STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345175	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithfield Manor Nursing and Rehab	**902 Berkshire Road , Smithfield, North Carolina, 27577**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The survey team entered the facility on 9/10/25 to conduct a complaint investigation survey. The survey team was onsite 9/10/25 and 9/11/25. Additional information was obtained offsite on 9/12/25. Therefore, the exit date was 9/12/25. Event ID# 1D6C60-H1. The following intake was investigated: 2609129. This intake resulted in immediate jeopardy. 1 of the 8 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Non-noncompliance began on 8/26/25. Immediate jeopardy was removed on 9/3/25. The facility came back in compliance effective 9/3/25. A partial extended survey was conducted.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with the resident, staff, and the Medical Director, the facility failed to follow the manufacturer's	F0689	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0689 SS = SQC-J	Continued from page 1 instructions for wheelchair securement in a transportation van. On August 26, 2025, the Transport Driver incorrectly anchored all four securement straps to the rear wheels of the wheelchair, leaving the front of the wheelchair unsecured. As the vehicle accelerated, the unsecured wheelchair tipped backward, causing Resident #1 to fall and strike her head and back on the floor of the van. She was transported to the hospital, where she was diagnosed with posterior (back) neck and upper back pain, a superficial laceration on the tip of her tongue, paraspinal (muscles located along the spine) tenderness in the upper thoracic (part of the body between the neck and the abdomen) region, and a superficial abrasion on her right hand. A computed tomography (CT) (non-invasive imaging test that uses x-rays and computer technology to create detailed images of the body's internal structures) scan revealed no evidence of hemorrhage (bleeding) or acute fracture. Resident #1 was discharged back to the facility later that evening. The noncompliance had the high likelihood to cause serious injury, harm, impairment or death. The deficient practice affected 1 of 3 residents reviewed for accident-related incidents (Resident #1). The findings included: The undated manufacturer's instructions for wheelchair tie-downs used by the facility revealed it read in part, "Attach the four tie-down hooks to solid frame members or weldments (parts joined by welding), near seat level [of the wheelchair]. Ensure tie-downs are fixed at approximately 45 degrees. Do not attach hooks to wheels, plastic, or removable parts of wheelchair." Resident #1 was admitted to the facility on 1/20/24. Her active diagnoses included neuropathy, chronic ischemic heart disease osteomyelitis, atherosclerotic heart disease, diabetes, amputation of the right toes and left leg above the knee, and generalized anxiety disorder. Resident #1's Minimum Data Set assessment dated 6/13/25 revealed she was assessed as cognitively intact. She had range of motion impairment on both sides of her lower extremities. She was dependent on staff for transfers and required setup assistance with wheelchair mobility. She was also assessed to receive scheduled and as needed pain medication. She had pain or hurting during the 5 days prior to the assessment and was documented as having pain occur rarely or not at all and described the pain as mild. She received an opioid for her pain control during the lookback period.	F0689		

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F0689 SS = SQC-J	Continued from page 2 Resident #1's orders revealed on 7/18/25 she was ordered oxycodone 5 milligram tablet every 8 hours as needed for pain. On 7/19/25 she had orders for chewable aspirin 81 milligrams one time a day related to chronic ischemic heart disease as well as clopidogrel bisulfate oral tablet 75 milligrams, an anti-platelet medication, in the morning related to atherosclerotic heart disease. During an interview on 9/10/25 at 10:33 AM Resident #1 stated the Transport Driver came to her room on 8/26/25 and rolled her out to the transport van for a dentist appointment. This van was the facility's transport van that opened in the back and had a ramp on which the Transport Driver pushed her up. The Transport Driver would always do something with the floor that would lock her wheelchair in place and to the best of her memory, the Transport Driver did something, and it seemed like she had locked the wheelchair in the van as she normally did, and Resident #1 did not know what failed this time. She confirmed her seatbelt was also in place. During transport, everything seemed normal until they had stopped at a red light. When the light turned green, the Transport Driver pressed the gas to go straight, and as the van accelerated at a normal pace, her wheelchair came loose. The chair flipped backwards resulting in her landing on her back still seated in the wheelchair. The ramp had been pulled up in the back and stored, and she hit her head on the steel ramp as she fell backwards. She bit her tongue, causing some bleeding but she could not remember how bad it bled. She stated the Transport Driver parked the van, but she could not say how long it took to come to a stop. Her back was in pain due to the sudden jerk of the wheelchair flipping over and the doctors at the hospital said she probably had some whiplash from the incident once she had made it to the emergency department. Resident #1 stated her pain was a 9 out of 10 (0 being no pain and 10 being the worst pain imaginable). The Transport Driver came into the back of the van after parking and called Emergency Medical Services (EMS) as well as the facility. Three people came from the facility to where they were parked, arriving before EMS as the van had not made it far from the facility. The three staff members who arrived at the van were the Director of Nursing, the Administrator, and the Maintenance Director. It did not take them long to get there but she was unsure of the length of time. She was still lying on her back, seated in the flipped wheelchair when the three staff members arrived. The Administrator began taking pictures of the van and the things on the floor of the van that anchored the chair to the van, and the Maintenance Director was inspecting the van. The Director of	F0689		

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F0689 SS = SQC-J	Continued from page 3 Nursing assessed her and explained they would need to wait for EMS to ensure Resident #1 was moved safely. During an interview on 9/10/25 at 12:36 PM the Transport Driver stated Resident #1 had a dental appointment on 8/26/25 at 2:30 PM. At around 2:00 PM to 2:15 PM she went to Resident #1's room to take her to the van and get her set up for transport. Once Resident #1 was in the van, she locked the wheels on the wheelchair and then secured the two front straps and two back straps from the floor of the van to the large, back wheels of the wheelchair, one front and one back strap per wheel. She then did a pull test to make sure the wheelchair did not move by pulling back on the chair handles to ensure it was securely in place and allow the automatic tension to tighten. She stated she heard the clicking of the locking mechanisms which indicated the wheelchair was securely in place. She then put on Resident #1's seatbelt. One belt went around the resident's waist and locked into the floor on the right and left side of the resident. Then another belt attached to the side wall of the van is pulled over the resident's right shoulder and locked into the waist belt. She then completed another pull test by pulling back on the wheelchair by its handles and asked Resident #1 if she was comfortable or if the seat belt was too tight. Resident #1 indicated she was comfortable. The ramp was folded and stored by folding it to sit upright in the back of the van and then the doors of the van were closed. Everything continued without incident, and they stopped at a stop light. When the light turned green, she pressed the gas, and as she accelerated through the light, Resident #1 shouted, and she heard a noise from the back. She asked Resident #1 what happened, and the resident responded she had come out of the chair. The Transport Driver told Resident #1 to just hold on as she was trying to get out of the road and park. She pulled to the shoulder of the road and parked the van. The Transport Driver told Resident #1 to keep talking to her to keep her conscious and told Resident #1 she could not move her before a medical professional assessed her. The Transport Driver then called the EMS as well as the Administrator. She stated by then she had moved to the back of the van with Resident #1. The wheelchair had tipped over backwards with Resident #1 in it, resulting in her lying on the floor of the van on her back, halfway in the wheelchair with her buttock having shifted up to the middle of the back rest of the wheelchair. She stated Resident #1 asked if she could get her up and the Transport Driver told her she could not move her due to the increased risk of injury. Resident #1 told the Transport Driver she thought she had hit her head. The top of Resident #1's head was up	F0689		

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F0689 SS = SQC-J	Continued from page 4 against the ramp which was folded and stored behind Resident #1. At no point did she move the resident or move any items including the ramp due to the risk of moving the resident, causing more injury. The only thing she moved was to unlock the right front anchor strap which was still secured on the wheel and the van floor when she first entered the back of the van. She did this to get back to Resident #1 without having to step over the anchors. The Director of Nursing and Administrator arrived 7 to 10 minutes prior to EMS arriving. The Transport Driver stated she demonstrated how she had anchored Resident #1's wheelchair in the van for the Maintenance Director, Director of Nursing, and Administrator. This was completed while still pulled over to the side of the road. After the demonstration, she was informed she could not drive the van again until the investigation was completed and she had been reeducated on how to secure resident wheelchairs in the van. The Maintenance Director drove the van back to the facility. The Transport Driver indicated she attended training, watched instructional videos, and took tests during the investigation which she completed on 9/2/25 and she was now currently monitored with a monitoring tool by the Maintenance Director. The Transport Driver stated she was educated that by attaching both the front and rear anchors to the same rear wheel on each side, the frame of the wheelchair was still free to rotate and flip over. She stated she had done it correctly in the past as far as she could recall and did not know why she attached it this way on 8/26/25. During an interview on 9/10/25 at 2:23 PM the Maintenance Director stated he was in the building when the incident happened on 8/26/25, and he got a call from the Administrator to come to the location of the incident. The Administrator informed him an incident had occurred during transport of Resident #1 in the facility van. When he arrived, EMS was already there on the scene, and the side door was open and through the side door he noted Resident #1 lying on her back. The Director of Nursing and Administrator were already on there as well. EMS was in the process of getting Resident #1 out of the van, and once the resident was safely removed from the van and on the way to the hospital, he was then able to examine the van, and they could start their investigation. The Transport Driver explained what happened and he asked her how she had attached the anchor straps to the chair and floor of the van. She demonstrated how she attached the anchors to the wheelchair, and it was done incorrectly. He stated when a wheelchair was anchored in a transport van, it must be anchored by the front and back frame of the wheelchair. Wheels should never be used to anchor a	F0689		

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F0689 SS = SQC-J	Continued from page 5 wheelchair down. Also, she had anchored the left front and back anchors to the same larger back left wheel and anchored the right front and back anchors to the same larger back right wheel. Because she anchored both the back and front anchors to the same wheel on either side, the frame was still free to rotate while the back wheels stayed stationary. When the van had accelerated, the wheelchair was free to rotate backwards, causing the incident. He stated they inspected the van and found all parts were functioning correctly. The EMS narrative dated 8/26/25 revealed EMS documented that upon arrival, Resident #1 was found laying on her back in a transport van. The resident was partially in her wheelchair and partially on the floor of the van. Resident #1 indicated she tipped over during transport and now her neck and upper back were hurting. No deformities were noted with assessment. Resident #1 was lifted from the floor and placed back in her wheelchair. The facility staff present informed EMS she did take blood thinners, and she had hit her head. Resident #1 was transferred to the ambulance and was complaining of 8 out of 10 pain in her neck and back. Resident #1 was transported to the hospital. Resident #1's hospital record dated 8/26/25 revealed Resident #1 was in a vehicle transport going to an appointment when her wheelchair flipped backwards resulting in her striking her head on the floor of the van. Resident #1 indicated she saw stars but did not lose consciousness. She suffered back and neck pain as well. She was transported to the emergency department for further evaluation. Resident #1 indicated she had posterior neck pain and upper back pain but was otherwise at her baseline. She denied any other symptoms. She was documented to take clopidogrel bisulfate and aspirin but denied any other anticoagulant medication. CT scans demonstrated no evidence of hemorrhage or acute fracture. Blood work was unremarkable for acute issues and Resident #1 was discharged back to the facility on 8/26/25. A nursing note dated 8/26/25 revealed Resident #1 was documented to have returned to the facility via transport Med-X/stretcher from hospital where she had been evaluated for possible head injury from a fall. The nurse documented the hospital found negative findings from CT scans and lab work up. A provider note dated 8/27/25 revealed the Nurse Practitioner saw Resident #1 and documented Resident #1 was in a transport van headed to a dental appointment when the van accelerated, causing her wheelchair to tip over. She struck her head, neck, and back on the floor	F0689		

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F0689 SS = SQC-J	Continued from page 6 of the van. She also bit her tongue and sustained scrapes. She was taken to the emergency department where CT scans of the head and cervical spine were performed, all of which were negative for acute findings. She was discharged back to the facility with instructions to rest in bed for a few days. Resident #1 reported persistent pain, particularly in the shoulders and neck, and was ordered oxycodone 5 mg every 8 hours as needed for pain. Resident #1's diagnoses were acute whiplash injury, contusion of tongue, and pain. During an interview on 9/11/25 at 10:05 AM the Medical Director stated she was notified of the incident on 8/26/25, the day it happened. She further stated the main concern with an accident of this type would be internal bleeding because of the fall which thankfully did not occur. Another concern would be fractures because of the impact of the fall. She stated they had been seeing her regularly due to her medical condition and the incident to monitor Resident #1's status. The Medical Director stated the resident had not mentioned any fear of transportation or increase in her pain since the initial acute pain from the fall. During an interview on 9/11/25 at 10:54 AM the Director of Nursing (DON) stated on 8/26/25 she was informed by the Administrator they had to go because there had been a van incident. They got in the Administrator's car and arrived in less than 5 minutes. The van was parked on the shoulder of the road, and the Director of Nursing heard the Transport Driver saying, "I'm in here" as she opened the passenger front door. At that point she saw the Driver in the back of the van with Resident #1. The resident was in the wheelchair, on her back, with the front wheels in the air. Resident #1 told the Director of Nursing she bit her tongue and there was some bleeding but there was no pooling of blood as well as no indication or observed risk of choking on blood by Resident #1. EMS arrived shortly after the DON assessed Resident #1. EMS got in the van, assessed the resident and asked her questions. EMS transferred Resident #1 to a stretcher, placed her in the ambulance, and took her to the hospital. The Director of Nursing, Transport Driver, Administrator, and Maintenance Director examined the van. They had the Transport Driver demonstrate how she had anchored the wheelchair in the van. The Transport Driver had anchored both left and right front and rear straps to the rear wheels. At that point they determined the wheelchair had been anchored incorrectly by the Transport Driver. During an interview on 9/11/25 at 12:10 PM the Administrator stated she received a call from the Transport Driver on 8/26/25 and she told her there had	F0689		

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F0689 SS = SQC-J	Continued from page 7 been an incident with the van. The Administrator found out where the transport van was parked and then instructed the Transport Driver to call 911 if she had not done so. The Administrator then got the Director of Nursing and told her what she knew, and they got in her car and drove to the transport van. She stated Resident #1 was alert and oriented and talking with her and the other staff members. While the Director of Nursing assessed the resident, she called the Maintenance Director and asked him to come to the location as well so that he could examine the transport van after Resident #1 was taken care of. She stated shortly after this, EMS arrived and worked with the Director of Nursing to safely transfer Resident #1 to the ambulance and take her to the hospital. While this was happening, the Maintenance Director arrived. After Resident #1 had been transferred to the ambulance, she requested the Transport Driver demonstrate to her, the Director of Nursing, and Maintenance Director, how she had anchored the wheelchair to the van. Following her demonstration, they understood she had attached the anchors incorrectly to the rear wheels on both sides. The Transport Driver was suspended from transportation, and the Maintenance Director drove the van back to the facility. The Administrator was notified of the immediate jeopardy on 9/10/25 at 4:12 PM. The facility provided the following corrective action plan: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 8/26/25 Resident #1's wheelchair tipped backwards in the facility transportation van due to the transportation driver failing to follow manufacturer's instructions for wheelchair securement. The driver had improperly anchored both left and right front and rear straps to the rear wheels, leaving the front of the wheelchair unsecured. When the vehicle accelerated, the wheelchair tipped backwards, causing Resident #1's head and back to strike the floor of the van. Emergency services were called, and Resident #1 was transported to the hospital where she was treated for posterior neck pain, upper back pain, a superficial tongue laceration, paraspinal tenderness, and a superficial abrasion to her right hand. A CT scan revealed no evidence of hemorrhage or acute fracture, and the resident was discharged back to the facility the evening of 8/26/25.	F0689		

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F0689 SS = SQC-J	Continued from page 8 On 8/26/25, the transportation driver was removed from driving duties pending retraining and competency validation. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 8/26/25 the facility conducted a 100% audit of progress notes, transport log and interview with the Transportation Driver of in-house facility residents' transports for the past 90 days by the Assistant Director of Nursing (ADON) that was completed on 8/27/25, with no concerns identified. The Assistant Director of Nursing reviewed the transport log to identify any resident that would potentially be transported with facility van. No residents were to be transported until investigation and retraining completed. All scheduled appointments were scheduled by the Transportation Driver with a contracted outside transportation company beginning 8/27/25. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility has two employees who drive the transportation van. The Transportation Driver is the primary driver and the Maintenance Director is the back up driver. The Administrator audited on 8/26/25 the transport employee files: audit to include training, valid driver's license, van maintenance checklist to include proper alignment of the wheelchair between the tie down straps, attaching the rear tie down straps to the rear frame, front tie down straps to the front frame, ensuring tightness on both the front and rear tie downs, and securing seatbelt around resident, and employee vehicle policy to include but not limited to vehicle purpose, driver licensing, maintenance of company van, proof of insurance on company van, traffic violations, usage of cellular phone, accidents involving company vehicle, theft of company vehicle and driver responsibilities in regards to operation of vehicle, use of seatbelts and securement devices and reporting requirements with no concerns identified. The Maintenance Director did the initial education for the Transportation Driver on site of incident and return demonstration on 8/26/25. The Administrator reviewed the manufacturer's video and training documents provided by the facility and re-educated post incident on 8/27/25. The Maintenance Director conducted	F0689		

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F0689 SS = SQC-J	Continued from page 9 education and an initial return demonstration with the Transportation Driver, Director of Nursing and Administrator on 8/26/25 that included proper securement of the wheelchair and van anchors per manufacturer's instructions. Outside Maintenance Director from a sister facility provided additional education to the Administrator, Maintenance Director and Transportation Driver regarding proper securement of the wheelchair and van anchors per manufacturer's instructions on 9/2/25. On 8/27/25 the Administrator initiated 100% in-service with the Maintenance Director and Transportation Driver about proper securement of wheelchairs during transport per manufacturer's instructions. The in-service was completed by 8/28/2025. All newly hired Transport Drivers will be in-serviced by the Maintenance Director during orientation to include the skills check list. The skills check list includes but is not limited to a competency validation of loading, securing and unloading a resident and a return demonstration. The Maintenance Director sent the van out for inspection that included checking functional status of the wheelchair anchors that was completed on 8/27/25 with no concerns identified. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. On 8/26/25 the facility initiated 10% audit of all residents being transported by the facility to be completed by the Maintenance Director weekly x 4 weeks then monthly x 2 months utilizing the Van Transport Audit Tool to ensure proper securing of the resident before leaving the facility and this was taken to Quality Assurance committee meeting on 8/26/25. This audit is an observational audit to determine proper securement of the resident, wheelchair, and van anchors. The results will be documented on the Van Transport Audit Tool. All areas of concern will be addressed by the Administrator and/or Maintenance Director immediately. The Administrator will forward the results of the Van Transport Audit Tool to the Executive Quality Assurance Committee to include Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Infection Control Preventionist/Staff Development Nurse, Activities Director, social workers, unit managers and unit coordinators, Maintenance Director, Minimum Data Set nurse, Dietary Manager, Medical Director and additional staff representatives monthly x 3 months for review to determine trends and / or issues that may need further interventions put into	F0689		

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F0689 SS = SQC-J	Continued from page 10 place and to determine the need for further and / or frequency of monitoring. Completion date 9/3/25 Onsite validation of the facility's corrective action plan was completed on 9/11/25. The initial audit results were reviewed. The in-service education records completed 9/2/25 were reviewed. Interviews with the Transport Driver and Maintenance Director as well as observations of a demonstration of anchoring a wheelchair to a transport van by both staff members were completed. The monitoring results were reviewed, and the Quality Assurance meeting minutes were reviewed. The facility's immediate jeopardy removal date of 9/3/25 was validated.	F0689		