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	03/11/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Resident Representative (RR), Nurse Practitioner (NP), and physician interviews, the facility failed to obtain a STAT (immediate or rapid response) mobile x-ray exam when Resident #1 fell and experienced left leg pain for 1 of 3 residents reviewed for falls.Findings included:Resident #1 was admitted to the facility most recently on 02/03/26 with diagnoses that included, in part: End stage renal disease, primary pulmonary hypertension (admission diagnosis), chronic obstructive pulmonary disease, chronic respiratory failure, dependence on renal dialysis, congestive heart failure, paroxysmal atrial fibrillation, sick sinus syndrome, presence of cardiac pacemaker, essential primary hypertension, Type 2 Diabetes Mellitus, poly osteoarthritis, unsteadiness on feet, difficulty in walking, muscle weakness, and limitation of activities due to disability. Review of an admission Minimum Data Set assessment dated [DATE] revealed Resident #1 had severely impaired cognition. She could be understood and did understand others. She had no moods or behaviors. She had impairments to both upper extremities and no impairment to either lower extremity. She had no falls since admission. She received a mechanically altered, therapeutic diet. She had no pressure ulcers. Resident #1 had received anticoagulant medication. She denied pain at the time of the assessment. She received dialysis services. Resident #1 had received Speech Therapy, Occupational Therapy, and Physical Therapy during the assessment look back period. The family of Resident #1 provided the information for the assessment.Review of the care plan for Resident #1 last updated on 02/05/26 revealed the following problem: Resident at risk for falling related to debility and difficulty walking. The category was falls. The goal was for Resident #1 to remain free from falls with major injury with a target date of 05/05/26. Approaches included: 02/17/2026 actual fall, resident sent to emergency room for evaluation and treatment per physician order; therapy evaluation and treat as needed; staff to assist resident with transfers as needed; arrange for a clutter free environment as resident will allow; Keep personal items and frequently used items within reach; encourage and assist resident to assume a standing position slowly; and keep call light in reach.A progress note written by Nurse #2 on 02/16/26 at 7:20 AM was reviewed. Nurse #2 documented she was called to Resident #1's room by the nurse aide where she found Resident #1 laying on the floor. Nurse #2 documented that Resident #1 stated she slid off the bed while trying to sit on the edge. The Resident #1 denied hitting her head or hurting anywhere. The Resident #1 was assessed for any injuries and there were none. She was put back to bed by the nurse aides. Resident #1 was talking about going out to a store shopping during the assessment.An interview was conducted with Nurse #2 on 02/10/26 at 2:15 PM. Nurse #2 stated that she was the wound care nurse; however, staff had called her to Resident #1's room the morning of 02/16/26 because the other nurses were busy elsewhere. She explained Resident #1 was sitting on the floor when she arrived. She assessed the resident including range of motion on all extremities. She found no injury and the resident denied pain. She repeated that there were no indications that the resident had been injured. Nurse #1 recalled Resident #1 was talking about going shopping during the assessment.In a second interview with Nurse #2 on 03/11/26 at 10:05 AM she stated that she had called the RR on the morning of 02/16/26 after Resident #1 fell. Nurse #2 explained she informed the RR that Resident #1 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 so that dialysis could access her intravenous port easier. Nurse #3 recalled Resident #1 had been sitting on the side of the bed joking with the RR and laughing prior to going to dialysis. Nurse #3 stated that at no time while they were dressing the resident to go to dialysis on the morning of 02/17/26 did the resident indicate she was in pain or even say, ouch, when she was getting ready. Nurse #3 reported that the mobile x-ray technician came to the facility to do the STAT x-ray but Resident #1 had already went to dialysis. Nurse #3 stated that she had called the dialysis unit around 1:30 PM on 02/17/26 to check on Resident #1 because the RR had voiced concern that Resident #1 was in pain and was told by the dialysis nurse that Resident #1slept through her treatment from her arrival until the time she called to inquire. Nurse #3 reiterated that the dialysis nurse did not report to her that the resident was in any pain.An additional interview with Nurse #3 was conducted on 03/11/26 at 3:34 PM at her request. Nurse #3 stated that she did remember that the RR had told her that she thought Resident #1 was in pain around 8:30 AM or 9:00 AM the morning of 02/17/26. Nurse #3 stated she did recall she went to the room and assessed Resident #1. Resident #1 told her she was not in pain. Nurse #3 stated she listened to her lungs, palpated her stomach, palpated both hip areas and moved both of her legs by bending each leg at the knee. She did not note any signs of pain as she assessed Resident #1. She stated it was at that point that she assisted the RR to change the residents shirt. She stated the RR asked her to medicate Resident #1 for pain and she did administer (2) Tylenol 325 Milligram pills to the resident but forgot to record the administration on the Medication Administration Record (MAR). Nurse #3 stated she felt Resident #1 was okay to go to her dialysis appointment.Record review of the February 2026 MAR for Resident #1 showed that no Tylenol medication had been administered to Resident #1 on 02/17/26.In an interview on 03/10/26 at 3:23 PM the Director of Nursing (DON) She stated that Resident #1's RR was at the facility the morning of 02/17/26 and requested that the resident be administered Tylenol for pain prior to going to dialysis. The DON explained that she told the daughter she would assess the resident herself when the resident returned from dialysis and that she would also call the dialysis unit while the resident was there to check her status. She reported that she had called the dialysis facility and was told by the dialysis staff that the resident was fine and was sleeping as usual with no complaints of pain. The DON stated when Resident #1 returned from dialysis she assessed the resident and found that when she attempted to rotate her left leg she grimaced and guarded her leg. The DON reported that she immediately called the provider and obtained an order to send the resident to the emergency room for an evaluation. The DON noted Resident #1 was sent to the emergency room that day at 4:41 PM. She stated she had interviewed Nurse #1 the morning of 02/17/26 and that Nurse #1 told her Resident #1 had been found on the floor the previous evening and when she assessed the resident she found no injury and the resident did not show any signs of pain during range of motion. Nurse #1 explained that she had called the provider and had received an order for a STAT x-ray. The DON stated STAT mobile x-rays were normally completed within 4 hours. She noted that when she called the mobile x-ray provider she was told the provider would have to conduct their own investigation to determine why the STAT x-ray was not completed. The DON explained that she had provided the mobile x-ray technicians with the code to unlock the facility doors but that she learned that the technician who responded to the STAT order was new, did not have the code to the door, and was not able to alert staff that she was there to do the x-ray because after repeated attempts no staff answered the doorbell or the phone. The DON stated that on 02/17/26 when the mobile x-ray technician returned to the facility at 3:01 PM to do the exam, Resident #1 was at dialysis. In an additional interview on 03/11/26 at 1:58 PM, the DON recalled that she had placed a call to the NP on the morning of 02/17/26 and explained that Resident #1 had not received the STAT x-ray that had been ordered the evening of 02/16/26. She reported that the NP told her that if Resident #1 was not in distress that it was okay for her to go to dialysis and get the x-ray later. The DON did not assess Resident #1 for pain at that time because she saw the resident sitting in her wheelchair and laughing as she waited to go to dialysis. She also clarified that she had mistakenly reported that she had called the dialysis unit to (continued on next page)

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