STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Person Memorial Hospital	615 Ridge Road Roxboro, NC 27573

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, Family Member, and Physician Assistant interviews, the facility failed to provide care in a safe manner when a resident rolled off the raised bed while incontinence care was being provided. The resident had a history of stroke with residual left side weakness. Nurse Aide #1 turned the resident away from her onto her left side with the resident holding the upper side rail with her right hand. While care was being provided Resident #1 stated she could not hold on anymore and rolled out of the bed landing on her knees and immediately complained of pain in her knees, back and legs. Resident #1 was transferred to the local hospital by emergency medical services (EMS) for evaluation and a CT scan (computed tomography scan) confirmed distal right femur (thigh bone just above the knee joint) fracture. It was determined that the resident required a higher level of care and she was transferred to a local trauma center for further evaluation and treatment. CT scans of the lower extremities revealed an oblique fracture (broken at an angle) on the right and left distal femur and left lateral tibial fracture (break in the upper part of the shin bone that forms the lower part of the knee joint). Resident #1 had a surgical procedure used to repair severe fractures by realigning broken bones and securing them with metal hardware of bilateral femur fractures and the left tibial plateau fracture (flat top part of the shin bone). At discharge the resident required acetaminophen 975 milligrams (mg) three times a day, oxycodone (opioid analgesic) 7.5-10 mg every 4 hours as needed and gabapentin 300 mg at bedtime for pain relief. An interview with a Family Member revealed more than two months after the fall and surgical interventions Resident #1 remained in severe pain, her mobility had decreased with physical movements, and her cognition continued to decline. The occurred for 1 of 3 residents reviewed for accidents (Resident #1). Immediate jeopardy began on 7/28/25 when Resident #1 rolled out of the bed onto her knees while Nurse Aide #1 was providing care and resulted in severe fractures. Immediate jeopardy was removed on 11/15/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D which is no actual harm with potential for more than harm that is, not immediate jeopardy to ensure staff education and monitoring systems put in place are effective.Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses included right middle cerebral artery stroke with residual left side weakness, atrial fibrillation and diabetes.Resident #1's quarterly Minimum Data Set, dated [DATE] indicated moderately impaired cognition. She required extensive assistance with transfers and locomotion and one person assistance with activities of daily living and mechanical lift for transfer. Resident #1 was dependent upon staff for bed mobility. She did not have any falls in the past 6 months or since admission. She required as needed pain medication for frequent pain. Resident #1's weight was 135.Review of the Medication Administration Record (MAR) revealed ticagrelor (an antiplatelet medication used to prevent blood clots) 90 milligrams twice a day was started on 5/16/22 for cerebral vascular accident. A focused area of the care plan dated 4/25/25 revealed Resident #1 was at risk for falls related to cerebral vascular accident. The goal included Resident #1 would be free of falls. Interventions included the staff would anticipate and meet the resident needs, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Physical therapy would evaluate and treat as ordered or as needed. Resident #1 needed a safe environment with (even floors, free from spills, and/or clutter), the bed in lower position at night and items within reach. The resident had an activity of daily living self-care deficit related to cerebral vascular accident. The goal was resident would maintain current level of function in daily care needs. Intervention included the resident will have 1/4 side rails up as per physician orders for safety during care provision and to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury. The resident required staff assistance to turn and reposition. The resident required 1-2-person assistance with bathing/showering and the use of a mechanical lift for transfers.A written statement from Nurse Aide #1 dated 7/29/25 indicated nothing had been reported as change in condition regarding the resident to Nurse Aide #1. Resident #1 was her normal self, alert during resident care. Nurse Aide #1 described the incident as she was changing the resident and her sheets, standing on the right side of hospital type bed next to the window. She had the sheet rolled under resident and was placing brief, Resident #1 was holding onto top upper bed rail and said, I can't hold on. Resident #1 turned loose and rolled off bed onto her knees. Nurse Aide #1 said she helped move the residents' legs and laid her down, placed pillow under her head and went to get help. Nurse Aide #2 was across the hall and immediately