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 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Roanoke Rapids	**305 East Fourteenth Street , Roanoke Rapids, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/04/26 through 05/07/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 230567-H1.	E0000		05/15/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/04/26 through 05/07/26. Event ID# 230567-H1. The following intakes were investigated: 2793750, 2744181, 2743171, 2717934, 2693754, 2674936, 2662707, 2659713, 2637165, 2624302, and 2625193. 1 of the 29 complaint allegations resulted in deficiency.	F0000		05/15/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #17 continues to reside in the facility and remains in stable condition. On 5/7/26 Resident #17's Minimum Data Set (MDS) Section N 0415E was modified and transmitted to Center for Medicare and Medicaid Services (CMS) by MDS RN to reflect the use of an anticoagulant. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/7/26 the Clinical Reimbursement Specialist completed an audit of most recent MDS for all current residents on anticoagulant medications to ensure N 0415E is accurately completed. One (1) additional resident was found to have inaccurate coding for anticoagulation use. The Clinical Reimbursement Specialist RN modified and transmitted to Center for Medicare and Medicaid Services (CMS) Section N0415 reflecting use of anticoagulant.	05/27/2026

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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F0641 SS = D	Continued from page 1 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of the use of an anticoagulant medication for 1 of 30 residents whose MDS assessments were reviewed (Resident #17). The findings included: Resident #17 was admitted to the facility on 4/17/26 with diagnoses which included cerebrovascular accident (CVA). Resident #17 had an active physician order dated 4/17/26 for dabigatran (an anticoagulant medication) 150 milligram (mg) capsule; give one capsule twice a day by mouth. The order was noted as on hold for 4/18/26 and 4/19/26. The Medication Administration Record for April 2026 revealed the anticoagulant medication was administered to Resident #17 as ordered twice a day on 4/20/26, 4/21/26, 4/22/26, and 4/23/26. The Minimum Data Set (MDS) admission assessment dated 4/23/26 revealed Resident #17 was not coded for the use of an anticoagulant medication during the 7-day look back period. A telephone interview was conducted with MDS Nurse #2 on 5/07/26 at 10:23 am. MDS Nurse #2 reviewed the electronic health record and confirmed that Resident #17 had been administered the anticoagulant medication during the 7-day look back	F0641	Continued from page 1 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/7/26, the Clinical reimbursement Specialist completed education with the MDS nurses regarding accuracy of assessments, the RAI Manual Chapter 3 Section N0415E for MDS and the importance of reviewing all documentation during MDS look back period. After 5/7/26 any newly hired MDS nurses will be educated by the Clinical Reimbursement Specialist or designee during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Clinical Reimbursement Specialist will monitor three (3) residents' Section N0415E (anticoagulant) compliance utilizing the F641 Quality Assurance Tool, weekly for four (4) weeks, and monthly for two (2) months. The Clinical Reimbursement Specialist will present the findings of audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Date of Compliance: 5/27/26	05/27/2026

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F0641 SS = D	Continued from page 2 period of the admission assessment. MDS Nurse #2 stated when she completed the MDS assessment for Resident #17 she missed the use of the anticoagulant medication and did not code the assessment accurately for the use of the medication. The Administrator was interviewed on 5/07/26 at 2:31 pm. The Administrator stated MDS Nurse #2 was responsible for making sure Resident #17's MDS assessment was coded correctly when it was completed.	F0641		05/27/2026
F0695 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 observations, record review, and staff interviews the facility failed to post cautionary and safety signs indicating the use of supplemental oxygen for 2 of 3 residents reviewed for respiratory care (Resident #1 and Resident #17). The findings included: During the survey entrance conference with the Administrator on 5/04/26 at 10:10 am the Administrator reported the facility was a smoking facility. 1. Resident #1 was admitted to the facility on 4/21/26 with diagnoses which included chronic obstructive pulmonary disease and dependence on supplemental oxygen. Resident #1 had a physician order dated 4/21/26 for oxygen therapy; oxygen via nasal cannula (NC) at 3 liters per minute continuous every shift for hypoxia (low levels of oxygen in the body tissue).	F0695	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents #1 and #17 continue to reside in the facility and remain in stable condition. On 5/7/26 The Director of Nursing ensured residents #1 and #17's oxygen signage was posted on the door frame outside of the residents' doors. On 5/7/26 the Director of Nursing initiated education with Unit Managers #1 and #2 on the importance of ensuring all residents who utilize oxygen have signage posted outside of their door. Education was completed on 5/8/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/7/26 the Director of Nursing and Nursing Administration audited current residents who utilize oxygen to ensure oxygen signage was posted on the door frame outside the residents' doors. Two (2) of 19 residents were identified as not having oxygen signage posted. The Director of Nursing posted signage on the door framed outside of the residents' doors. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/7/26 the Director of Nursing initiated education with all licensed nurses, medication aides and nurse aides regarding oxygen signage on the door frame of residents' rooms for all residents who utilize oxygen. Education was completed on 5/20/26. After 5/20/26 any newly hired licensed nurses, medication aides and/or nurse aides will be educated by the Staff Development Coordinator. Any agency nursing staff will be educated by the Director of Nursing or	05/27/2026

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F0695 SS = D	Continued from page 3 Resident #1's census history revealed a room change had occurred on 4/26/26. Observations were conducted on 5/04/26 at 10:46 am and 2:37 pm of Resident #1. Resident #1 was observed in bed with supplemental oxygen in place. Resident #1 did not have the cautionary and safety signage posted that indicated supplemental oxygen was in use. During an interview on 5/07/26 at 9:37 am with Unit Manager #2 confirmed she was responsible for Resident #1's unit. Unit Manager #2 revealed that all residents that used supplemental oxygen should have the safety oxygen in use sign posted on the door frame. Unit Manager #2 stated any staff member was able to put the oxygen in use signage up on Resident #1's door when supplemental oxygen was used. Unit Manager #2 stated that Resident #1 had a recent room change and the safety signage must not have been moved to the new room when the room change was completed. The Director of Nursing (DON) was interviewed on 5/07/26 at 2:03 pm. The DON stated that Resident #1's oxygen in use signage must have been missed when the room change occurred. During an interview on 5/07/26 at 2:29 pm with the Administrator she revealed that when a resident was admitted to the facility and required supplemental oxygen the safety signage should be posted on the residents door. The Administrator stated that nursing administration should follow up and ensure the oxygen in use signs were posted on Resident #1's door. 2. Resident #17 was admitted to the facility on 4/17/26 with diagnoses which included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. Resident #17 had a physician order dated 4/17/26 for oxygen therapy; oxygen at 2 liters per minute via nasal cannula continuous every shift for hypoxia (low levels of oxygen in the body tissue). Resident #17's census history revealed a room change had occurred on 4/29/26.	F0695	Continued from page 3 designee prior to beginning their scheduled shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Director of Nursing or designee will complete five (5) oxygen signage checks three (3) times a week for four (4) weeks then monthly for two (2) months to ensure oxygen signage is posted on the door frame outside the resident's room. The Director of Nursing will present the findings of audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Date of Compliance: 5/2726	05/27/2026

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F0695 SS = D	Continued from page 4 An observation was conducted on 5/04/26 at 1:51 pm of Resident #17 who was observed to be in bed with supplemental oxygen in place. Resident #17 did not have the cautionary and safety signage posted that indicated supplemental oxygen was in use. An observation and interview were conducted on 5/07/26 at 9:03 am with Unit Manager #1 of Resident #17's room. Unit Manager #1 confirmed the oxygen in use signage was not posted to indicate supplemental oxygen was in use. Unit Manager #1 stated she was not responsible for unit that Resident #17 resided on but she stated that any nurse was able to put the oxygen in use signage on the door when it was needed. During an interview on 5/07/26 at 9:37 am with Unit Manager #2 confirmed she was responsible for Resident #17's unit. Unit Manager #2 revealed that all residents that used supplemental oxygen should have the safety oxygen in use sign posted on the door frame. Unit Manager #2 stated any staff member was able to put the oxygen in use signage up on Resident #17's door when supplemental oxygen was used. Unit Manager #2 stated that Resident #17 had recent room change and the safety signage must not have been moved to the new room when the change was completed. The Director of Nursing (DON) was interviewed on 5/07/26 at 2:03 pm. The DON stated that Resident #17's oxygen in use signage must have been missed when the room change occurred. During an interview on 5/07/26 at 2:29 pm with the Administrator she revealed that when a resident was admitted to the facility and required supplemental oxygen the safety signage should be posted on the residents door. The Administrator stated that nursing administration should follow up and ensure the oxygen in use signs were posted on Resident #17's door.	F0695		05/27/2026
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F0759	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents #26 and #6 continue to reside in the facility and remain in stable condition. On 5/6/26 the Director of Nursing ensured resident #26's Cholecalciferol and Fenofibrate were administered	05/27/2026

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F0759 SS = D	Continued from page 5 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, manufacturer recommendations, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 39 opportunities, resulting in a medication error rate of 7.69% for 2 of 4 residents observed during the medication administration observations (Resident #6 and Resident #26). The findings included: 1. Resident #26 was admitted to the facility on 5/26/21 with diagnoses that included vitamin D deficiency and hyperlipidemia (condition of high cholesterol or fats in the blood). A review of Resident #26's current physician's orders revealed a medication order was initiated on 3/25/26 for cholecalciferol (a vitamin supplement to replace Vitamin D) 25 micrograms (mcg) one tablet by mouth one time a day for vitamin deficiency and a medication order initiated on 3/25/26 for fenofibrate 40 milligram (mg) to be given as one tablet by mouth one time a day for hyperlipidemia (condition of high cholesterol or fats in the blood). A review of Resident #26's May 2026 Medication Administration Record (MAR) revealed that the Cholecalciferol and Fenofibrate were scheduled to be administered daily between 7:00 AM and 11:00 AM. On 5/6/26 at 9:03 AM, Nurse #1 was observed as he prepared and administered nine (9) medications to Resident #26. The medications administered to the resident did not include cholecalciferol and Fenofibrate. An interview was conducted on 5/6/26 at 9:22 AM with Nurse #1 with the Assistant Director of Nursing (ADON) present. During the interview, Nurse #1 pulled up Resident #26's May 2026 MAR and reviewed her physician's order for the cholecalciferol and fenofibrate. At that time, Nurse #1 confirmed the order indicated Resident #26 was supposed to receive cholecalciferol 25 mcg once	F0759	Continued from page 5 and ensured the Cholecalciferol and Fenofibrate was available on the medication cart for future medication administration. On 5/6/26 Licensed Nurse #6 returned to Resident #6 to ensure the resident rinsed and spit following Fluticasone Propionate-Salmeterol inhaler use. On 5/8/26 the Director of Nursing completed education and medication administration competency with Licensed Nurses #1 regarding ensuring all medications are available on the medication cart prior to medication pass and administered per physician order. On 5/8/26 the Director of Nursing completed education with Licensed Nurse #6 regarding the importance of ensuring residents who utilize corticosteroid inhalers have additional instruction of "rinse and spit" under the special instructions section of the order and the indication of "rinse and spit" to prevent throat discomfort and/or oral thrush. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/18/26 the Director of Nursing completed an audit of current residents, including Resident #6, who utilize corticosteroid inhalers to ensure "rinse and spit" is included under the special instruction section of the order. Two (2) of two (2) residents were missing "rinse and spit" under the special instructions section of the order. The Director of Nursing corrected the orders. On 5/18/26 the Director of Nursing completed an audit of current residents, including Resident #26, who utilize Cholecalciferol and Fenofibrate to ensure these medications are available on the medication carts. No concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/8/26 the Director of Nursing and/or Staff Development Coordinator initiated education for all licensed nurses and medication aides, including agency, regarding 1) medication administration with emphasis on ensuring medications are available on the medication cart prior to medication pass and	05/27/2026

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F0759 SS = D	Continued from page 6 daily and confirmed the order indicated Resident #26 was supposed to receive fenofibrate 40 mg tablet once daily. Nurse #1 stated the stock medication bottle contained cholecalciferol 20 mcg, so he did not administer the cholecalciferol medication. Nurse #1 further stated that the fenofibrate medication was not available for administration and he would follow up with pharmacy to see when medication would be delivered. The ADON stated she would review the orders with the provider for further instructions. An interview was conducted on 5/7/26 at 2:03 PM with the facility's Director of Nursing (DON). The DON stated that staff were to follow up with the pharmacy when medications were not available for administration. The DON stated she expected the staff to notify the provider to see what recommendations they had for the medication order. The DON also stated that she expected staff to notify her of the missing medication, the steps they took, and document that the medication was not given on the MAR. An interview conducted with the Administrator on 05/07/2026 at 2:40 PM revealed medication errors were to be managed by Nursing administration and the DON. The Administrator stated she expected the DON and Nursing administration to ensure medications were available and administered as ordered. The Administrator further stated she expected staff would notify the DON, Unit Manager, and Pharmacy when medications were not available. 2. Resident #6 was admitted to the facility on 12/5/24 with diagnoses that included chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe). Fluticasone propion-salmeterol 500-50 micrograms (mcg)/dose is an aerosol powder for inhalation used for the management of chronic obstructive pulmonary disease (COPD) and/or asthma. The manufacturer's Full Prescribing Information that was undated for the Fluticasone propion-salmeterol inhaled medication included "Administration Information." These instructions read, in part: "After inhalation, the patient should rinse his/her mouth with water without swallowing to prevent thrush (a yeast infection of the mouth). A review of Resident #6's current orders revealed a	F0759	Continued from page 6 administered per physician order and 2) orders for corticosteroid inhalers include "rinse and spit" under the special instruction section of the order. Education was completed on 5/19/26. After 5/19/26 any newly hired licensed nurses and/or medication aides will be educated by the Staff Development Coordinator or designee during orientation. Any agency staff will be educated by the Director of Nursing or designee prior to beginning their next scheduled shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Director of Nursing will complete medication observations with three (3) licensed nurses/medication aides weekly for four (4) weeks then monthly for two (2) months with emphasis on 1) ensuring medication availability and 2) ensuring "rinse and spit" is included in corticosteroid inhaler orders. The Director of Nursing will present the findings of audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Date of Compliance: 5/27/26	05/27/2026

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F0759 SS = D	Continued from page 7 medication order was initiated on 1/16/26 for 500-50 mcg per actuation of Fluticasone propion-salmeterol aerosol powder to be given as one puff by mouth twice a day for COPD. There was no notation included in the order to “rinse mouth and spit after use.” On 5/6/26 at 10:11AM, Nurse #6 was observed as she prepared and administered Fourteen (14) medications to Resident #6. The medications administered to the resident included 500-50 micrograms (mcg) per actuation of Fluticasone propion-salmeterol powder given as one puff by mouth. After Resident #6 inhaled one puff of the Fluticasone propion-salmeterol, Nurse #6 collected the inhaler and walked out of the room back to the medication cart. Nurse #6 did not prompt the resident to rinse his mouth with water and then spit the water out after using the inhaled medication. An interview was conducted on 5/6/26 at 10:24 AM with Nurse #6. During the interview, Nurse #6 reviewed the manufacturer’s instruction and confirmed the manufacturer’s instruction read, in part: “After inhalation, the patient should rinse his/her mouth with water without swallowing after use of Fluticasone propion-salmeterol. Nurse #6 pulled up Resident #6’s May 2026 Medication Administration Record (MAR) and reviewed his physician’s order for the Fluticasone propion-salmeterol. When asked, Nurse #6 stated Resident #6 knew that she was supposed to rinse her mouth out after the Fluticasone propion-salmeterol was administered. Nurse #6 acknowledged she did not prompt Resident #6 to rinse and spit the water out. Nurse #6 stated she would go remind Resident #6 to rinse/spit after using the Fluticasone propion-salmeterol. An interview was conducted on 5/7/26 at 2:03 PM with the facility’s Director of Nursing (DON). The DON reported she would expect the nursing staff administering a steroid inhaler to remind the resident to rinse and spit the water out after administering the inhaler. An interview conducted with the Administrator on 05/07/2026 at 2:40 PM revealed medication errors were to be managed by Nursing administration and the DON. She stated she expected the DON and Nursing administration to ensure medications were available and administered as ordered.	F0759		05/27/2026