the resident including range of motion on all extremities. She found no injury and the resident denied pain. She repeated that there were no indications that the resident had been injured. Nurse #1 recalled Resident #1 was talking about going shopping during the</p>	F0684	<p>Continued from page 1 expectations, abnormal or critical results</p> <p>As of 4/2/26, 0 staff members have not attended the in-service. The Director of Nursing and Staff Development Coordinator will ensure that all new hires and agency staff will not be allowed to work until the training is completed. This training was completed on 4/2/26.</p> <p>The Director of Nursing will monitor all Stat Xray orders weekly for 4 weeks and then monthly for 3 months using a Stat Xray Review QA tool. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the Weekly and Monthly Quality Assurance Committee Meeting. The Weekly Quality Assurance Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, Medical Records, Activities Director, Social Services, and the Dietary Manager.</p>	

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F0684 SS = D	<p>Continued from page 2 assessment.</p> <p>In a second interview with Nurse #2 on 03/11/26 at 10:05 AM she stated that she had called the RR on the morning of 02/16/26 after Resident #1 fell. Nurse #2 explained she informed the RR that Resident #1 had slid off the bed onto the floor and had not been injured. Nurse #2 stated the RR told her she would be in to see Resident #1 later and she would remind Resident #1 to call for assistance when she wanted to sit on the edge of the bed. Nurse #2 explained that when she documented the fall on the Event Report dated 02/16/2026 she accidentally typed that she notified the resident instead of the RR in error.</p> <p>Review of the Event Report dated 02/16/26 for Resident #1 revealed Nurse #2 documented that she had notified Resident #1 of the incident, not the RR.</p> <p>An interview was conducted with Nurse Aide #4 on 03/10/26 at 2:23 PM. She stated she was normally assigned to care for Resident #1. Nurse Aide #4 recalled she had just arrived at work on 02/16/26 at 7:00 AM when she heard Resident #1 holler, "Hello...Hello." When she went into the room, Resident #1 was on the floor. Nurse #1 came to the room and assessed Resident #1. Nurse Aide #4 remembered that Resident #1 had not complained of any pain as the nurse assessed her and she was able to move all her extremities.</p> <p>An interview was conducted with Nurse Aide #1 on 03/10/26 at 3:44 PM. She stated she helped to care for Resident #1 on 02/16/26 on the day shift. Nurse Aide #1 recalled she and another Nurse Aide #4 found resident #1 on the floor on the morning of 02/16/26. She explained that a third nurse aide on the hall went and got Nurse #1 who came immediately and assessed Resident #1. Once Nurse #1 completed a full body assessment and cleared the resident, she helped put Resident #1 back in bed. Nurse Aide #1 stated Resident #1 was not showing any signs of pain after the fall and she was not aware of any complaints of any pain during the shift on 02/16/26 from 7:00 AM – 7:00 PM while she was working. She recalled after the resident was put back in bed Resident #1 asked Nurse Aide #1 where was breakfast?</p> <p>A progress note was recorded as a late entry on 02/18/2026 at 9:32 AM for 02/16/26 at 11:18 PM by Nurse #1. Nurse #1 documented that she was called to Resident #1's room by the Nurse Aide because the resident had been found on the floor at her bedside facing the foot of the bed. Nurse #1 documented that on assessment</p>	F0684		

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F0684 SS = D	<p>Continued from page 3</p> <p>Resident #1 denied hitting her head, and had no bruising or bleeding noted. Nurse #1 assessed the resident for range of motion and the resident complained of left leg pain with no deformity noted. Nurse #1 notified the physician on call and received a new order for a STAT x-ray of the left leg and hip. Nurse #1 documented that she called the RR and made her aware of the findings and the new order.</p> <p>The following physician order for Resident #1 was reviewed: Radiology Order: 02/16/26 at 10:18 PM: STAT-immediately; Left Femur; Left Hip related to fall.</p> <p>Nurse #1 was not available for interview.</p> <p>The following progress note was documented by Nurse #3 on 02/17/26 at 4:25 PM: "This writer was informed from the (RR) that the resident had a fall over night and asked if the writer could come to help reposition the resident. When helping the resident to get repositioned back in the bed the (RR) stated that the resident stated that she was having pain to the left side of her leg. This writer asked the resident if she could put her hand where the pain was coming from, she then stated that she was not hurting but when being moved the resident did grimace. This writer first palpated the right leg; no pain then proceeded to the left leg the resident did not verbalize any pain but closed her eyes. This writer gave the resident Tylenol for pain. The residents (RR) got (Resident #1) ready for dialysis. The resident then was picked up by medical transport for dialysis. About an hour in a half before the resident was due back from dialysis the x-ray tech came to the unit and stated that she was at the facility to complete an x-ray of the resident left femur and bilateral hips. This writer informed the tech that the resident was out to dialysis and the tech then stated that the x-ray will be rescheduled for later that evening. The resident returned from dialysis about an hour early and was seen by the DON and then the MD (Medical Director). The MD advised that the resident be sent out to the ER (emergency room) for evaluation. (RR) was informed that the resident is being sent out to the ER for evaluation."</p> <p>In an interview with Nurse #3 on 03/11/26 at 2:41 PM she stated on the morning of 02/17/26 she did not complete an assessment on Resident #1 because Nurse #1 who was going off shift had reported to her that she had assessed the Resident #1 on her shift and had ordered a STAT x-ray. Nurse #3 stated that no range of motion assessment had been done prior to sending her to dialysis. She recalled that the RR was present on the morning of 02/17/26 and that she had helped the RR get</p>	F0684		

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F0684 SS = D	<p>Continued from page 4 the resident ready to go to dialysis. She helped the RR put a button down shirt on Resident #1 so that dialysis could access her intravenous port easier. Nurse #3 recalled Resident #1 had been sitting on the side of the bed joking with the RR and laughing prior to going to dialysis. Nurse #3 stated that at no time while they were dressing the resident to go to dialysis on the morning of 02/17/26 did the resident indicate she was in pain or even say, "ouch", when she was getting ready. Nurse #3 reported that the mobile x-ray technician came to the facility to do the STAT x-ray but Resident #1 had already went to dialysis. Nurse #3 stated that she had called the dialysis unit around 1:30 PM on 02/17/26 to check on Resident #1 because the RR had voiced concern that Resident #1 was in pain and was told by the dialysis nurse that Resident #1 slept through her treatment from her arrival until the time she called to inquire. Nurse #3 reiterated that the dialysis nurse did not report to her that the resident was in any pain.</p> <p>An additional interview with Nurse #3 was conducted on 03/11/26 at 3:34 PM at her request. Nurse #3 stated that she did remember that the RR had told her that she thought Resident #1 was in pain around 8:30 AM or 9:00 AM the morning of 02/17/26. Nurse #3 stated she did recall she went to the room and assessed Resident #1. Resident #1 told her she was not in pain. Nurse #3 stated she listened to her lungs, palpated her stomach, palpated both hip areas and moved both of her legs by bending each leg at the knee. She did not note any signs of pain as she assessed Resident #1. She stated it was at that point that she assisted the RR to change the residents shirt. She stated the RR asked her to medicate Resident #1 for pain and she did administer (2) Tylenol 325 Milligram pills to the resident but forgot to record the administration on the Medication Administration Record (MAR). Nurse #3 stated she felt Resident #1 was okay to go to her dialysis appointment.</p> <p>Record review of the February 2026 MAR for Resident #1 showed that no Tylenol medication had been administered to Resident #1 on 02/17/26.</p> <p>In an interview on 03/10/26 at 3:23 PM the Director of Nursing (DON) She stated that Resident #1's RR was at the facility the morning of 02/17/26 and requested that the resident be administered Tylenol for pain prior to going to dialysis. The DON explained that she told the daughter she would assess the resident herself when the resident returned from dialysis and that she would also call the dialysis unit while the resident was there to check her status. She reported that she had called the dialysis facility and was told by the dialysis staff</p>	F0684		

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F0684 SS = D	<p>Continued from page 5 that the resident was fine and was sleeping as usual with no complaints of pain. The DON stated when Resident #1 returned from dialysis she assessed the resident and found that when she attempted to rotate her left leg she grimaced and guarded her leg. The DON reported that she immediately called the provider and obtained an order to send the resident to the emergency room for an evaluation. The DON noted Resident #1 was sent to the emergency room that day at 4:41 PM. She stated she had interviewed Nurse #1 the morning of 02/17/26 and that Nurse #1 told her Resident #1 had been found on the floor the previous evening and when she assessed the resident she found no injury and the resident did not show any signs of pain during range of motion. Nurse #1 explained that she had called the provider and had received an order for a STAT x-ray. The DON stated STAT mobile x-rays were normally completed within 4 hours. She noted that when she called the mobile x-ray provider she was told the provider would have to conduct their own investigation to determine why the STAT x-ray was not completed. The DON explained that she had provided the mobile x-ray technicians with the code to unlock the facility doors but that she learned that the technician who responded to the STAT order was new, did not have the code to the door, and was not able to alert staff that she was there to do the x-ray because after repeated attempts no staff answered the doorbell or the phone. The DON stated that on 02/17/26 when the mobile x-ray technician returned to the facility at 3:01 PM to do the exam, Resident #1 was at dialysis. In an additional interview on 03/11/26 at 1:58 PM, the DON recalled that she had placed a call to the NP on the morning of 02/17/26 and explained that Resident #1 had not received the STAT x-ray that had been ordered the evening of 02/16/26. She reported that the NP told her that if Resident #1 was not in distress that it was okay for her to go to dialysis and get the x-ray later. The DON did not assess Resident #1 for pain at that time because she saw the resident sitting in her wheelchair and laughing as she waited to go to dialysis. She also clarified that she had mistakenly reported that she had called the dialysis unit to check on Resident #1 on 02/17/26 but had delegated the task to the staff nurse.</p> <p>Review of the Dialysis Handoff Communication Form dated 02/17/26 for Resident #1 documented the following problem during dialysis: "Continues to complain of left lower extremity pain during dialysis."</p> <p>An interview was conducted with the Dialysis Provider Clinical Coordinator on 03/11/26 at 11:03 AM. She stated on 02/17/26 that Dialysis Nurse #1 documented</p>	F0684		

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F0684 SS = D	<p>Continued from page 6</p> <p>Resident #1 complained of left lower leg pain and that Resident #1 requested to end her dialysis treatment 2.5 hours into the treatment. The Dialysis Provider Clinical Coordinator explained that Resident #1's normal dialysis treatment was 4 hours. She stated there were no other dialysis nurses notes for 02/17/26. She reported there was no documentation that indicated anyone from the nursing home had called to check on Resident #1 while she was there. She stated that Dialysis Nurse #1 who provided the dialysis treatment to Resident #1 was not available for interview.</p> <p>A Compliant/Grievance Report filed by the RR dated 02/17/26 was reviewed. The concern details were that the RR called with concerns related to Resident #1's falls thinking that all residents are sent to the emergency room after all falls. The DON was assigned to investigate the concern. The findings of the investigation were that the DON called the RR and explained she would herself would call dialysis to check on Resident #1 and would assess Resident #1 herself on return from dialysis. The results of actions taken were that dialysis reported Resident #1 was asleep as usual during treatment with no signs or symptoms of distress. On return Resident #1 was assessed. The physician gave an order to send Resident #1 to the emergency room for evaluation and treatment. The RR was made aware and was thankful. The RR had been contacted by telephone.</p> <p>An interview was conducted with the RR of Resident #1 on 03/10/26 at 11:18 AM. The RR noted that she had been notified of the second fall that had occurred at 10:18 PM on 02/16/26 but not the first fall earlier that day. The RR stated she had asked the nurse to send Resident #1 out to the hospital for evaluation after she fell on 02/16/26 at 10:18 PM but that the facility staff had not been in agreement to send her out. The RR stated that because it was late when she received the call she told the nurse she would come in the morning to see Resident #1. She explained when she arrived at the facility the next morning on 02/17/26 Resident #1 was moaning in pain and the nurse told her the facility was waiting on a mobile x-ray. The RR stated she asked for Resident #1 to receive Tylenol for pain, and Resident #1 was sent to dialysis. The RR explained that she then called the facility Corporate Complaint line and complained that Resident #1 had not been sent out to have an x-ray done at the hospital after she fell the night before. She stated that later in the day between 4:00 PM and 5:00 PM on 02/17/26 that the Director of Nursing (DON) called her and told her she had assessed Resident #1 and that the resident had been sent to the hospital for an assessment. The RR reported that she</p>	F0684		

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F0684 SS = D	<p>Continued from page 7 went to the hospital and discovered Resident #1 had to have surgery for a hip fracture. The RR stated she felt Resident #1 should have been sent to the hospital after she fell the night before on 02/16/26.</p> <p>An interview was conducted with the NP on 03/11/26 at 9:43 AM. He stated he had assessed Resident #1 on 02/16/26 during the day with the family present. He recalled the focus of the visit was complaints of gout pain in Resident #1's great left toe. The NP also stated he had checked her leg because she had fallen earlier that day and she had normal range of motion with no suspicion of a hip fracture and Resident #1 showed no signs of pain at that time. In an additional interview with the NP on 03/11/26 at 2:40 PM he stated he had not seen or assessed Resident #1 on 2/17/26 after the second fall the previous evening. He noted there were no triage communication notes documented for 02/17/26. He checked his personal cell phone and reported that he had received a call from the facility on 02/17/26 at 10:53 AM but did not recall the conversation. The NP explained had the facility used the preferred method of communication through the physician triage center there would have been a recording of the conversation, but they had contacted him on his personal phone which was not preferred for this reason. He reviewed all the diagnoses for Resident #1 and stated that because she did have a fractured hip when she was transferred to dialysis she was at risk for becoming short of breath or for having a cardiovascular event (heart problem). The NP noted that Resident #1 had not experienced either risk as a result of a delay in treatment for a fractured hip.</p> <p>An interview was conducted with the Medical Director on 03/11/26 at 1:58 PM. He stated that he had not seen or assessed Resident #1 on 02/16/26 or 02/17/26. He explained that a hip fracture could be a life threatening situation but that hip fractures were also sometimes left to heal without surgery in residents with dementia. He stated after reviewing the medical notes he did not feel any further damage had been caused by a delay in treatment in this situation with Resident #1.</p>	F0684		