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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithfield Manor Rehabilitation and Healthcare Cen	902 Berkshire Road Smithfield, NC 27577

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithfield Manor Rehabilitation and Healthcare Cen	902 Berkshire Road Smithfield, NC 27577

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with the resident, staff, and the Medical Director, the facility failed to follow the manufacturer's 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 [NAME]), 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 [DATE]. 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 [DATE] 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. 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