STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. Building B. Wing	12/03/2025

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

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included:a. Resident #1 was admitted to the facility on [DATE] with diagnoses which included diabetes. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #1 was cognitively intact and was coded for hypoglycemic medication which included insulin.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.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. b. Resident #3 was admitted to the facility on [DATE] with diagnoses which included diabetes. The MDS quarterly assessment dated [DATE] revealed Resident #3 had severe cognitive impairment and was coded for use of hypoglycemic medication which included insulin. 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. 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. 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. 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 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. 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. An

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:1a. Resident # 1 was admitted to the facility on [DATE] with diagnoses which included diabetes. 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. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #1 was cognitively intact and was coded for hypoglycemic medication which included insulin. 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.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. 1b. Resident #3 was admitted to the facility on [DATE] with diagnoses which included diabetes. 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 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.The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #3 had severe cognitive impairment and was coded for hypoglycemic medication which included insulin. 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. 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.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 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