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 _____	C 05/01/2025

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

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F 000	INITIAL COMMENTS A complaint investigation was conducted 4/30/2025 to 5/1/2025. Event ID # QJK811. The following intakes were investigated: NC00229406, NC00228480, and NC00228465. One of the six allegations resulted in a deficiency. Past Non-Compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G) Non-compliance began on 3/30/2025. The facility came back into compliance effective 4/4/2025.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and nurse consultant interview, the facility failed to perform a transfer from the wheelchair to the bed according to the care plan for one (Resident #1) of three residents reviewed for accidents. Resident #1 sustained a left leg fracture above the knee with extreme pain requiring a visit to the emergency room at the hospital after being transferred without a mechanical lift. Findings included:	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/05/2025

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Resident #1 had resided in the facility since 7/17/2019 and had multiple diagnoses some of which included cerebral vascular accident, hemiplegia, hemiparesis, heart failure, and diabetes mellitus.

Documentation on a quarterly Minimum Data Set Assessment dated 1/24/2025 revealed that Resident #1 was coded as cognitively intact and dependent on staff for a chair-to-bed transfer. On the same assessment, she was also coded as having a range of motion impairment on one side of her upper and lower extremities.

Documentation on the care plan initiated on 5/6/2024 under the problem area entitled "Profile Care Guide" revealed Resident #1 required the intervention of a mechanical lift for transfers.

During an initial tour on 4/30/2025 at 9:03 AM, Resident #1 provided the following information. Resident #1 indicated a male nurse aide picked her up and threw her on the bed. Resident #1 told the male nurse aide that he couldn't pick her up knowing what she weighed. Resident #1 stated she hit the bed hard, and it hurt. Resident #1 revealed she was in a lot of pain, so she was transported to the hospital where they put a brace on her leg.

An interview was conducted with Nurse #2 on 4/30/2025 at 11:09 AM. Nurse #2 was assigned to care for Resident #1 on 3/30/2025 for the 7:00 AM to 7:00 PM shift. Nurse #2 stated on 3/30/2025 after dinner Nurse Aide (NA) #1 put Resident #1 back to bed at the resident's request. Nurse #2 indicated she checked with Resident #1 at the end of her shift before going home and she

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was asleep. Nurse #2 revealed NA #1 did not tell her he transferred Resident #1 without a lift and Nurse #2 was not told Resident #1 had any pain.

Attempts to contact NA #1 via the telephone during the survey were unsuccessful.

The facility provided the following statement from NA #1 obtained on 4/1/2025 by the former Director of Nursing: "The writer spoke with [NA #1] to obtain the details on what happened with the transfer of [Resident #1] Agency [Certified Nursing Assistant]. [NA #1] was oriented to the facility with the agency orientation binder. [NA #1] worked 3/30/2025 from 7:00 AM to 7:00 PM. [NA #1] was assigned to [Resident #1]. [NA #1] got [Resident #1] up to the wheelchair with no issues noted. Around 5:30 PM [Resident #1] requested to be put back into bed. [NA #1] states at 5:37 PM he performed a one-person assist from the wheelchair to the bed. [NA #1] wheeled the wheelchair beside the bed and locked it into place. The bed was lowered, and he did a single-person lift. The first lift was unsuccessful, so he placed [her] back into the wheelchair. The second lift was successful and placed [Resident #1] into the bed. [Resident #1] was low in the bed. [Resident #1] complained of mild pain. [Resident #1] stated [to NA #1] the pain was relieved with repositioning. [Resident #1] told [NA #1] "Don't do that by yourself again." [NA #1] states that he told [Resident #1] he would not attempt again. [NA #1] states that [Resident #1's] leg made no contact with the wheelchair or the bed. [NA #1] states that there was no twisting of [Resident #1's] leg at the time of the transfer. [NA #1] was educated on the proper transfer process and the importance of timely reporting of resident pain."

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NA #2 was interviewed on 4/30/2025 at 11:32 AM and the following information was provided. NA #2 worked in the same hallway as NA #1 on 3/30/2025 from 7:00 AM to 7:00 PM. NA #1 was an agency nurse aide, so NA #2 specifically instructed NA #1 to transfer Resident #1 with a mechanical lift. NA #1 did not come to NA #2 to request help transferring Resident #1. NA #2 also revealed she told NA #1 she was available to answer questions and help during the shift. NA #2 stated all agency nurse aides are instructed how to use the kiosk with the care plan information for the residents, reiterating she was available to ask during the shift on 3/30/2025 if NA #1 did not know the resident care needs.

NA #3 was interviewed on 4/30/2025 at 3:22 PM. NA #3 stated she worked in the facility on 3/30/2025 from 12:00 PM to 7:00 PM. NA #3 explained she was called into Resident #1's room sometime after dinner because NA #1 needed assistance pulling Resident #1 up in the bed. NA #3 indicated Resident #1 was very low in the bed, positioned toward the foot of the bed, and needed to be repositioned toward the head of the bed. NA #3 did not recall Resident #1 complaining of pain before leaving the room after assisting.

Documentation in the nursing progress notes dated 3/30/2025 written by Nurse #1 at 10:32 PM revealed, "Resident [complained of] left knee pain. Left knee noted with swelling and discomfort. Painful upon assessment. Received [an] order to obtain an x-ray of [the] left knee. Left voicemail for [Responsible party] to return call to facility."

Nurse #1 was interviewed on 4/30/2025 at 4:35 PM. Nurse #1 confirmed she was assigned to

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care for Resident #1 on 3/30/2025 for the 7:00 PM to 7:00 AM shift. Nurse #1 indicated she did not receive any concerns regarding Resident #1 when she received a report regarding the residents from Nurse #2 at the end of her shift. Nurse #1 revealed that as soon as her shift began NA # 4 came to her while she was in another resident's room and requested, she come to see Resident #1. Nurse #1 stated she went immediately to the room of Resident #1 who told her she was thrown into the bed hurting her knee. Nurse #1 stated she assessed the left knee and observed it was swollen, and Resident #1 was in severe pain. Nurse #1 stated she called the resident's physician, and he requested a mobile x-ray of the left knee. Nurse #1 stated she received a call from the Mobile x-ray company stating they would be at the facility at 7:00 AM on 3/31/2025. Nurse #1 stated she gave Resident #1 650 milligrams of Acetaminophen for the pain, but Resident #1 remained awake on and off with complaints of pain. Nurse #1 revealed she called the physician back due to the continued complaints of pain from Resident #1 and the concern of giving her too much Acetaminophen due to her receiving the scheduled 500 mg of Acetaminophen at night as well as receiving the as-needed dose of 650 mg Acetaminophen for the knee pain. Nurse #1 revealed the physician ordered Resident #1 to receive 20 mg of Prednisone daily for pain and swelling for 5 days. Nurse #1 indicated she also put ice on her knee and elevated her left leg. Nurse #1 admitted the measures put in place to help alleviate pain for Resident #1 helped temporarily but Resident #1 was very upset as to what happened and did not get a lot of sleep.

Documentation on the medication administration

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record (MAR) for 4/30/2025, revealed Resident #1 was administered the scheduled 500 mg of Acetaminophen by mouth on the night shift by Nurse #1 and an additional 650 mg of Acetaminophen by mouth on an as-needed basis at 10:36 PM. The 650 mg of Acetaminophen at 10:36 PM were documented as not effective. Nurse #1 documented the pain level for Resident #1 on 4/30/2025 on the night shift was an 8 on a scale from 1 to 10.

An interview was conducted with Nurse #2 on 4/30/2025 at 11:09 AM. Nurse #2 revealed when she returned to the facility on 3/31/2025 for her 7:00 AM to 7:00 PM shift, she was informed by Nurse #1 that Resident #1 was transferred by NA #1 without a mechanical lift and Resident #1 had been complaining of pain on and off throughout the night. Nurse #2 additionally found out an x-ray of the left knee of Resident #1 was ordered for 7:00 AM on 3/31/2025 but they never arrived. Nurse #2 stated that Unit Manager #1 obtained orders for Resident #1 to be sent to the emergency department for x-rays due to the delay. Nurse #2 stated Resident #1's pain was relieved with Acetaminophen on the morning of 3/31/2025. Nurse #2 revealed she found out from the responsible party as she was leaving on 3/31/2024 at the end of her shift that Resident #1 had broken her leg and had to keep an immobilizer on her left leg.

Documentation on the MAR for 4/31/2025 revealed Nurse #1 administered the scheduled 500 mg of Acetaminophen by mouth to Resident #1 on the day shift. Nurse #1 documented Resident #1's pain level on the day shift as a 3 on a scale of 1 out of 10.

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Documentation in the nursing progress notes dated 3/31/2025 at 3:39 PM written by Nurse #2 revealed Resident #1 was sent to the emergency room for further evaluation per the Unit Manager and transported via emergency medical services.

Documentation on the emergency department course and medical decision-making dated 3/31/2025 revealed the following information. X-rays were obtained of the left knee and femur. Resident #1 sustained a comminuted and displaced fracture of the distal metaphysis of the left femur with some impaction of the fracture fragments. A comminuted and displaced fracture of the distal metaphysis of the left femur means the bone at the lower end of the thighbone (femur) near the knee was broken into multiple pieces (comminuted) and those pieces had shifted out of alignment (displaced). A knee immobilizer was placed to help stabilize her leg if she was being moved.

The former Director of Nursing (DON) was interviewed on 4/30/2025 at 2:14 PM. The former DON stated she was a travel DON and was the DON at the facility from 3/10/2025 to 4/7/2025. The former DON confirmed she took immediate action when it was confirmed NA #1 had not used a mechanical lift to transfer Resident #1 resulting in a fracture. The former DON stated she worked closely with the "SCC" (facility nurse consultant) to provide education and training for the nursing staff to make sure all the residents were being safely transferred. The former DON stated for specific information on the corrective actions taken, the SCC could provide the details because the former DON was no longer in the facility.

An interview was conducted with the facility nurse

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consultant (SCC) on 4/30/2025 at 2:44 PM. The SCC confirmed she assisted the former Director of Nursing with investigating the fracture sustained by Resident #1 on 3/30/2025. The SCC stated NA #1, an agency nurse aide, lifted Resident #1 from the wheelchair under her arms and placed her on the bed. The SCC noted the unit manager had made sure all the agency nurse aides knew how to access the care plans of each resident on the kiosk as well as making sure the agency staff were made aware binders on how to use the kiosk were located at each nursing station. The SCC stated that agency staff could have always asked another nursing staff member if assistance was needed. The SCC stated that NA #1 decided of his own volition that he would transfer Resident #1 without the assistance of a mechanical lift and another nurse aide causing Resident #1 to fracture her leg during a transfer. The SCC stated that the actions taken by NA #1 were not acceptable and he no longer will return to the facility.

The facility provided the following corrective action plan with a completion date of 4/4/2025.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 3/30/25 an Agency Certified Nursing Assistant #1 completed a one-person assist transfer with Resident #1, which required a Mechanical Lift. Resident #1 complained of pain during transfer however this was resolved with repositioning.

On 3/30/2025 Resident #1 was assessed by Licensed Nurse #1 with noted swelling and 650mg of Acetaminophen was administered for

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pain with good effects. The Physician and the Responsible party were notified of Resident #1 change in condition and new orders were received for Mobile X-ray. On 3/31/25, the mobile X-ray company called and stated they would arrive at approximately 7:00 AM. On 3/31/25, Resident #1 complained of left knee pain and discomfort. Swelling remained. The Physician was made aware. New orders were received for Prednisone for 5 days and additional Acetaminophen was given with good effects. On 3/31/25 the Facility Mobile X-ray Company called Licensed Nurse #2 and stated there was a delay in their arrival.

On 3/31/25 at 3:39 PM, Resident #1 was transported to the local emergency room with left knee pain and swelling. Resident #1 returned on 4/1/25 to the facility with x-ray results, of a closed fracture of the distal end of the femur, with an immobilizer in place. Orders were placed in the chart to assess pain every shift, immobilizer to the affected extremity, in addition to skin and circulation checks to be performed every 4 hours, and follow up appointments made with orthopedics on 4/9/2025 and 4/23/2025 for additional follow-up.

On 4/1/25 the Director of Nursing ensured Agency Certified Nursing Assistant #1 was re-educated and placed on the do not return list.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected.

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On 4/1/25, in-house assessments of all residents with a BIMS (Basic Interview for Mental Status) of 8 or below were completed by Unit Manager #1. No concerns noted. All residents with BIMS above 8 were interviewed by Licensed Social Worker #1 to ensure all residents were treated with dignity and respect and the facility staff were following the care plan, including transfer status. No additional concerns were noted.

On 4/4/25, the Clinical Reimbursement Nurse Consultant audited all residents' care assist profiles to ensure all transfer statuses were accurate and present. This was completed on 4/4/25.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 4/1/25 All facility Nurses and Nursing assistants received the training below:

All Licensed Nurses and Nursing Assistants should review the resident's transfer status before performing a transfer. This can be found easily in the resident profile in Care Assistance/Matrix Care Electronic Medical Record. If there is no transfer status on the resident see the nurse before attempting to transfer. Also, please be sure to report any complaints of pain, new or otherwise, to the nurse for assessment promptly. A stop and watch (Reporting method for resident changes in conditions) may be coupled with this as well.

The Director of Nursing and Staff Development Coordinator made sure all nursing staff received

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and retained education as of 4/3/25.

As of 4/3/25, 100% of Licenses Nurses and Certified Nursing Assistants have received the in-service on the above.

The Director of Nursing and Staff Development Coordinator will ensure that any new nursing staff, including agency staff, will be in-serviced and not allowed to work until the training is completed.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed.

Quality Assurance Performance Improvement Plan initiated: 4/1/2025

The Facility Nurse Consultant will monitor five randomly selected transfers weekly to ensure proper resident transfers. This will be documented on a facility Quality Assurance tool. This will be completed weekly for 8 weeks, then monthly times 2. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nursing to ensure corrective action is completed as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and Dietary Manager.

Compliance date of 4/4/2025

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F 689	Continued From page 11 Validation of the corrective action plan was completed on 5/1/2025. The Quality Assessment and Performance Improvement Plan was reviewed with corresponding documentation to support the actions taken by the facility. Interviews were conducted with a sample of nurses and nurse aides from all nursing shifts to verify education was provided for licensed nurses and certified nursing assistants regarding assuring the correct transfer method was being used before performing a transfer, as well as notification of any new changes in pain. The documentation for in-service records was reviewed. Social Worker #1 was interviewed to confirm all alert and oriented residents were interviewed to verify no other inappropriate transfers had occurred. The Clinical Reimbursement Nurse Consultant was interviewed to confirm the transfer status of each resident was present and accurate in each resident care guide. The audits were verified as well as the ongoing monitoring audits to ensure residents were being transferred with the appropriate transfer method for each resident. The compliance date of 4/4/2025 was validated.	F 689		