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	11/04/2025

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 - Actual harm 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
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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff and physician interviews, the facility failed to provide care in a safe manner on 10/26/25 when Resident #1 rolled out of bed while a nurse aide was providing care sustaining a left distal tibia and fibula fracture (two main bones in the lower leg). Resident #1 required surgical intervention to repair the fractures and was discharged back to the facility on [DATE] with a splint applied to her left leg. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included osteoporosis (a disease that makes bones weak and brittle increasing the risk of fractures from falls), vitamin D deficiency, atrial fibrillation (an irregular heartbeat), and dementia. A review of Resident #1's Physician's orders revealed an order dated 7/6/2024 for Apixaban (anticoagulant medication) 5 milligrams (mg) by mouth twice daily for atrial fibrillation. An ADL care plan last revised on 5/19/2025 included the following intervention: the Resident required 2 staff members to assist with ADL. An at risk for falls care plan due to impaired mobility, poor safety awareness, and impulsiveness last revised on 5/19/2025 included the following interventions: ensure the bed is in the lowest position and place frequently used items by the resident within easy reach.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was coded as having memory problems, no alteration in mood or behaviors, required partial to moderate assistance from staff for toileting hygiene, and supervision/touching assistance from staff with rolling from her left to right side in the bed, was coded as receiving physical therapy and occupational therapy services during the assessment period, and receiving a blood thinner. A Physical Therapy discharge summary note dated 10/22/2025 stated Resident #1's discharge functional status for bed mobility was supervision/touch assistance from 1 staff member. A review of Resident #1's undated Care Guide (a guide that explained the level of care a resident required) revealed Resident #1 required assistance from 2 staff members to complete activities of daily living (ADL). An interview was completed on 11/4/2025 at 3:05pm with the Administrator. The Administrator stated at the time of the incident Resident #1's assessed level of bed mobility per Physical Therapy was 1 person supervision/touch. The Administrator stated the therapy department had notified nursing of the change upon Resident #1's discharge from therapy services on 10/22/2025, but her care plan and Care Guide had not been updated yet at the time of the 10/25/25 fall.A telephone interview was completed on 11/4/2025 at 1:12pm with NA #1. The NA stated she was completing incontinence care for Resident #1 on 10/26/2025. NA #1 revealed she raised Resident #1's bed to her waist height and positioned Resident #1 towards the middle of the bed on her back prior to her beginning care. The NA stated she informed Resident #1 she was going to turn her to her left side to clean her. NA #1 stated as she was having Resident #1 turn on her left side away from her, the resident swung her right leg over her left leg and slid off the bed to the floor. NA #1 revealed Resident #1's Care Guide stated she was a 2 person assist with ADL. The NA stated was unable to say why she did not request assistance from another staff member. NA #1 further stated she should have rolled Resident #1 towards her when repositioning her. An Incident Report dated 10/26/25 at 5:40am was completed by Nurse #1 regarding a fall for Resident #1. The nursing description portion of the incident report stated Resident #1 rolled to her left side for Nursing Assistant (NA) #1 to provide ADL care, kept going and rolled off the bed to the floor onto her left side. Resident #1 revealed to Nurse #1 she believed she hit her head during the fall. The resident description portion of the incident report stated she fell off the bed while NA #1 was changing the bed. Nurse #1 assessed Resident #1, and no injuries were observed at the time of the incident. The Resident's Representative was notified on 10/26/2025 at 5:50am and the Physician was notified on 10/26/2025 at 6:11am. A telephone interview was completed on 11/4/2025 at 12:45pm with Nurse #1. The Nurse stated he was the 11:00pm to 7:00am nursing supervisor on the morning of 10/26/25 when Resident #1 fell. Nurse #1 stated he was called to the Resident's room by NA #1 stating Resident #1 had fallen. Nurse #1 stated when he arrived at the room Resident #1's bed raised to his waist height (unable to state how many feet) and Resident #1 was lying on her left side on the floor between the bed and the wall. Nurse #1 revealed the resident stated to him she hit her head as she was falling, but he did not observe any redness, bruising, or swelling. Nurse #1 stated during the assessment of Resident #1, the Resident did not have any complaints of pain or discomfort. The Nurse stated Resident #1 revealed to him she fell from bed as the NA was rolling her to provide care. Nurse #1 stated he notified the Physician of the fall and the resident being prescribed an anticoagulant and was given a verbal order to send