

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 12/03/2025
----------------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------	-------------------------------------------------

NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids	STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870
-------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------

(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was conducted from 12/2/2025 through 12/3/2025. Event ID# 1DCF64-HI</p> <p>The following intakes were investigated: 2594591, 2595775, 2671402, and 2568024.</p> <p>4 of 16 complaint allegations resulted in deficiency.</p>	F0000		01/05/2026
F0725 SS = D	<p>Sufficient Nursing Staff</p> <p>CFR(s): 483.35(a)(1)(2)</p> <p>§483.35 Nursing Services.</p> <p>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.</p> <p>§483.35(a) Sufficient Staff.</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (f) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p>	F0725	<p>1.Address how corrective action will be accomplished for those residents found to have been affected by deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice of medication errors due to sufficient staffing.</p> <p>On 8/14/2025 the Medical Director and responsible parties of Resident #1 and Resident #3 were notified by the Interim DON of the medications that were not administered on 8/14/2025 by the nurse.</p> <p>Resident #1 nor Resident # 3 was sent out to the hospital. New medication orders were provided for Residents # 1 and # 3 by the Medical Director and received by the Interim DON and followed on 8/14/2025.</p> <p>No additional negative findings of medication errors were observed by Nurse # 1 on 8/14/2025.</p> <p>On 12/09/2025 the Unit Manager #1 that was involved in the deficient practice was reeducated on the importance of medication administration with emphasis on ensuring that timely medication administration occurs in the facility daily, shift to shift, reporting process, and the importance of following physician orders by the facility Administrator and the Regional Nurse Consultant.</p> <p>On 12/09/2025, the Staffing Coordinator was reeducated</p>	01/06/2026

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
-----------------------------------------------------------------------	-------	-----------

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0725 SS = D	<p>Continued from page 1 This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interviews with resident and staff, the facility failed to ensure sufficient nursing staff to provide nursing services to residents when 2 of 3 assigned staff members (Medication Aide #2 and Unit Manager #1) did not report to work as scheduled. This deficient practice resulted in significant medication not being administered as ordered for 2 of 3 residents reviewed for significant medication error (Resident #1 and Resident #3).</p> <p>The findings included:</p> <p>a. Resident #1 was admitted to the facility on 7/18/19 with diagnoses which included diabetes.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 7/10/25 revealed Resident #1 was cognitively intact and was coded for hypoglycemic medication which included insulin.</p> <p>The Medication Administration Record (MAR) was reviewed for 8/14/25 and revealed Resident #1 was not administered the scheduled morning dose of insulin aspart (rapid-acting insulin). The MAR administration note, written by Nurse #1, revealed the medication was not administered due to overlapping doses from late administration and the physician was aware.</p> <p>An interview was conducted with Resident #1 on 12/02/25 at 11:43 am who revealed on 8/14/25 he did not receive his morning dose of rapid-acting insulin after he ate his breakfast because the staff member assigned to his care did not come to work. Resident #1 stated he could not remember exactly how he found out what happened that morning, but he stated he probably just went out and asked someone that was working on the unit and was told the staff did not show up for work.</p> <p>b. Resident #3 was admitted to the facility on 2/07/25 with diagnoses which included diabetes.</p> <p>The MDS quarterly assessment dated 8/09/25 revealed Resident #3 had severe cognitive impairment and was coded for use of hypoglycemic medication which included insulin.</p>	F0725	<p>Continued from page 1 by the Facility Administrator on the importance of reporting call outs or staffing concerns timely to the On Call nurse to always ensure appropriate staffing in the facility.</p> <p>Unit Manager # 1 that was involved and all Medication Aides were educated on 12/31/2025 by the current DON regarding the importance of following the work schedule and call off policy as it pertains to the work schedule.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>To ensure that no other resident was affected by the alleged deficient practice on 12/31/2025 the DON audited the Administration Compliance report for the date of 8/14/2025 to ensure that no other resident was affected. No other resident was found to be affected.</p> <p>On 12/31/2025 The Facility Administrator and the DON reviewed August 14th, 2025, through September 30, 2025 On Call Schedule to ensure all Nursing Administrative Staff were scheduled and assigned for Med pass and reviewed the daily Administration report to ensure all Medication were given. No other residents were found to be affected.</p> <p>3. What measure would be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>In order to ensure the deficient practice will not recur on 12/10/2025 the Director of Nursing and or designee educated all Licensed Nurses including agency, and Medication Aides on Shift-to-Shift reporting procedures. Education was completed on 12/10/2025 for all current license nurses and Med Aides.</p> <p>On 12/08/2025 the Facility Administrator educated the Nursing Administration staff on the ON Call policy and procedures and the expectation.</p> <p>On 12/09/2025 the Facility Administrator re- educated the Nursing Administration team on their job description including the Staffing Coordinator and had them to sign verifying their obligations, expectations and understanding.</p> <p>On 12/09/2025 the Facility Administrator reeducated Nursing Administration including Staffing Coordinator</p>	

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0725 SS = D	<p>Continued from page 2</p> <p>The Medication Administration Record (MAR) was reviewed for 8/14/25 and revealed Resident #3 was not administered the scheduled morning dose of insulin apart was not administered. The MAR administration note, written by Nurse #1, revealed the medication was not administered due to overlapping doses from late administration and the physician was aware.</p> <p>The facility's daily assignment sheet dated 8/14/25 revealed the facility census was 79 and the following staff were scheduled to work during the day shift (7:00 am-3:00 pm) for medication administration. Medication Aide #2 was assigned to work on Unit 1 from 7:00 am-3:00 pm, Nurse #2 was assigned to work on Unit 2 from 7:00 am-3:00 pm, and Unit Manager #1 was assigned to work on Unit 3 from 7:00 am-7:00 pm.</p> <p>The daily attendance reports were reviewed and revealed the following nursing staff attendance time for 8/14/25. Medication Aide #2 had no work hours recorded for 8/14/25, Nurse #2 clocked in for the shift at 6:42 am, and Unit Manager #1 clocked in for the shift at 11:10 am. The daily attendance report dated 8/14/25 further noted that the previous Director of Nursing (DON) clocked in at the facility at 12:10 pm and the Nurse #1, the Infection Preventionist, clocked in at the facility at 12:30 pm.</p> <p>An interview was conducted with the Scheduler on 12/02/25 at 2:48 pm who revealed she arrived at the facility on 8/14/25 at approximately 8:30 am and saw that some staff had not yet shown up for their scheduled work shift. The Scheduler stated she contacted Medication Aide #2 who reported she was enroute to the facility, but she later called and said she was not coming to work. The Scheduler stated Unit Manager #1 was the nurse on call for 8/14/25 and was already scheduled to work on a medication cart due to a known staffing shortage for that day so she should have arrived at the facility as scheduled at 7:00 am. The Scheduler stated she did not follow up with the previous DON about why Unit Manager #1 was late to the facility because Unit Manager #1 did not report to the scheduler and she assumed the previous DON and Unit Manager #1 were in contact with each other. The Scheduler stated she did notify the previous DON when she (previous DON) arrived at the facility and the previous DON reported she was already aware of the staffing issue at the facility on 8/14/25. The Scheduler stated she continued to make phone calls to</p>	F0725	<p>Continued from page 2 on the Facility Emergency Staffing plan and implementation; including, educating Nursing Administration on the Facility Scheduling Standards.</p> <p>To ensure future compliance The New Director of Nursing and or SDC will educate upon hiring in orientation all newly hired Nurses, Nurse Managers, Med Aides and agency nurses to the shift-shift procedure, on-call policy and procedure, call- off policy and job duties.</p> <p>4. To make sure that solutions are sustained regarding sufficient staffing</p> <p>The Administrator and or Designee will monitor staffing, which will include daily staffing assignments, shift to shift report, and On Call follow-up with expectations. Weekly x's 4 weeks and then Monthly x's 3 months.</p> <p>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 Meetings.</p> <p>Compliance Date: 01/06/2026</p>	

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0725 SS = D	<p>Continued from page 3 replace Medication Aide #2 but was unsuccessful to find a replacement so the previous DON sent Nurse #1 was sent to Unit 1 to pass medications.</p> <p>An interview was conducted with Nurse #1 on 12/02/25 at 3:46 pm who revealed he arrived at the facility on 8/14/25 at 12:30 pm due to a previously scheduled appointment and he was not aware staff had not shown to work. Nurse #1 stated he was not notified until approximately 2:00 pm that he needed to take the medication cart on Unit 1 by the previous DON because medications had not yet been administered. He stated he went to Unit 1 and began administering resident medications to the residents, but he stated he was unable to administer the morning insulin for Resident #1 and Resident #3 because he was not present in the facility at the time the insulin was scheduled to be administered. Nurse #1 reported that the previous DON notified the Medical Director of the staffing issue and missed or late medication administration to the residents.</p> <p>An attempt to conduct a telephone interview with Medication Aide #2 on 12/03/25 at 9:43 am was unsuccessful.</p> <p>Multiple attempts to conduct a telephone interview with Unit Manager #1 were unsuccessful.</p> <p>A telephone interview was conducted on 12/03/25 at 2:36 pm with Nurse Aide (NA) #1 who was assigned to Unit 1 on 8/14/25 during the 7:00 am to 3:00 pm shift. NA #1 stated she recalled the facility did not have anyone to administer resident medications in the morning on 8/14/25. NA #1 stated that she did ask Nurse #2, who was working on Unit 2, to come and pass medications because a resident had reported to her that she had not received any medication. NA #1 stated she did not report there was no nurse on Unit 1 to anyone because she was told by other staff that the facility was aware.</p> <p>A telephone interview was conducted on 12/03/25 at 11:17 am with Nurse #2 who worked during the 7:00 am to 3:00 pm shift 8/14/25. Nurse #2 stated when she arrived at work on the morning of 8/14/25 she clocked in and went right back to Unit 2, which was located at the back of the building, and began working. Nurse #2 reported she was not aware no other nursing staff</p>	F0725		

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0725 SS = D	Continued from page 4 members were in the facility until she was told by NA #1 sometime during the late morning hours. She reported that NA #1 had requested that she administer a resident pain medication because Unit 1 did not have a nurse. Nurse #2 stated she went over and began passing medications to the residents on Unit 1 and she did her best to pass medications to as many residents as she could until Nurse #1 arrived and came to pass medications. A telephone interview was conducted with the previous DON on 12/02/25 at 2:15 pm who revealed she did not recall the exact situation that occurred at the facility on 8/14/25 or if she was notified about a staffing issue at the facility. She reported she was unable to recall at this time why Resident #1 and Resident #3 did not get the insulin as ordered but she did recall speaking to the physician about medications not being administered on time. During an interview on 12/03/25 at 12:46 pm with the Administrator she revealed she was made aware of the staffing issue and that morning medications were not administered when she arrived at the facility on 8/14/25. The Administrator stated the physician was also notified by the previous DON and the staff made the adjustments as approved by the physician. The Administrator stated the facility should have notified her when the staffing issue was identified.	F0725		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, resident, and Medical Director interviews, the facility failed to administer doses of scheduled rapid-acting insulin due to a staffing issue (Resident #1 and Resident #3) and failed to follow up with a pulmonary consultation recommendation to discontinue a steroid medication (Resident #2) for 3 of 3 residents reviewed for significant medication error. The findings included:	F0760	1, Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents have the potential to be affected by the alleged deficient practice on 8/14/2025 the Medical Director and responsible parties of Resident #1 and Resident #3 were notified by the Interim Director of Nursing that the residents did not receive their morning dose of insulin and order was given to hold morning insulin. Resident # 1 and Resident # 3 did not sustain any negative outcomes nor did they require hospitalization. The alleged deficient practice was corrected for Resident #1 and Resident #3 receiving their second dose of insulin on time from Nurse #1. On 12/10/2025 Licensed Nurse #1 was reeducated on	01/06/2026

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0760 SS = E	<p>Continued from page 5</p> <p>1a. Resident # 1 was admitted to the facility on 7/18/19 with diagnoses which included diabetes.</p> <p>Resident #1 had an active physician order dated 9/16/24 for insulin aspart (rapid-acting insulin) 100 units per milliliter (mL). Administer subcutaneous (under skin) as directed three times a day (8:00 am-11:00 am, 11:15 am-3:00 pm, and 5:00 pm-7:00 pm). Give 15 minutes after each meal: 0 units if no food is eaten, 2 units if 25% of meal eaten, 4 units if 50% of meal eaten, 6 units if 100% of meal eaten. The physician order also included to record the blood sugar before insulin was administered.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 7/10/25 revealed Resident #1 was cognitively intact and was coded for hypoglycemic medication which included insulin.</p> <p>The Medication Administration Record (MAR) for 8/14/25 revealed Resident #1 did not receive the scheduled 8:00 am-11:00 am dose of insulin aspart and there was no blood sugar noted. The MAR administration note, written by Nurse #1, revealed the medication was not administered due to overlapping dose from late administration, physician aware. The MAR further noted that Resident #1 received the next scheduled dose of insulin during the scheduled 11:15 am-3:00 pm timeframe for a blood sugar of 238 mg/dl (milligrams per deciliter) by Nurse #1.</p> <p>An interview was conducted with Resident #1 on 12/02/25 at 11:43 am who revealed he did not receive his morning dose of insulin on 8/14/25 after he ate breakfast because the facility did not have a nurse to administer the medication. Resident #1 stated he did not have any adverse events from not having his insulin but he stated he should have been administered his medication as it was ordered.</p> <p>1b. Resident #3 was admitted to the facility on 2/07/25 with diagnoses which included diabetes.</p> <p>Resident #3 had a physician order dated 3/18/25 for insulin aspart (rapid-acting insulin) 100 units per milliliter (ml). Administer 13 units subcutaneous (under the skin) twice a day that was scheduled to be</p>	F0760	<p>Continued from page 5 medication administration with emphasis on administering timely medication administration by the DON.</p> <p>On 11/11/2025 Resident #2 prednisone was discontinued once error was found resident had no signs or symptoms to the adverse effect of the medication and was not sent to the hospital due to any negative findings.</p> <p>The responsible party of Resident #2 was notified on 11/11/2025 of the medication error by the DON.</p> <p>The Unit Manager #1 that should have reviewed and reported the Consultation report regarding resident # 2 did not receive education due to no longer working for the facility.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents receiving medications have the potential to also be affected by the alleged deficient practice.</p> <p>As of 12/30/25 The DON reviewed Medication administration from the past 7 days to ensure that all medications were completed timely and per physician order there were no negative findings.</p> <p>On 12/30/2025 The DON reviewed the last 7 days of consultations to ensure all physician orders were followed there were no negative findings.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>To ensure that the deficient practice does not recur on 12/10/2025 the DON and or Designee has in serviced all license Nurses, and Med Aides including on timely medication administration. Facility is agency free therefore education was not provided.</p> <p>On 12/30/2025 the DON reeducated nursing</p>	

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0760 SS = E	<p>Continued from page 6 administered between 7:00 am-9:00 am and 4:00 pm-5:00 pm. The physician order also included to record the blood sugar before insulin was administered.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 8/09/25 revealed Resident #3 had severe cognitive impairment and was coded for hypoglycemic medication which included insulin.</p> <p>The Medication Administration Record (MAR) for 8/14/25 revealed Resident #3 did not receive the scheduled 7:00 am-9:00 am morning dose of insulin aspart 13 units and there was no blood sugar noted. The MAR administration note, written by Nurse #1 revealed the insulin was not administered due to overlapping dose from late administration and the physician was aware. The MAR noted the next scheduled dose (4:00 pm-5:00 pm) dose was administered for a blood sugar of 512 mg/dl (milligrams per deciliter) by Nurse #1.</p> <p>During an interview with Nurse #1 on 12/02/25 at 3:46 pm he revealed he arrived at the facility on 8/14/25 at approximately 12:30 pm and went directly to his office and began working. Nurse #1 stated that he was notified by the previous Director of Nursing (DON) around 2:00 pm that he needed to pass medications on Unit 1 because the scheduled staff had not shown up for work and the residents had not received their morning medications. He stated that he did not administer Resident #1's or Resident #3's morning insulin aspart doses because by the time he started passing medications it was time for the second doses of insulin aspart to be administered. Nurse #1 stated that the previous DON made the physician aware that the morning doses of insulin were not administered and the physician gave permission to administer the next scheduled doses of insulin aspart for Resident #1 and Resident #3. Nurse #1 stated that all medications that were ordered to be administered daily or twice a day were administered late on that day but he was unable to administer the morning insulin aspart since the next doses were scheduled to be administered.</p> <p>A telephone interview was conducted with the previous Medical Director on 12/03/25 at 10:40 am. The previous Medical Director confirmed he was the physician assigned to Resident #1 and Resident #3 on 8/14/25. He revealed he was notified by the facility that Resident #1 and Resident #3 had not received their morning dose of insulin aspart due to a staffing issue at the</p>	F0760	<p>Continued from page 6 Administration/ Clinical team on reviewing recommendations, notify the Medical Director, upload in system and finalize per Medical Director's clarification daily in clinical whiteboard meeting.</p> <p>On 12/10/2025, the DON ensured that all licensed nurses and Med Aides has completed the Med Pass competency on medication administration.</p> <p>The Director of nursing will ensure that all future hired nurses, Med Aides and or agency nurses (if applicable), will receive educational training during orientation on timely medication administration and consultation reporting,</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Director of Nursing and/ or Designee will monitor timely medication administration.</p> <p>This monitoring will be completed on three (3) random nurses or Med aides weekly.</p> <p>This monitoring will be completed on a Medication Administration Observation Tool weekly x'4 and then Monthly X's 2.</p> <p>The Director of Nursing and/ or Designee will monitor Consults 3 days a week x' s 4 weeks and then Monthly x's 2 using a consult QI Tool.</p> <p>Reports will be presented at the weekly QA Committee meeting by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate.</p> <p>Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meetings.</p> <p>Compliance Date: 01/06/2025</p>	

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0760 SS = E	<p>Continued from page 7 facility. The previous Medical Director stated he gave permission to hold the morning insulin aspart since Resident #1 and Resident #3 had additional doses that would have overlapped administration times and told the facility to administer the next scheduled dose. He stated he made the best decision that was possible due to the staffing situation at the facility that morning and Resident #1 and Resident #3 did not have a negative outcome from their missed morning dose of insulin aspart.</p> <p>A telephone interview was conducted with the previous DON on 12/02/25 at 2:15 pm who revealed she did not recall the exact situation that occurred at the facility on 8/14/25 but she stated she did notify the physician that the morning dose of Resident #1's and Resident #3's insulin aspart were not administered. The previous DON stated the physician gave the direction for staff to administer the next scheduled dose of insulin aspart for Resident #1 and Resident #3 and to hold the missed doses that were scheduled to be administered that morning.</p> <p>During an interview on 12/03/25 at 12:46 pm with the Administrator she revealed she was made aware of the staffing issue 8/14/25 and that morning medications were not administered when she arrived at the facility. The Administrator stated the physician was made aware of the what had occurred at the facility by the previous DON.</p> <p>2. Resident #2 was admitted to the facility on 10/28/20 with diagnoses which included sarcoidosis of the lung (an inflammatory disease where immune cells form tiny lumps in organs, most commonly in the lungs, lymph nodes, skin, and eyes).</p> <p>Resident #2 had a physician order dated 4/23/25 for prednisone (corticosteroid medication used to reduce inflammation and suppresses the immune system) tablet 2.5 milligrams (mg). Administer 2.5 mg once a day every other day for sarcoidosis until return pulmonology visit. Resident #2's prednisone order was discontinued on 11/11/25.</p> <p>The report of consultation dated 7/30/25 revealed Resident #2 was seen by the pulmonologist for a diagnosis of pulmonary sarcoidosis. The report of consultation further noted to discontinue prednisone,</p>	F0760		

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0760 SS = E	<p>Continued from page 8 continue budesonide formoterol (inhaled corticosteroid and bronchodilator medication), and monitor for respiratory symptoms. The report of consultation was signed by Unit Manager #1 on 7/30/25.</p> <p>Resident #2's Medication Administration Record (MAR) from July 2025 through November 2025 was reviewed and revealed the prednisone was administered daily every other day until discontinued on 11/11/25.</p> <p>Multiple attempts to conduct a telephone interview with Unit Manager #1 were unsuccessful.</p> <p>An attempt to conduct a telephone interview with the pulmonology office on 12/03/25 at 9:44 am was unsuccessful.</p> <p>A telephone interview was conducted with the previous Medical Director on 12/03/25 at 10:40 am. The previous Medical Director confirmed he was Resident #2's assigned physician at the time the pulmonary consultation occurred. He stated he did not recall the recommendation to discontinue the prednisone for Resident #2 and stated he would have most likely agreed with the recommendation and discontinued the medication. The previous Medical Director stated Resident #2 was ordered a very low dose of prednisone every other day so it would not cause the resident any harm to continue the prednisone until it was discontinued.</p> <p>A telephone interview was conducted on 12/03/25 at 10:49 am with the Medical Director who confirmed they were the assigned physician for Resident #2 since October 2025. The Medical Director stated he was unable to recall if he saw the consultation report from the pulmonology visit in July when he was reviewing the chart or he just decided that the prednisone medication was no longer needed when he discontinued the order for Resident #2.</p> <p>A telephone interview was conducted on 12/02/25 at 2:15 pm with the previous Director of Nursing (DON) who revealed she was the DON at the time of the pulmonology consultation for Resident #2. The previous DON stated Unit Manager #1 was responsible for reviewing the consultation reports for recommendations, contact the physician to discuss the recommendations, and</p>	F0760		

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Roanoke Rapids			STREET ADDRESS, CITY, STATE, ZIP CODE 305 East Fourteenth Street , Roanoke Rapids, North Carolina, 27870	
(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
F0760 SS = E	Continued from page 9 discontinue the medication if agreed upon by the physician. She stated after the Unit Manager reviewed the consultation report with the provider and made the necessary changes, the report would be reviewed during the morning clinical meeting. She stated she was unable to recall if Resident #2's consultation report from the pulmonology visit was reviewed during the morning clinical meeting at that time. The previous DON was unable to state why Unit Manager #1 would have signed the consultation report but not discussed it with the physician and discontinued the medication as recommended. An interview was conducted with the Administrator on 12/03/25 at 12:46 pm who revealed she was not aware Resident #2's pulmonary visit consultation report was not reviewed with the physician. The Administrator stated the DON was responsible for ensuring the consultation reports were reviewed with providers and any changes that were recommended were implemented.	F0760		