STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING ______ B. WING ______	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 EAST FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced reccertification survey was conducted on 1/5/2025 through 1/8/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# AAHC11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 1/5/2025 through 1/8/2025. Event ID# AAHC11.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		1/29/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/25/2025

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.

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F 623	Continued From page 1 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 2 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of a resident transfer for 2 of 3 residents reviewed for hospitalization (Resident #35 and Resident #11). The findings included: 1. Resident #35 was admitted to the facility on	F 623	Ftag 623 Notice Requirements Before Transfer Discharge Corrective action for resident involved On 1/23/25The Director of Nursing and Social Services notified the Omsbudman in writing of all transfers and discharges out of the facility for the last 6 months.	

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F 623 Continued From page 3
5/31/24.

a. The nursing progress note dated 8/03/24 at 10:22 pm revealed Resident #35 was transferred to the hospital for further evaluation.

Resident #35 was discharged from the facility on 8/03/24 and returned to the facility on 8/12/24.

Review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was not notified of Resident #35's transfer to the hospital on 8/03/24.

b. The nursing progress note dated 9/16/24 at 4:29 am revealed Resident #35 was transferred to the hospital for further evaluation.

Resident #35 was discharged from the facility on 9/16/24 and returned to the facility on 9/26/24.

A review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was not notified of Resident #35's transfer to the hospital on 9/16/24.

A telephone interview was conducted on 1/07/25 at 9:44 am with the Ombudsman who revealed she did not receive notification from the facility of Resident #35's hospital transfers on 8/03/24 or 9/16/24.

An interview was conducted with the Social Service Director on 1/07/25 at 10:06 am who revealed she started in the position in July 2024, and she stated she had been running the wrong report to send to the Ombudsman since that time. She stated when she ran the report to send to the Ombudsman, the report did not show any

F 623

On 1/22/25 The Sr. Social Services Director re educated the Social Services Director on how to pull the report, when to submit the report, and who and how to submit the report to timely.

Corrective action for potentially impacted residents
All residents that have been transfer and discharge have the potential to be affected by the alleged deficient practice. On 1/23/25 the Director of Nursing and Social Service Director reviewed the last 6 months of transfers and discharges to ensure any missed notifications to Ombudsman. Were sent per policy and regulation. This review was completed on 1/23/25. All missed notifications were sent on 1/23/25, by the Director of Nursing.

Systemic Changes On 1/22/25, the Senior Social Services Director in serviced the facility Social Services Director on The Importance of ensuring the Omsbudsman
notification is sent timely and efficiently per policy and procedure.
- How to pull the report, when to submit the report, and who and how to submit the report to timely.
This education was completed on 1/22/25.

Quality Assurance The Administrator will monitor the Transfer and Discharge Notifications to the Ombsudman bi weekly for 2 weeks, then weekly times 8 weeks, and then monthly times 2, thereafter

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F 623	Continued From page 4 resident transfers or discharges from the facility. The Social Service Director stated she was recently shown how to run the correct report to send to the Ombudsman for resident transfers. A telephone interview was conducted on 1/08/25 at 9:34 am with the Corporate Social Service Director who revealed she provided education to the current Social Service Director which included how to pull the transfer report, when to submit the report, and who to submit the report to. The Corporate Social Service Director stated she was not aware the facility's Social Service Director did not know how to pull the correct report. During an interview on 1/08/25 at 11:29 am with the Administrator she revealed she was not aware the Social Service Director did not know how to run the correct report to send to the Ombudsman, but she stated education would be provided. 2. Resident #11 was admitted to the facility on 10/28/20. a. The change in condition assessment dated 10/21/24 revealed Resident #11 was sent to the Emergency Department due to abnormal vital signs. Record review of the nursing progress notes revealed there was no documentation Resident #11's Ombudsman received written notification of the reason for transfer to the Emergency Department. b. The change in condition assessment dated 4/25/24 revealed Resident #11 was sent to the Emergency Department due to abnormal breathing and verbally responsive.	F 623	using the facility Omsbudman notification QA Tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F 623	Continued From page 5 Record review of the nursing progress notes revealed there was no documentation Resident #11's Ombudsman received written notification of the reason for transfer to the Emergency Department. An interview was conducted with the Social Services Director on 1/07/25 at 10:06 a.m. who revealed she started in the position in July 2024, and she stated she had been running the wrong report to send to the Ombudsman since that time. She stated that when she ran the report to send to the Ombudsman, the report did not show any resident transfers or discharges from the facility. The Social Service Director stated she was recently shown how to run the correct report to send to the Ombudsman for resident transfers In an interview with the Director of Nursing (DON) on 1/8/24 at 9:00 a.m. she stated it was the responsibility of the Social Services Director to send the notification of discharge for Resident #11 to the Ombudsman. She stated she was not aware the notification was not sent to the Ombudsman. During an interview with the interim Administrator on 1/8/24 at 11:38 a.m. he revealed it was the responsibility of the Social Services Director to send notification of discharges to the Ombudsman every month. He further stated the Social Services Director will receive retraining to ensure compliance with the requirement.	F 623		
F 637 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	F 637		1/29/25

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F 637

Continued From page 6

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 interviews, the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment for 1 of 23 residents whose MDS assessments were reviewed (Resident #56).

Findings included:

Resident# 56 had been admitted to the facility on 10/20/24 with diagnoses of malignant neoplasm.

Resident #56"s admission MDS was dated 10/20/24 and identified Resident #56 as cognitively intact had a tracheotomy (a surgical opening in the neck to provide air into the lungs) and revealed she was not receiving hospice services.

Review of Resident# 56's medical record revealed a Physician order dated 11/21/24 to admit resident to Hospice related to the terminal diagnosis of malignant neoplasm, if the disease runs normal course life expectancy is 6 months or less.

Review of Resident# 56's medical record revealed no documentation that a MDS significant

F 637

F tag 637 Comprehensive Assessment After Significant Change

Corrective action for resident involved
Resident #56 Significant change assessment was completed on 1/8/25 by MDS Nurse.

On 1/8/25 the MDS Nurse #1 and #2 was reeducated by the Regional Clinical Reimbursement Specialist

Corrective action for potentially impacted residents On 1/8/25 the Regional Clinical Reimbursement Specialist audited all current residents on hospice that has the potential to be affected by the alleged deficient practice. The results included: 0 out of 2 hospice residents required a significant change assessment.

On 1/8/25 the Clinical Reimbursement Specialist implemented corrective action to ensure the Significant Change assessment is completed in a timely

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F 637	Continued From page 7 change in status assessment had been completed to reflect Resident #56 was receiving Hospice Services. An interview was conducted on 1/08/24 at 9:00 AM with the MDS Nurse #1 who stated Resident #56 should have had a significant change in status assessment completed when she began Hospice Services. An interview was conducted on 1/08/24 at 11:06 PM with the Administrator who stated the MDS Nurse should have reviewed Resident #56 for a significant change in status assessment when she elected Hospice services.	F 637	manner. Systemic Changes On 1/8/25, the Regional Clinical Reimbursement Specialist in serviced the MDS nurses on When to do a Significant Change This training included: 03. Significant Change in Status Assessment (SCSA) (A0310A = 04) The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change. • An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the	

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F 637	Continued From page 8	F 637	initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. • If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0110K1. Completing an Admission assessment followed by an SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required. • An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the	

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F 637	Continued From page 9	F 637	certification of terminal illness; or 3) the date of the physician’s or medical director’s order stating the resident is no longer terminally ill. • If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0110K1. Completing an Admission assessment followed by an SCSA is not required. Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required. • The ARD must be less than or equal to 14 days after the IDT’s determination that the criteria for an SCSA are met (determination date + 14 calendar days) • The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than. • When an SCSA is completed, the nursing home must review all triggered care areas compared to the resident’s previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the	

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F 637	Continued From page 10	F 637	supporting documentation can be located in the medical record. • The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion. • The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days). Quality Assurance The Clinical Reimbursement Specialist or designee will monitor compliance utilizing the F641 Quality Assurance Tool weekly x 4 weeks and monthly x 3 months. The tool will monitor facility identified concerns that need to be addressed by the QA committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly Quality Assurance meeting, indefinitely or until no longer deemed necessary for compliance with the MDS process. The weekly quality assurance meeting is attended by the Administrator, Director of Nursing, MDS	

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F 637	Continued From page 11	F 637	coordinator, Therapy Manager, Medical Records, and the Dietary Manager.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of dialysis (Resident #15 and Resident #70), use of a wander elopement alarm (Resident #57), use of hypoglycemic medication (medication that help lower blood sugar levels in people diagnosed with diabetes) (Resident #44), for 4 of 23 residents whose MDS assessments were reviewed. The findings included: 1. Resident # 15 was admitted to the facility on 8/28/24 with diagnoses which included end stage renal disease and dependence on dialysis (treatment to filter wastes and water from the blood). Review of the hospital discharge summary dated 9/10/24 revealed Resident #15 was hospitalized on 9/03/24 for acute kidney injury. Resident #15 was seen by the Nephrology (a specialized physician focused on kidney function) and was noted to have improved kidney function and dialysis was discontinued. Resident #15 was discharged back to the facility	F 641	1. Corrective action for resident (s) affected by the alleged deficient practice: On 1/6/2025 resident #44 Section N on the MDS was Modified to ensure accuracy On 1/7/2025 resident #70 Section O on the MDS was Modified to ensure accuracy On 1/7/2025 resident #15 Section O on the MDS was Modified to ensure accuracy On 1/7/2025 resident #15 Section O on the MDS was Modified to ensure accuracy On 1/6/2025 resident #57 Section P on the MDS was Modified to ensure accuracy The following education was provided to the MDS Nurses regarding accurate coding of residents Insulin, dialysis, and wander guard coding on 1/8/2025 Provided by: Lisa Gipson, Clinical Reimbursement Specialist 2. Corrective action for residents with the potential to be affected by alleged deficient practice: • On 1/8/2025 the Clinical Reimbursement Specialist audited the last 14 days of resident assessment for accuracy on Section N, O, and P.	1/29/25

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SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 EAST FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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F 641	Continued From page 12 on 9/10/24 with no orders for dialysis treatment. Resident #15 had an active physician order dated 9/14/24 to monitor for bruit (a whooshing sound heard at the fistula site with a stethoscope) and thrill (vibration caused by blood flow felt with fingers) to shunt every shift in right arm. A review of Resident #15's medical record revealed no physician order for dialysis. Review of the Nurse Practitioner (NP) progress note dated 10/02/24 revealed Resident #15 was hospitalized on 9/03/24 through 9/10/24 and was noted to have been seen by nephrology to have improved kidney function and no longer required hemodialysis. The Minimum Data Set (MDS) significant change assessment dated 12/06/24 and completed by MDS Nurse #1 revealed Resident #15 was coded for dialysis. An interview was conducted on 1/07/25 at 2:44 pm with MDS Nurse #1 who revealed she must have assumed Resident #15 received dialysis treatment because she saw the physician order for monitoring the shunt site. MDS Nurse #1 stated she coded Resident #15's MDS assessment in error. During an interview on 1/07/25 at 12:35 pm the Director of Nursing (DON) revealed Resident #15 had not received dialysis treatments while he resided at the facility and did not have physician orders for dialysis. An interview was conducted with the Administrator on 1/08/25 at 11:28 am who stated	F 641	Findings 0 out of 25 MDS assessments need to be modified. These audits were completed on 1/8/2025. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/8/2025. The Clinical reimbursement Specialist in-serviced the MDS nurses on the accuracy of assessments Education: Section Z- Assessment Administration Z400. Signature of persons completing the assessment or entry/death. Reporting I certified that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate quality care, and as a basis for payment for federal funds. I further understand that payment of such federal funds and continued participation in the government funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil and or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on	

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F 641

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the MDS Nurse was responsible to ensure resident assessments were coded accurately.

2. Resident #57 was admitted to the facility on 6/04/24 with diagnoses which included vascular dementia.

Resident #57 had an active physician order dated 6/04/24 for wander guard alarm placement to right wrist.

Review of Resident #57's Medication Administration Record (MAR) for December 2024 revealed the wander guard alarm was in place as ordered.

The Minimum Data Set (MDS) quarterly assessment dated 12/26/24 revealed Resident #57 was not coded for use of a wander or elopement alarm.

An observation on 1/05/25 at 12:59 pm revealed Resident #57 was noted to have a wander guard alarm bracelet on the right wrist.

An interview was conducted on 1/07/25 at 2:47 pm with MDS Nurse #1 who revealed she was aware Resident #57 was a wanderer and had a wander guard in place. MDS Nurse #1 stated she just missed it when she completed Resident #57's assessment.

An interview was conducted with the Administrator on 1/08/25 at 11:28 am who stated the MDS Nurse was responsible to ensure resident assessments were coded accurately.

3. Resident #44 was admitted to the facility on 12/02/22 with diagnoses which included diabetes.

F 641

its behalf.

RAI Manual Chapter 3 Section N:
Insulin coding
High risk drug classes
o Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
o Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class.
N0415J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
RAI Manual Chapter 3 Section O:
Dialysis
Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0520A (Parenteral/IV), O0110H (IV medications), or O0110I (transfusions). This item may be coded if the resident performs their own dialysis. — O0110J2, Hemodialysis Check when the dialysis was

F 641

Continued From page 14

Resident #44 had an active physician order dated 4/30/24 for insulin glargine (long-acting insulin) 100 units per milliliter (ml). Administer 24 units once a day at bedtime.

Resident #44 had an active physician order dated 4/30/24 for insulin glargine100 units per ml. Administer 28 units once a day scheduled to be administered between 7:15 am through 11:00 am.

Review of Resident #44's Medication Administration Record (MAR) for October 2024 revealed the insulin glargine was administered as ordered.

The Minimum Data Set (MDS) quarterly assessment dated 10/17/24 revealed Resident #44 was not coded for use of hypoglycemic medication.

An interview was conducted on 1/07/25 at 2:41 pm with MDS Nurse #1 who revealed the normal process she used to complete the assessment included reviewing the medical record for pertinent information needed to code the assessment. MDS Nurse #1 stated she just missed Resident #44's hypoglycemic medication when she completed the assessment.

During an interview with the Administrator on 1/08/25 at 11:28 am who stated the MDS Nurse was responsible to ensure resident assessments were coded accurately.

4. Resident # 70 was re-admitted to the facility on 12/03/24 from a hospital. His cumulative diagnosis included end stage renal dialysis with dependence on renal dialysis.

F 641

hemodialysis. In hemodialysis the patient’s blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood. — O0110J3, Peritoneal dialysis Check when the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) serves as a filter to remove the waste products and excess fluid from the blood.
RAI Manual Chapter 3 Section P: Restraints
Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident’s clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident’s assistive device (e.g., walker, wheelchair, cane) or other belongings.

4. Monitoring Procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Clinical Reimbursement Specialist or designee will monitor compliance utilizing the F641 Quality Assurance Tool weekly x

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F 641	Continued From page 15 Review of the nurse note dated 11/29/24 revealed Resident #70 was sent to Dialysis this morning and has not returned on his usual schedule. The nurse called the hospital and found out that the resident has been transferred from dialysis and admitted to the hospital for sepsis. The physician was made aware. Resident #70 was discharged back to the facility on 12/03/24 with no orders for dialysis treatment. Review of Resident #70's Minimum Data Set (MDS) assessment dated 12/07/24 did not indicate he had end stage renal disease or was receiving renal dialysis services. An interview was conducted on 1/07/25 at 1:50PM with MDS Nurse #1 who revealed the MDS should have been coded to indicate Resident #70 was receiving dialysis. An interview was conducted on 1/07/24 at 3:33 PM with the Director of Nursing who revealed Resident #70, was listed as a resident who received Dialysis. She reported that staff failed to pull the dialysis order back up when he returned from the hospital. An interview was conducted on 1/08/24 at 11:06 PM with the Administrator who stated the MDS Nurse was responsible for ensuring resident assessments were coded accurately.	F 641	4 weeks and monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly Quality Assurance meeting, indefinitely or until no longer deemed necessary for compliance with the MDS process. The weekly quality assurance meeting is attended by the Administrator, Director of Nursing, MDS coordinator, Therapy Manager, Medical Records, and the Dietary Manager.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		1/29/25

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F 656	Continued From page 16 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 17 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Responsible Party (RP) interviews, the facility failed to develop a person-centered care plan for 1 of 1resident reviewed for activities (Resident #44). The findings included: Resident #44 was admitted to the facility on 12/02/22 with diagnoses which included stroke and dementia. Review of the Minimum Data Set (MDS) annual assessment dated 1/04/24 and completed by MDS Nurse #2 revealed Resident #44 had severe cognitive impairment. Resident #44 reported the following activity preferences were very important: books, newspapers, and magazines to read, listen to music, religious services, and be outdoors for fresh air when weather was good. Review of the Life Enrichment Record for October 2024 through January 2025 revealed Resident #44 refused participation in group activites when offered and one to one (1:1) room visits were conducted daily. Resident #44's 1:1 activities included sports and devotionals on television and listening to music. Resident #44's care plan last reviewed on 1/03/25 revealed no care plan related to activity preferences.	F 656	Corrective action for resident involved Resident #44 received a person-centered care plan on 1/22/25 completed by 1/22/25. On 1/23/25 facility MDS Coordinator reeducated the Activities Director on Resident centered care plans are to be initiated/updated on completion of assessments. Corrective action for potentially impacted residents On 1/22/25 the Regional Clinical Reimbursement Specialist audited all current residents that has the potential to be affected by the alleged deficient practice. The results included: 44 out of 73 Activity Care plans were person center. On 1/24/25 the Clinical Reimbursement Specialist implemented and completed corrective action to ensure all Activity Care Plans were person centered. Systemic Changes On 1/23/25, the MDS Coordinator in serviced the Activity #1 and Activity #2 and MDS #2 on developing person centered care plans related to activities. This training included: ¿ All residents are to have a Life Enrichment assessment completed on Admission, Annually, Quarterly & with	

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F 656	Continued From page 18 Observations were conducted of Resident #44 on 1/05/25 at 1:46 pm, 1/06/25 at 1:14 pm, 1/07/25 at 8:07 am and 1:49 pm, and 1/08/25 at 10:30 am. Resident #44 was noted to be in the room with the television on during all observations. During an interview with Resident #44's Responsible Party (RP) on 1/05/24 at 2:41 pm she revealed she was not sure what kind of activities the facility provided for Resident #44. The RP stated she normally visited in the afternoons, and she did not observe Resident #44 involved in any activities when she was at the facility. An interview was conducted with the Activity Director on 1/06/25 at 2:59 pm who revealed she had worked at the facility for over one year. She stated she visited with Resident #44 daily and would offer to participate in the group activities but he would refuse. The Activity Director stated she completed 1:1 room visits for Resident #44 which included sports and devotionals on television, and he enjoyed music. The Activity Director stated she had not done resident care plans since she started working at the facility, but she was just shown how to create a care plan and will start doing the care plans. During an interview on 1/07/25 at 2:44 pm with MDS Nurse #2 who revealed the Activity Director was responsible for implementing the activity focused care plan for Resident #44. An interview was conducted with the Administrator on 1/08/25 at 11:22 am who revealed the Activity Director was responsible for creating the activity care plan for Resident #44, but she expected the MDS Nurses to assist with	F 656	Significant Changes. ¿ Resident centered care plans are to be initiated/updated on completion of assessments. Quality Assurance The Clinical Reimbursement Specialist or designee will monitor compliance utilizing the F656 Quality Assurance Tool weekly x 4 weeks and monthly x 3 months. The tool will monitor facility identified concerns that need to be addressed by the QA committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly Quality Assurance meeting, indefinitely or until no longer deemed necessary for compliance with the MDS process. The weekly quality assurance meeting is attended by the Administrator, Director of Nursing, MDS coordinator, Therapy Manager, Medical Records, and the Dietary Manager.	

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F 656	Continued From page 19 care plans when needed.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to obtain a physician order for tracheostomy (a surgical opening through the front of the neck into the windpipe for an air passage to help breathe) care for 1 of 2 residents reviewed for tracheostomy (Resident #35). The findings included: Resident #35 was admitted to the facility on 5/31/24 with diagnoses which included tracheostomy. The nursing progress note dated 11/23/24 revealed Resident #35 was transferred to the hospital on 11/23/24 and returned to the facility on 12/04/24. Resident #35 had a physician order dated 12/04/24 for oxygen via tracheostomy collar at 28% humification with 5 liters per minute continuously.	F 695	Ftag 695 Respiratory Tracheostomy Care and Suctioning Corrective action for resident involved On 1/8/25 The Director of Nursing received a physician order from MD for resident #35 for Tracheostomy Care. On 1/8/25 The Director of Nursing re-educated Unit Manager #1, Nurse #3, and Nurse #5 on the Importance of ensuring all resident with tracheostomies have appropriate physician orders for care every shift and as needed. This education was completed on 1/8/25. Corrective action for potentially impacted residents On 1/9/25 the Director of Nursing and Nursing Administration audited all current residents in the facility with a tracheostomy to ensure all received and had appropriate physician orders for care per policy and resident need.	1/29/25

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Resident #35 had a physician order dated 12/04/24 to assess for need of suctioning tracheostomy every shift.

Review of Resident #35's physician orders revealed no physician order for tracheostomy site care.

Review of the Treatment Administration Record (TAR) for December 2024 and January 2025 revealed no documentation for tracheostomy site care for Resident #35.

Review of the care plan last reviewed 12/11/24 revealed Resident #35 was at risk for adverse outcomes related to tracheostomy with interventions which included tracheostomy stoma care per physician orders.

The Minimum Data Set (MDS) quarterly assessment dated 12/11/24 revealed Resident #35 was coded for tracheostomy care, suctioning, and oxygen use.

An observation was conducted on 1/05/25 at 11:37 am of Resident #35 who was noted to have a tracheostomy opening, without a tracheostomy tube, and oxygen at 5 liters per minute supplied via tracheostomy collar.

An interview was conducted with Nurse #5 on 1/05/25 at 1:16 pm who was assigned to Resident #35. Nurse #5 revealed Resident #35 did not use a tracheostomy tube, but she has oxygen to the tracheostomy collar. Nurse #5 stated she provided tracheostomy care to Resident #35 which included cleaning around the tracheostomy site, and she stated the care was

F 695

The result was: 2 out of 2 tracheostomy residents received and had appropriate physician orders for care per policy. This was completed on 1/9/25.

Systemic Changes On 1/23/25 all Licensed nurses (to include Agency) were reeducated on the importance of ensuring all residents with Tracheostomies received appropriate physician orders for care . This was completed on 1/24/25.

As of 1/24/25 , 0 licensed nurses (to include Agency) have not received the in-service on Importance of receiving appropriate orders for Tracheostomy care from the MD. The Director of Nursing will ensure that any of the above-identified staff who do not complete the in-service training by 1/24/25 will not be allowed to work until the training is completed.

Quality Assurance The Director of Nursing or designee will monitor for Tracheostomy Care Orders in the facility Daily Clinical Meeting M-F. This will occur weekly for 4 weeks and then monthly for 3 months using a Residents Tracheostomy care monitoring QA tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS

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F 695	Continued From page 21 provided at least once a shift. Nurse #5 stated Resident #35 also received suctioning of the tracheostomy as needed. An interview was conducted with Nurse #3 on 1/08/25 at 9:21 am who revealed she performed tracheostomy care on her shift for Resident #35 which included cleaning the tracheostomy opening with sterile water and skin care around the tracheostomy site. Nurse #3 stated Resident #35 normally required suctioning once per shift dependent upon the amount of secretions present. During an interview on 1/08/25 at 10:14 am with Unit Manager #1 revealed Resident #35 received tracheostomy care once a shift. Unit Manager #1 confirmed Resident #35 did not have a physician order for the tracheostomy care but stated the order should have been entered when Resident #35 was admitted. Unit Manager #1 reported orders were reviewed in the clinical meetings, but she stated Resident #35's tracheostomy care order was just missed. An interview was conducted on 1/08/25 at 11:50 am with the Director of Nursing (DON) who revealed the Unit Manager was responsible to enter the initial admission orders and the admission packet was then reviewed in the clinical morning meeting. The DON was unable to state how Resident #35's tracheostomy care order was missed.	F 695	Coordinator, Therapy, HIM, and the Dietary Manager.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		1/29/25

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SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 EAST FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 22 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident receiving dialysis had a physician's order for dialysis. This was for 1 of 2 sampled residents reviewed for receiving dialysis. (Resident #70). The findings included: Resident # 70 was admitted to the facility on 11/7/24 with cumulative diagnosis that included end stage renal dialysis with dependence on renal dialysis. Resident # 70's care plan dated 11/12/24 noted he had a diagnosis of chronic renal failure and has the potential for complications from hemodialysis. Staff were to provide communication with dialysis center regarding medication, diet, and lab results. Coordinate resident's care in collaboration with dialysis center, check shunt site for signs/symptoms of infection, pain, or bleeding daily and as needed, Notify MD (Medical Doctor) to absence of thrill or bruit. Review of the nurse note dated 11/29/24 revealed Resident #70 was sent to Dialysis this morning and had not returned on his usual schedule. The nurse called the hospital and found out that the resident had been transferred from dialysis and admitted to the hospital for sepsis. The physician was made aware.	F 698	Ftag 698 Dialysis Corrective action for resident involved On 1/07/25 The Director of Nursing received dialysis physician orders for resident #70. On 1/23/25 The Regional Nurse Consultant re educated the Director of Nursing on the Importance of ensuring all residents on Dialysis have appropriate physician orders. Corrective action for potentially impacted residents All residents on dialysis have the potential to be affected by the alleged deficient practice. On 1/25/25 the Regional Nurse Consultant reviewed all residents receiving dialysis orders to ensure they had appropriate dialysis physician orders. Findings were: 2 out of 2 had appropriate dialysis orders. This review was completed on 1/25/25. Systemic Changes On 1/23/25, the Director of nursing/or designee in serviced all licensed Nurses on the importance of ensuring all dialysis residents receive appropriate dialysis orders and review of the policy. This education was completed on 1/24/25.	

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F 698	Continued From page 23 Resident #70's readmission orders dated 12/03/24 did not include an order for dialysis. Review of Resident #70's Minimum Data Set assessment dated 12/07/24 did not indicate he had end stage renal disease or was receiving renal dialysis services. Review of the nurse's note dated 12/22/24 at 12:24 PM documented Resident #70 returned from dialysis via stretcher with no distress noted. The Resident was safely put back to bed, will continue plan of care. Able to make needs known to staff. An interview with Unit Manager #1 on 1/07/24 at 3:35 PM revealed there was no order for his dialysis. She indicated Resident #70 had gone out to the hospital and on his return his dialysis order was not picked back up. An interview was conducted on 1/07/24 at 3:33 PM with the Director of Nursing who revealed Resident #70, was listed as a Dialysis resident. She reported that staff failed to pull the dialysis order back up when he returned from the hospital. An interview was conducted on 1/08/24 at 11:06 PM with the Administrator who stated staff should have seen Resident #70's physician order for dialysis.	F 698	As of 1/24/25 , 0 licensed nurses (to include Agency) have not received the in-service on Importance of receiving appropriate orders for dialysis care from the MD. The Director of Nursing will ensure that any of the above-identified staff who do not complete the in-service training by 1/24/25 will not be allowed to work until the training is completed. Quality Assurance The Director of Nursing or designee will monitor all Dialysis residents physician orders to ensure presence and appropriateness. This will be documented on the facility Dialysis QA tool. This will be completed weekly for 8 weeks, then monthly times 2. Using the facility Dialysis Physician Orders QA Tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		1/29/25

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F 761	Continued From page 24 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to (1) label and date an open insulin injector pen and an open albuterol inhaler (Unit 3) and failed to refrigerate a medication according to the manufacturer's recommendation (Unit 1) for 2 of 2 medications carts reviewed, and (2) failed to ensure 1 of 3 wound treatment carts were secured while unattended (Unit 3). The findings included: 1.a. During an observation of the Unit 3 medication cart with Unit Manager #1 on 1/07/25 at 2:00 pm the following was observed. Unit Manager #1 confirmed all findings before the	F 761	Ftag 761 Label/Storage Drugs and Biologicals Corrective action for resident involved On 1/7/25 the Unit Manager removed the Insulin Injector pen, albuterol inhaler (Unit 3), unrefrigerated medication, and eye drops to appropriately disposed of them to ensure they could not be used. On 1/8/25 the Director of Nursing ensured all treatment and medications cart were locked when unattended. Corrective action for potentially impacted residents On 1/8/25 the Director of	

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F 761	Continued From page 25 removal of the items. One insulin lispro (rapid-acting insulin used to manage diabetes) injector pen was in the back of the top drawer, open with no open date noted and no resident identifiers. The label read expires 14-days after opening. The insulin lispro injector pen was not stored in the same location as the current residents insulin injector pens. One albuterol (a medication to relax the muscles in the airways used for asthma and chronic obstructive pulmonary disease) 90 microgram inhaler was observed open, with no open date or resident identifiers. An immediate interview was conducted with Unit Manager #1 who revealed the insulin injector pen should not have been in the medication cart without resident identification and dated when opened. Unit Manager #2 and this surveyor confirmed the insulin lispro injector pen was opened but unused with the orange stopper at the base of the pen below the beginning line of insulin. Unit Manager #1 stated the albuterol inhaler may have been brought in from a resident's home because the facility did not use that type of inhaler, but she stated it should not have been in the medication cart. An interview was conducted on 1/07/25 at 3:41 pm with Nurse #1 who was assigned to Unit 3 medication cart who revealed she did not know the medications were in the cart and she stated she did not use any medications that were not labeled with a resident name. During an interview with the Director of Nursing (DON) on 1/08/25 at 11:44 am she revealed all	F 761	Nursing and Nursing Administration audited all medication carts, medication rooms, and treatment carts to ensure no further inappropriate biologicals were present and checked to ensure all carts/med rooms locks were functioning and in good condition. This was completed on 1/8/25. Systemic Changes On 1/8/25 All Licensed nurses were reeducated on Secured Medication/ Label/Storage Drugs and Biologicals per company policy. This was completed on 1/20/25. As of 1/21/25, 0 licensed nurses have not received the in-service on Label/Storage Drugs and Biologicals. The Director of Nursing will ensure that any of the above-identified staff who do not complete the in-service training by 1/24/25 will not be allowed to work until the training is completed. Quality Assurance The Director of Nursing and Nursing Administration will monitor Secured Medication Storage/Labeling Drugs and Biologicals. This will occur weekly for 4 weeks and then monthly for 3 months using a Secured Medication Storage monitoring QA tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM,	

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F 761	Continued From page 26	F 761		

nurses were responsible for making sure the medication carts did not have medications without resident identifiers and that all medications required an open date. She stated the Unit Managers conduct weekly audits, and the pharmacy also conducted auditing of the medication cart, so she was unable to state how the medications were missed in the cart.

b. During an observation of the Unit 1 medication cart with Unit Manager #1 on 1/07/25 at 2:20 pm the following was observed. Unit Manager #1 confirmed the finding before the removal of the item.

One squeeze bottle of netarsudil ophthalmic solution (eye drop used to lower pressure inside the eye, used treat glaucoma) unopened with a label on the container that read keep in refrigerator. The manufacturer's storage recommendations for an unopened netarsudil ophthalmic solution were to be stored in the refrigerator at 36 to 46 degrees Fahrenheit.

An immediate interview was conducted with Unit Manager #1 who revealed the ophthalmic solution should have been stored in the refrigerator until it was ready to be used.

During an interview on 1/08/25 at 11:44 am with the Director of Nursing she revealed the nurses were responsible for checking the medication carts to ensure all medications were stored as recommended.

2. An observation on 1/08/25 at 8:00 am on Unit 3 revealed the wound treatment cart was unattended and unlocked with the lock in the outward position. The wound treatment cart was

and the Dietary Manager.

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F 761	Continued From page 27 located across from the nursing station and the facility vending machines. The Administrator and Nurse #2 were observed to be at the nursing station. The Administrator approached this surveyor, and an observation of the wound treatment cart was conducted in the presence of the Administrator. The wound treatment cart was noted to contain resident creams and ointments, medicated dressings, and treatment supplies. The Administrator stated she believed the wound treatment cart was left unlocked for the night shift in the event something was needed but she would check with the Director of Nursing. On 1/08/25 at 8:02 am the Administrator returned to the treatment cart and pushed the lock in to secure the wound treatment cart. The Administrator stated she would try to find out who left the wound treatment cart unlocked. An interview was conducted on 1/08/25 at 8:07 am with Nurse #2 who confirmed she was assigned to Unit 3 on 1/07/25 during the 7:00 pm through 7:00 am shift. Nurse #2 stated she did not use the wound treatment cart during her shift, but she stated another nurse did come over and took something from the wound treatment cart when she started her shift and must have left the cart unlocked. Nurse #2 stated had she had not gone over to the wound treatment cart during her shift and did not notice it was unlocked until reported by this surveyor. During an interview on 1/08/25 at 8:05 am the Director of Nursing (DON) stated the wound treatment cart was to be locked when unattended and all nursing staff knew to lock the cart.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		1/29/25

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F 812	Continued From page 28 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent the potential cross contamination of food by failing to clean 1 of 1 plate dispenser and failed to clean the shelf under the steam table for 1 of 1 steam tables observed. These practices had the potential to affect food served to residents. The findings included: 1. During the lunch meal observation on 1/6/25 at 12:14 PM the tray line area was observed. The two-cylinder plate dispenser was observed with dark dried food particles in the bottom of both cylinders and the plate tray had dried liquid stains.	F 812	Ftag 812 Food Procurement Store Prepare Serve Sanitary Corrective action for resident involved On 1/8/25 the District Dietary Manager and Certified Dietary Manager cleaned the plate dispenser and the 6ft area under the steam table. On 1/24/25 the District Dietary Manager ensure these areas were added to the Dietary daily cleaning schedule. This was completed on 1/24/25. Corrective action for potentially impacted residents On 1/23/25 the Director of Operations completed a Dietary Sanitation audit to ensure all areas of the kitchen	

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F 812

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An observation on 1/07/25 at 3:14 PM revealed the two-cylinder plate dispenser was observed in the same condition.

An interview was conducted with the District Dietary Manager on 1/08/24 at 9:45 AM. She indicated that the two-cylinder plated dispenser was kept plugged in at all times and staff overlooked cleaning inside the cylinders.

2. Observations of the kitchen were conducted on 1/07/25 at 3:14 PM, and 1/08/25 at 9:34 AM, and revealed the 6-foot shelf under the steam table was observed to be covered with dark dried food particles.

An interview was conducted on 1/08/25 at 9:48 AM with the Certified Dietary Manager (CDM). She stated she had a weekly cleaning schedule, and the steam table was included in that schedule.

An interview was conducted with the District Dietary Manager on 1/08/24 at 9:45 AM. She indicated that the two-cylinder plated dispenser was kept plugged in at all times and staff overlooked the weekly cleaning of the plate dispenser.

An interview was conducted on 1/08/25 at 11:02 AM with the Administrator. She stated the dietary staff should keep all areas in the kitchen clean and include the plate dispenser and steam table shelves to the cleaning schedule.

F 812

remains sanitary and free from dried food particles.
On 1/24/2025 the District Dietary Manager reaudited each area to ensure corrections were complete.

Systemic Changes On 1/8/25, the District Dietary Manager in serviced all Dietary staff to include all cooks and dietary aides. This training included:

¿ Manager will be delegating, cleaning assignments to each dietary employee. Huddles will be conducted daily to ensure proper cleaning breakdown before employees clock out, the Manager will walk though to make sure it□s done correctly, two-cylinder plate dispenser 6ft shelf under the steamtable.

As of 1/24/25, 0 staff members have not attended the in-service. The Certified Dietary Manager will ensure that any new dietary staff going forward, will receive this education prior to starting work.
Quality Assurance The facility Administrator will monitor the Dietary Daily Cleaning 3 times a weekly for 2 weeks, 1 time a week for 2 weeks, and then monthly for 3 months using a Dietary Cleaning Observation QA tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS

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F 812	Continued From page 30	F 812	Coordinator, Therapy, HIM, and the Dietary Manager.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to ensure garbage was contained in a closed dumpster and doors were kept closed for 1of 2 dumpsters observed. The findings included: An observation of the dumpster area was conducted on 1/07/24 at 8:07 AM. Dumpster #1 was observed with a large bag of garbage hanging out of the dumpster lid and 2 disposable gloves were on the ground behind the dumpster. An observation of the dumpster area with the Dietary District Manager was made on 1/07/24 at 3:03 PM. Dumpster #1 lid was open, and the right-side door was open. There were 3 disposable gloves, a soda bottle and straw papers loose on the ground surrounding Dumpster #1. In an interview on 1/07/24 at 3:29 PM the Dietary District Manager revealed the dumpster area had been cleaned that morning and the Waste company had emptied the trash and not picked up what was dropped. In an interview with the Administrator on 1/08/24 at 11:10 AM revealed all staff were responsible	F 814	Ftag 814 Dispose Garbage and Refuse Corrective action for resident involved On 1/8/25 the District Dietary Manager ensured the dumpster areas was free from trash and debris. Corrective action for potentially impacted residents On 1/23/25 the Director of Operations completed a Dietary Sanitation audit to ensure all areas of the dumpster remain free from trash and debris. On 1/24/2025 the District Dietary Manager reaudited each area to ensure corrective action. Systemic Changes On 1/8/25, the District Dietary Manager in serviced all Dietary staff to include all cooks and dietary aides. This training included: ¿ Manager will be delegating, cleaning assignments to each dietary employee. Huddles will be conducted daily to ensure proper cleaning breakdown before employees clock out, the Manager will walk through to make sure it□s done correctly to include dumpster and areas	1/29/25

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F 814	Continued From page 31 for the dumpster area and had been educated to keep the area clean. In an interview on 1/08/24 at 1:28 PM the Corporate Administrator indicated that a staff member should be assigned to inspect the dumpster area daily to keep the area clean and the doors closed.	F 814	around it are kept sanitary. As of 1/24/25, 0 staff members have not attended the in-service. The Certified Dietary Manager will ensure that any new dietary staff going forward, will receive this education prior to starting work. Quality Assurance The facility Administrator will monitor all dumpsters three times a weekly for 2 weeks, 1 a week for 2 weeks, and then monthly for 3 months using a Dumpster Observation QA tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this	F 838		1/29/25

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F 838	Continued From page 32	F 838		

assessment.

§483.71(a) The facility assessment must address or include the following:
§483.71(a)(1) The facility's resident population, including, but not limited to:
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;
(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;
(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and

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	345336	A. BUILDING ______ B. WING ______	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 EAST FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 33 those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets	F 838		

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F 838	Continued From page 34 necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to annually review and update the facility assessment, which had the potential to affect 80 of 80 residents in the facility, and to ensure the facility assessment identified and addressed the care required for the population of residents with a tracheostomy (Resident #35 and #56). The findings included: Review of the most recent facility assessment	F 838	Ftag 838 Facility Assessment Corrective action for resident involved On 1/27/25 the current Facility Administrator updated the Facility Assessment. This was completed on 1/28/25. The updated facility assessment was reviewed by Quality Assurance Performance Improvement Committee on 1/28/25.	

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F 838	Continued From page 35 revealed the assessment period was from January 1 through December 31, 2023. This facility assessment indicated there were no residents who required tracheostomy care. A review of the medical records revealed Resident #35 and Resident #56 had tracheostomies and required tracheostomy care. The facility could not provide documents to demonstrate it had reviewed and updated the facility assessment since 2023. An interview conducted with the Administrator on 1/6/25 at 9:42 a.m. revealed it was her responsibility to ensure a review of the facility assessment was conducted annually and updated to reflect accurate information to include the care required for the resident population. She stated she was not aware the facility assessment was not current and forgot to conduct a review of the assessment in 2024.	F 838	Corrective action for potentially impacted residents On 1/23/25 the Administrator reviewed the facility assessment to identified all inaccurate or outdated information. On 1/28/25 the Administrator implemented corrective action to ensure the facility assessment was up to date and accurate. Systemic Changes On 1/21/25, the Corporate Nurse Consultant in serviced the new facility Administrator on the requirements of keeping the facility assessment up to date and accurate. This training included but not limited to: The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. This education was completed by 1/23/25. Quality Assurance The Director of Nursing will monitor all surgical wounds weekly for four weeks and then monthly for three months using a Facility Assessment QA tool. Reports will be	

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F 838	Continued From page 36	F 838	presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	