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	03/26/2026

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with family member and staff, the facility failed to ensure transportation was arranged for a resident's follow-up appointments following his discharge from the hospital and subsequent admission to the facility for his medical care. This was for 1 of 3 residents reviewed for professional standards of practice (Resident # 1).The findings included:Record review revealed Resident # 1 was hospitalized from [DATE] to 3/5/25 and then admitted to the facility on [DATE] with a diagnosis of Stage IV basal cell carcinoma with metastatic disease to the lung and bone. Additionally Resident # 1 had a diagnosis of Stage IV Kidney disease.Review of Resident # 1's hospital Discharge summary dated [DATE] revealed it included information that Resident # 1 had diagnostic and physician appointments scheduled related to his cancer and kidney disease diagnosis for 3/18/26. The first appointment was scheduled at 7:00 AM on 3/18/26 and subsequent appointments had designated times already arranged for that same day. The appointments included such things as a preclinical PET (positron emission tomography scan) and appointments with an oncologist and nephrologist. (A PET scan is a nuclear imaging test that can help stage cancer.) The information in the discharge summary included the department and location of each appointment.A review of facility records revealed a physician's progress note, dated 3/9/26, noting that Resident # 1's family member was present and reporting to the physician that Resident # 1 had an oncology follow up scheduled for 10 days and was questioning if transportation could be arranged.Resident # 1's Family Member was interviewed on 3/24/26 at 12:12 PM and reported the following information. He (the family member) had gone to the oncology appointment on 3/18/26 with plans to meet Resident # 1 there. He thought the facility had arranged Resident # 1's transportation to the appointments. The Family Member indicated Resident # 1 did not show up and his appointments were missed.The Transportation Nurse Aide was interviewed on 3/26/26 at 1:00 PM and reported the following information. When a new resident arrives, the nursing staff read the discharge summary and then give the discharge summary to her so that she can review the information for any appointments on the discharge summary for which transportation needs to be arranged. Resident # 1's discharge summary was not given to her for review, and she did not know anything about his 3/18/26 appointments. The Transportation Nurse Aide also stated no one mentioned the appointments to her. She could have taken Resident # 1 to his 3/18/26 oncology appointments if she had known.The facility Social Worker was interviewed on 3/26/26 at 8:05 AM and reported the following information. She was not aware of any of Resident # 1's missed appointments. The Transportation Nurse Aide routinely checked hospital discharge summaries for pending appointments and arranged to transport residents. If the Transpiration Nurse Aide was absent, she would assist with the process.The Director of Nursing was interviewed on 3/25/26 at 7:56 PM and reported the Transportation Nurse Aide should have been given the discharge summary to arrange Resident # 1's transport to his oncology appointments on 3/18/26, but this had not happened. The Director of Nursing did not report why the Transportation Nurse Aide had not been given the information. She (the DON) had not been aware of the problem until after Resident # 1 missed his appointments. The DON further reported that Resident # 1 was transferred back to the hospital later in the day following his first missed appointment on (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/18/26 and therefore the facility had not had time to arrange for the follow ups to take place.Following the interview with the Transportation Nurse Aide on 3/26/26 at 1:00 PM during which the Transportation Aide reported that nursing staff had not given her Resident # 1's discharge summary in order that she knew to make transportation arrangements, an attempt was made to speak to Resident # 1's admitting nurse. According to an interview with the Corporate Nurse Consultant on 3/26/26 at 1:50 PM Nurse # 1, who had admitted Resident # 1 on 3/5/26, had experienced a personal emergency and was not available for interview.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, family member, and Wound Nurse Practitioner (NP), the facility failed to ensure a resident diagnosed with cancer was administered pain medication when the resident requested. This was for 1 of 3 sampled residents reviewed for pain (Resident # 1).The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE] at 6:53 PM and resided there until his discharge on [DATE]. Resident # 1 had diagnoses which included stage IV basal cell carcinoma with metastatic disease to the lung and bone, open malignant wound to the posterior left shoulder, neuropathy, and a history of cervical and thoracic spine surgery.Review of physician orders revealed Resident # 1 had orders dated 3/6/26, for hydrocodone (opioid pain medication) 5-325 mg (milligrams) every four hours as needed for pain, oxycodone (opioid pain medication) 10 mg every six hours as needed for pain, and gabapentin (medication used for neuropathic pain) 800 mg three times per day. Review of Resident # 1's admission Minimum Data Set assessment, dated 3/11/26, revealed Resident # 1 was cognitively intact and frequently experienced moderate pain which interfered with his day-to-day activities. During the last five days of the assessment period the resident had reported his highest pain level as a 7 on a scale of 1 to 10 (Zero would indicate no pain and ten would indicate the worst pain imaginable).Resident # 1's care plan, dated 3/16/26, included the information that Resident # 1 had complaints of pain related to his wound and cancer malignancy. Interventions on the care plan included to encourage Resident # 1 to request pain medication as needed and to offer the medication as ordered.During an interview with Resident # 1's family member on 3/24/26 at 12:12 PM, the family member reported the following information. Resident # 1 was alert and could ask for pain medication when he resided at the facility. Resident # 1 had voiced to him (the family member) that he would call for his pain medication, and it would take a couple of hours for the staff to administer pain medication. The family member did not reference a specific date when this had occurred but indicated it was a general problem. Resident # 1's pain was in his back and in his shoulders.On 3/24/26 at 1:17 PM the facility's Physical Therapist and Physical Therapy Assistant # 1 were interviewed together regarding Resident # 1's pain. The Physical Therapist reported Resident # 1 had pain, but he was able to stand on the day of her initial evaluation. Following the initial evaluation, PTA # 1 had then consistently worked with Resident # 1. PTA # 1 reported on her first day the resident pivoted but in following days he did not stand or pivot because pain limited his ability to get out of bed. His pain had been in his neck and upper back area. She therefore worked with him on positioning and saw that he would grimace. He would say that his pain was always a 8, 9, or 10. She (PTA # 1) would report the pain to the nursing staff.Nurse # 1, who had routinely cared for Resident # 1, was interviewed on 3/24/26 at 1:52 PM regarding Resident # 1's pain. Nurse # 1 reported the following information. Resident # 1 had both hydrocodone and oxycodone ordered for pain. The nursing staff would try to administer the hydrocodone first and then the oxycodone if needed. The resident was administered his pain medication when requested and when therapy reported the resident's pain. For the most part the pain medication was effective when administered.The Wound NP was interviewed on 3/26/26 at 10:28 PM about Resident # 1's pain. The Wound NP reported the resident's pain in his shoulder and neck were probably due to radiating cancer pain.Review of assignment sheets revealed Nurse # 2 was assigned to care for Resident # 1 starting at 7:00 PM on 3/16/26.Review of Resident # 1's March 2026 Medication Administration Record (MAR) revealed Resident # 1's evening dose of gabapentin was scheduled to be administered every day between an interval timeframe rather than a scheduled hour. The interval was from 7:00 PM to 11:00 PM. Nurse #2 was responsible for caring for Resident # 1 during this timeframe and Nurse #2's initials did not appear on the MAR by the 3/16/26 evening dose. (A nurse's initials by a medication on the MAR would indicate that nurse was the one to administer medication.) Instead, Nurse # 3's initials appeared by the gabapentin evening dose of 3/16/26 with no indication on the MAR when it was (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given. Further review of the MAR revealed the first dose of oxycodone on the shift which began at 7:00 PM on 3/16/26 was at 1:48 AM on 3/17/26. This was documented as administered by Nurse # 3 and as removed by Nurse # 3 on 3/17/26 at 2:00 AM from controlled medication storage for administration. There was no documentation Resident # 3 received hydrocodone-acetaminophen on the shift which began at 7:00 PM on 3/16/26. On 3/25/26 Nurse Aide (NA) # 1, who had cared for Resident # 1 on multiple occasions, was interviewed regarding Resident # 1's pain. NA # 1 reported the following information. Resident # 1 always had excess pain, and she knew to be careful with him. She was aware of one instance when he requested pain medication, and he did not receive it for several hours because she could not find the nurse. This was either on 3/16/26 or 3/17/26. She worked with him beginning at 7:00 PM on the night when the pain medication was delayed and she had made initial rounds between 7:00 PM and 7:30 PM. During that time, she had asked Resident # 1 if he needed anything. He had reported that he needed his pain medication, and she told him she would relay the message to the nurse. Resident # 1's Nurse (Nurse # 2) had been at the desk, and she (NA # 1) told Nurse # 2 that Resident # 1 was requesting his pain medication and Nurse # 2 replied she would get to it. Then she (NA # 1) went to attend to other duties. Around 8:30 PM she saw Resident # 1's call light on and he reported again he needed his pain medication and had not received any. She again told the resident that she would check with the nurse. At the time, Nurse # 2's cart was at a particular area in the hallway, and she had not seen it moved up and down the halls. NA #1 recalled she could not find the nurse. That evening Resident # 1 kept calling for his pain medication. He would see her (NA # 1) as she went up and down the halls and yell out to her, I am in pain. Nurse # 1's medication cart continued to stay in the same position throughout the evening, and she did not see her at the cart and could not find her. At some point she saw a Medication Aide (MA) who was assigned to another Unit. She thought it was MA # 1 and she (NA # 1) asked MA # 1 if she had seen Nurse # 2 and let her know she could not find her. She thought MA # 1 went to look for Nurse # 2 outside. At some point she thought she saw Nurse # 2 come back in after she (NA # 1) had mentioned the problem of not being able to locate the nurse, but she did not know what Nurse # 2 did and did not recall speaking to her. Several people called the Director of Nursing (DON) that night and the DON had to come to the facility and direct other staff to administer pain medication to Resident #1. She thought it was midnight or after before Resident # 1 received any pain medication because of this. NA # 1 was interviewed regarding whether Resident # 1 was able to go to sleep without his pain medication that night and reported he had not because he was hurting.Nurse # 3 was interviewed on 3/25/26 at 10:38 AM and reported the following information. She worked from 7:00 PM on 3/16/26 until 7:00 AM on 3/17/26 on Unit 2. Resident # 1 resided on Unit 3 and Nurse # 2 was assigned to care for Resident # 1. Other staff members had alerted her that Nurse # 2 was asleep in her car on the evening of 3/16/26 and that residents on Nurse # 2's unit needed their medications. Nurse # 3 did not specify who alerted her first to the problem. One of the residents, who was in need of medication, was Resident # 1 and he needed his pain medication. Nurse # 2 had the keys to Unit 3's medication cart in her pocket and therefore she (Nurse # 3) could not access Resident # 1's medications to administer the resident any pain medication. She called Nurse # 4, who was the on-call nurse, and requested for help because she had her own residents for whom to care and could not access any pain medication for Resident # 1. Nurse # 4 informed her that he had to work the next day at 7:00 AM and that she needed to go to the car and awaken Nurse # 2. Nurse #3 indicated she called the DON also and alerted her to the problem. Her first call was made at 8:29 PM to the DON and the DON also told her to try to awaken Nurse # 2. Nurse #3 stated she went to the car to awaken Nurse # 2, and two other staff members also went on separate occasions that evening to try to awaken Nurse # 2 that evening. When she (Nurse # 3) went to the car, Nurse # 2 cracked the door, and she did not talk but wiped her face and she never came into the facility. Nurse #2 closed the car door and went back to sleep. She (Nurse # 3) called the DON multiple times to alert her to the problem, and the DON repeatedly told her to try to awaken Nurse # 2. By midnight Nurse # 2 was still asleep in her car, and the DON said she would come to the facility. By (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	referencing her phone regarding phone calls, Nurse # 3 reported that the DON arrived at 12:28 AM and Resident # 1 still had not had his pain medication by that time. The DON got Nurse # 2 out of her car, had her come into the facility and count off (reconcile the controlled substances), and sent Nurse # 2 home. The reconciliation took longer because there was a problem that needed to be found and corrected. After the problem was accounted for, she (Nurse # 3) then started to help administer medications on Unit 3 since the keys could then be accessed to the medication cart. Resident # 1's pain medication had not been given by Nurse # 2. She (Nurse # 3) administered pain medication around 2:00 AM to Resident # 1. At the time Resident # 1 had tears in his eyes and rated his pain level a 20 on a scale of 1-10.MA # 3 was interviewed on 3/25/26 at 9:39 PM. MA # 3 indicated she had been in orientation with Nurse # 3 on the evening of 3/16/26 on Unit # 2 and reported the following information. She had accompanied Nurse # 3 to Unit 3 when the DON arrived on the shift which began at 7:00 PM on 3/16/26 and she had counted (reconciled controlled medications) with Nurse # 2 at that time. After the count was reconciled and Nurse # 2 was sent home, she helped administer medications. She did not recall going into Resident # 1's room when Nurse # 3 went to administer his pain medication. She did see the DON walk around and check on residents but could not attest to which rooms she went into. She (MA # 3) did not hear anyone yelling out or crying in pain while on Unit 3.MA # 1 was interviewed on 3/25/26 at 5:20 PM and reported the following information. She was not assigned to Resident # 1 but needed Nurse # 2 to help with a nursing task that was not related to Resident # 1 on the evening of 3/16/26. She tried to find Nurse # 2 and someone pointed to her that Nurse # 2 was outside. She went outside and found Nurse # 2 in the car. She banged on the door to get her attention and told her there was a resident that needed some assistance which she (MA # 1) could not render as a medication aide. At that point Nurse # 2 came into the facility but she did not know how long she was in the facility or what she did.Nurse # 2 was interviewed on 3/25/26 at 4:12 PM and reported the following information. She had not been feeling well on the evening of 3/16/26 and the DON was aware of this. She had gone to her car for break close to the time the DON came to relieve her. Nurse #2 indicated she was not aware of Resident # 1 being in pain and she had not administered pain medication to him.The DON was interviewed on 3/25/26 at 7:56 PM and reported the following information. She had received a call from Nurse # 3 around 8:00 Pm on 3/16/26 but it was not related to Nurse # 2 being in her car and not giving medications. She first received a call on 3/16/26 at 10:32 PM from Nurse # 3 about Nurse # 2 being asleep in her car. She directed Nurse # 3 to try to awaken Nurse # 2 and also told Nurse # 2 that she (the DON) would also call Nurse # 2. She called Nurse # 2 and told her that staff were reporting she was asleep in her car and Nurse # 2 responded that she was on break. She (the DON) responded to Nurse # 2 that staff were reporting she had been on break longer than her allowed break and she directed Nurse #2 to go back into the facility. At 12 something she received another call from Nurse # 3 saying that Nurse # 2 was back in her car and she went to the facility. The DON indicated she arrived at 12:28 AM and found Nurse # 2 in the car. She made Nurse # 2 get out of the car and went with her into the facility where she then had Nurse # 2 reconcile controlled medications with another staff member. There had been a problem with a controlled substance not being signed out but she (the DON) was able to review the MARs and reconcile where the problem had occurred. After the problem was reconciled, she then sent Nurse # 2 home. The DON stated she checked on all the residents to make sure they were okay. She did not recall exactly what time she had entered Resident # 1's room, but when she checked on him, he was asleep. Prior to coming to the facility, she had dressed quickly and needed to return home to dress in professional attire. She asked that other staff who were present attend to any medications needed while she went home quickly and returned to the facility. The DON was interviewed regarding why NA # 1 and Nurse # 3 would indicate that the resident had not been sleeping and had been in pain and reported she did not know.The interim Administrator was interviewed on 3/25/26 at 10:00 AM and reported the following information. She was aware that Nurse # 2 had gone to her car on the evening of 3/16/26 for a break and fallen asleep. She did not know the details of how long she was in the car (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or anything about Resident # 1 needing pain medication while the nurse was in the car. She knew the DON had been aware of the situation and had taken care of it.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with resident, staff, and pharmacist the facility failed to ensure the accurate documentation and administration of controlled medications (Residents # 1 and # 4) and that the facility's system to account for controlled medications was being followed between shift change and upon receipt and removal of controlled medications in sufficient detail to enable an accurate reconciliation. This was for 3 of 3 sampled residents whose controlled drug records were reviewed for accurate documentation of administration and removal from locked storage (Residents # 1, # 2, and # 4) and for 1 of 1 unit's records reviewed for accounting of controlled medications at shift change and upon receipt or return of controlled medications.The findings included:1. Record review revealed Resident # 1 was admitted to the facility on [DATE] at 6:53 PM and resided there until his discharge on [DATE]. Resident # 1 had diagnoses which included but were not limited to the following: Stage IV basal cell carcinoma with metastatic disease to the lung and bone, open malignant wound to the posterior left shoulder, neuropathy, and a history of cervical and thoracic spine surgery.Review of orders revealed Resident # 1 had an order, dated 3/6/26, for hydrocodone 5-325 mg (milligrams) every four hours as needed for pain.Review of orders revealed additionally Resident # 1 was ordered oxycodone 10 mg every six hours as needed for pain. This was originally ordered on 3/6/26.Review of Resident # 1's March 2026 Medication Administration Record (MAR) revealed Resident # 1 was documented on the MAR to receive hydrocodone 5-325 mg one time while he resided at the facility. This was on 3/10/26 at 9:35 PM and was noted to be administered by Nurse # 5.Review of Resident # 1's hydrocodone-acetaminophen 5-325 mg Controlled Drug Record revealed the hydrocodone-acetaminophen Controlled Drug Record did not reconcile with the MAR. The hydrocodone-acetaminophen was signed out 11 times from storage with no indication it was administered on the MAR. (A Controlled Drug Record sheet is a log on which nurses are to document their signature, date, and time when a controlled medication is removed from locked storage for administration.) The following documentation was on Resident # 1's hydrocodone-acetaminophen Controlled Drug Record:3/6/26 at 2:00 PM-Nurse # 1 signed for a removal of hydrocodone-acetaminophen3/9/26 at 9:00 AM-Nurse # 1 signed for a removal of hydrocodone-acetaminophen3/9/26 at 2:00 PM-Nurse # 1 signed for a removal of hydrocodone-acetaminophen3/10/26 at 1:30 AM Nurse # 6 signed for a removal of hydrocodone-acetaminophen3/10/26 at 8:30 AM Nurse # 1 signed for a removal of hydrocodone-acetaminophen3/10/26 at 2:30 PM Nurse # 1 signed for a removal of hydrocodone-acetaminophen3/11/26 at 6:00 AM Nurse # 5 signed for a removal of hydrocodone-acetaminophen3/11/26 Nurse # 5 signed for a removal of hydrocodone-acetaminophen (no time was documented)3/11/26 Nurse # 5 signed for a removal of hydrocodone-acetaminophen (no time was documented)3/13/26 at 9:00 AM Nurse # 1 signed for a removal of hydrocodone-acetaminophen3/13/26 at 2:00 PM Nurse # 1 signed for a removal of hydrocodone-acetaminophen Review of Resident # 1's March 2026 MAR revealed oxycodone 10 mg was administered 11 times while Resident # 1 resided at the facility. The following was documented on Resident # 1's MAR: 3/6/26 at 9:08 PM Nurse # 7 documented an administered dose of oxycodone3/7/26 at 5:43 AM Nurse # 7 documented an administered dose of oxycodone3/8/26 at 1:12 PM Nurse # 4 documented an administered dose of oxycodone3/8/26 at 10:56 Nurse # 8 documented an administered dose of oxycodone3/11/26 9:35 PM Nurse # 5 documented an administered dose of oxycodone3/12/26 at 10:03 AM MA # 2 documented an administered dose of oxycodone3/13/26 at 9:35 AM Nurse # 1 documented an administered dose of oxycodone3/14/26 at 1:31 PM MA # 4 documented an administered dose of oxycodone3/17/26 at 1:48 AM Nurse # 3 documented an administered dose of oxycodone3/17/26 at 10:08 AM Nurse # 1 documented an (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered dose of oxycodone3/18/26 at 4:26 AM Nurse # 9 documented an administered dose of oxycodone Review of Resident # 1's Oxycodone 10 mg Controlled Drug Record revealed the Oxycodone was removed from storage and signed out 13 times but was not initialed on the MAR as administered. The following was documented on Resident # 1's Oxycodone 10 mg Controlled Drug Records: 3/6/26 at 9:00 AM Nurse 10 signed for a removal of oxycodone3/6/26 at 2:00 PM Nurse # 1 signed for a removal of oxycodone3/9/26 at 4:05 AM Nurse # 11 signed for a removal of oxycodone3/9/26 at 10:15 AM Nurse # 1 signed for a removal of oxycodone3/9/26 at 4:20 PM Nurse # 1 signed for a removal of oxycodone3/10/26 at 11:00 AM Nurse # 1 signed for a removal of oxycodone3/11/26 at no documented time Nurse # 5 signed for a removal of oxycodone3/11/26 at no documented time Nurse # 5 signed for a removal of oxycodone3/13/26 at 6:00 PM Nurse # 1 signed for a removal of oxycodone3/14/26 at 2:40 AM Nurse # 2 signed for a removal of oxycodone3/14/26 at 10:45 PM Nurse # 2 signed for a removal of oxycodone3/15/26 at 10:00 AM Nurse # 1 signed for a removal of oxycodone3/16/26 at 1:35 PM Nurse # 1 signed for a removal of oxycodone Nurse # 5 was interviewed on 3/25/26 at 3:46 PM regarding signing out three doses of oxycodone and three doses of hydrocodone-acetaminophen from Resident # 1's supply of controlled medications on 3/11/26 with indication on the MAR that only one dose of oxycodone was administered on that date by him, and no doses of hydrocodone-acetaminophen were administered by him on that date. Nurse # 5 reported the following information. He was scheduled to work at 7:00 PM starting on 3/11/26. He arrived late and he did not think that he and Nurse # 1 counted controlled drugs that night before he took the keys and began work. He was not sure about whether they had or had not. Resident # 1 needed pain medication at 9:34 PM on 3/11/26 and he administered oxycodone for which he signed both on the MAR and the controlled drug record. At 6:00 AM on 3/12/26, Resident # 1 was in pain again. Therefore, he gave him some hydrocodone-acetaminophen but did not put the administration of the hydrocodone-acetaminophen on the MAR. Nurse # 5 also put it on the controlled drug sheet as being removed at 6:00 AM on 3/11/26 and it should have been 6:00 AM on 3/12/26. At the end of his shift at 7:00 AM on 3/12/26, the count was off for both Resident # 1's oxycodone and hydrocodone-acetaminophen. He thought Nurse # 1 had given some doses of both these pain medications on 3/11/26 which she had not signed as removed from storage and it had gone unnoted since they had not counted at 7:00 PM on 3/11/26. Therefore, he signed out two more oxycodone and two more hydrocodone and left the times blank so that Nurse # 1 could come back and fill in the times that the doses were removed by her. He felt he had to do that, or the count would not have been correct. Nurse #5 thought he had talked to Nurse # 12 about this issue. Nurse # 12 was the Unit Manager and had counted with him at 7:00 AM on 3/12/26. The interview further revealed if he had not talked to the Unit Manager about the count being incorrect, then he should have done so. According to the nurse he knew that he was to notify a manager if the count was not correct so that the count could be checked and a notation written about what action was taken. The Unit Manager (Nurse # 12) was interviewed on 3/26/26 at 10:00 AM and reported the following information. The number of controlled medications matched the number recorded on the sheets when she counted with Nurse # 5 at 7:00 AM on 3/12/26 and she had not noticed that Nurse # 5 had signed out for six doses of controlled drugs for Resident # 1 on 3/11/26. At the time of the count, she had been looking to ensure the number of controlled drug pills in storage matched the number on each Controlled Drug Record sheet and they matched which indicated no obvious problems with the count to her. Nurse # 5 had not talked to her about the count being off and that he had signed out extra medication to make the count correct. Nurse # 5 should not have signed out for controlled medications that he himself had not removed from storage. Nurse #12 stated each nurse that removed controlled medications from storage was supposed to sign, date, and time the removal of each individual dose and document the administration on the MAR. Nurse # 1 was interviewed on 3/25/26 at 12:40 PM and reported the following information. She had administered to Resident # 1 all the controlled drugs for which she had signed removal from his supply during his residency. He had experienced pain while he resided at the (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility and needed pain medication. Nurse #1 indicated she would get busy with her work and forget to document the administration on Resident # 1's MAR after she removed the doses from locked storage. During a follow up interview with Nurse # 1 on 3/25/26 at 5:30 PM regarding Nurse # 5's comments that he did not think she (Nurse # 1) and he (Nurse # 5) had counted at shift change on 7/11/26 at 7:00 PM and that some of his (Nurse # 5's) removals of oxycodone and hydrocodone-acetaminophen from drug storage was actually meant to reflect Nurse # 1's removal and administration on 3/11/26. During the interview, Nurse # 1 reviewed the count sheet and reported she could not specifically recall if this had been the case, but that it was possible that it had been. Nurse # 6 was interviewed on 3/26/26 at 1:08 PM regarding Resident # 1's dose of hydrocodone-acetaminophen she had removed from controlled drug storage on 3/10/26 at 1:30 AM without documentation of administration to Resident # 1. Nurse # 6 reported she had administered the hydrocodone-acetaminophen but had forgotten to sign for the administration on Resident # 1's MAR. On 3/26/26 at 12:06 PM an attempt was made to interview Nurse # 10 regarding the dose of oxycodone she removed from Resident # 1's controlled drug supply on 3/6/26 at 9:00 AM without documentation of administration. Nurse # 10 could not be reached on that date. On 3/26/26 at 12:00 PM an attempt was made to interview Nurse # 11 regarding the dose of oxycodone she removed from Resident # 1's controlled drug supply on 3/9/26 at 4:05 AM without documentation of administration. Nurse # 11 could not be reached. During interviews with the Director of Nursing (DON) on 3/24/26 at 7:10 PM and again on 3/25/26 at 7:56 PM, the DON reported the following. She would expect that the documentation of removal of controlled substances from locked storage should coincide with documentation of administration to a resident. She recalled speaking directly to Nurse # 5 at one point and did one on one training and educated him that he could not sign out controlled medications for another nurse. She thought this was regarding a problem with documentation related to Resident # 1 but did not recall for sure. The DON was not aware of unaccounted for controlled medications. Interview with the interim Administrator on 3/26/26 at 3:50 PM revealed there should be an accurate accounting of controlled medications, and she was not aware of problems with the accounting of controlled medications. 2. Unit 3's controlled substance count sheet was reviewed for dates and times which began on 3/10/26 at 7:00 PM through 3/19/26 at 7:00 AM. (The controlled substance count sheet is a document on which nurses sign they have reconciled the number of controlled medications between shifts.) The sheet contains columns where an off-going nurse is to sign with an oncoming nurse after they reconcile the count of controlled drugs. There are also columns for the off-going nurse and on-coming nurse to document the total number of cards/containers in the controlled drug storage and the total number of count sheets. (The number of count sheets should coincide with the number of cards/containers of controlled drugs in storage at each accounting between nurses.) There are also columns on the controlled substance count sheet to reflect if controlled medications and their accompanying count sheets have been removed from the total or added to the total during the shift. The columns include a place where nurses are to document a resident's name if a new card/container of medication has been added or subtracted to the number stored, the medication and strength added or subtracted, the number of cards/containers added or subtracted out each shift, the number of sheets added or subtracted out of the count each shift, and columns for two nurses to sign when cards/containers of medications and their accompanying sheets are added or subtracted out of the total count. For Unit 3, between 7:00 PM on 3/10/26 through 7:00 AM on 3/19/26 20, according to the column which noted the number of medication cards added or subtracted to the count, there were twenty (20) medications which were either signed in or out to the total count. For eleven (11) out of these twenty (20) times medications were added in or subtracted out of the total count, there was only one nurse's signature. For seven (7) of the twenty (20) medications added or subtracted out of the total there was no nurse's signature. For two (2) of the twenty (20) medications added in or subtracted out of the total count between 3/10/26 and 3/19/26, there was no notation about what medication was added, for which resident, and by which nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(There was just a +1 documented for these two occurrences without any further information.) Further review of Unit 3's controlled substance count sheet for 7:00 PM on 3/10/26 through 7:00 AM on 3/19/26, revealed the documentation did not always reveal which nurse was accountable for the reconciliation of controlled medications between shift changes on multiple days. The number of sheets and the number of cards/containers they counted and reconciled were also not consistently documented during each change of shift. Specifics were as follows: 3/11/26 at 7:00 PM -On-coming Nurse- no documented signature; The number of cards/containers/ medication sheets which were counted and reconciled was blank. (During an interview with Nurse # 5 on 3/25/26 at 3:46 PM, Nurse # 5 reported he was the on-coming nurse, and he thought that he and the off-going nurse had not counted and reconciled the controlled medications.) 3/12/26 at 7:00 AM -Off -going Nurse- no documented signature; The number of cards/containers/ medication sheets which were counted and reconciled was blank. 3/13/26 at 7:00 AM -Off-going Nurse no documented signature 3/14/26 -On-coming Nurse-no documented signature; There was no documented time the changeover and reconciliation occurred. The number of cards/containers/ medication sheets which were counted and reconciled was blank. 3/15/26-completely blank other than the date; This followed the 3/14/26 date which had no time. 3/15/26 at 7:00 PM- Off-going Nurse no documented signature; The number of cards/containers/ medication sheets was blank. 3/16/26 7:00 AM- The number of cards/containers/ medication sheets was blank. Between the 36-hour timeframe of 7:00 AM on 3/16/26 and the next day (3/17/26) at 7:00 PM there was no notation of a count and reconciliation of the controlled medications. During an interview with the DON on 3/25/26 at 7:56 PM, the DON reported that Nurse # 2 had been one of the nurses who had been responsible for the accounting of Unit 3's controlled medications at 7:00 PM on 3/16/26. The DON further reported Nurse # 2 left after midnight on 3/17/26 and the count was reconciled between Nurse # 2 and another staff member in her (the DON's) presence before Nurse # 2 left. According to the DON, the count was initially off and an error in documentation was found by her (the DON) which allowed the controlled substances to be reconciled in her presence. 3/17/26 7:00 PM- Off-going nurse- no documented signature 3/19/26 at 7:00 AM-On-coming nurse- no documented signature During an interview with Unit 3's Unit Manager on 3/26/26 at 10:00 AM, the Unit Manager reported that nurses were to reconcile, count, and sign at each change of shift the controlled medications. If controlled medications were subtracted or added to the total count, then two nurses were to witness and sign for the additions and subtractions. 3. Resident # 2 resided at the facility from 11/7/25 until her discharge on [DATE]. Resident # 2's diagnoses included chronic pain. Review of Resident # 2's medications revealed an order, dated 1/5/26, for Oxycontin 15 mg (milligrams) two times per day. The Pharmacist in charge of the facility's contracted pharmacy was interviewed on 3/26/26 at 11:05 AM regarding Resident # 2's most recent dispensed doses of Oxycontin prior to her discharge and any documentation of returned Oxycontin doses to the pharmacy following Resident # 2's final discharge. The Pharmacist reported the following information after reviewing the records in their pharmacy system. On 2/9/26 the pharmacy received a new Oxycontin prescription for a total of 60 tablets of Oxycontin. The pharmacy sent a 14-day supply which equated to 28 pills on that date (2/9/26). On 2/27/26 their pharmacy system showed that a facility request was submitted to the pharmacy for additional Oxycontin doses for Resident # 2. On 2/28/26 their pharmacy system showed that 17 doses of Resident # 2's Oxycontin dispensed on 2/9/26 was returned. On the same date (2/28/26) their pharmacy system showed a return of 17 doses, their system also showed they sent 28 more Oxycontin doses to the facility for Resident # 2. According to the Pharmacist in charge, the pharmacy was caught up with logging any returns and they did not have any records of returned Oxycontin from Resident # 1's doses sent on 2/28/26. The last return they had logged was on 2/28/26. The Pharmacist was interviewed regarding why the pharmacy's system would show a request of more Oxycontin doses on 2/27/26 while also showing a return of Oxycontin on 2/28/26 for Resident # 1. The Pharmacist in charge acknowledged that the information in their system did not make sense but that was what their system records were (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showing on the date of interview with the surveyor. According to the pharmacist in charge's records, they were still awaiting Resident # 2's unused Oxycontin from their dispense date of 2/28/26 to be returned to them. On 3/26/26 at 11:55 AM the facility's Corporate Nurse Consultant was interviewed and provided a form entitled. Medication Disposition Record Med Returns to [Name of contracted pharmacy]. The form contained multiple controlled medications for multiple residents which had been returned to the pharmacy. At the top of the form was a scanned date of 3/9/26 and a status notation of in transit. Seventeen doses of Resident # 2's Oxycontin, which was shown to be dispensed by the pharmacy to the facility on 2/9/26, was listed on the return sheet as returned. The Corporate Nurse Consultant also provided the individual Controlled Drug Records for Resident # 1's last two dispensed Oxycontin fills they had received from the pharmacy. The first of these two Oxycontin Controlled Drug Records included a pharmacy sticker which included information that 28 doses were filled on 2/9/26 which left 32 remaining doses on the prescription which could be requested by the facility. A nurse signed on 2/10/26 that the 28 Oxycontin doses were received by the facility. A review of this Controlled Drug Record which was filled on 2/9/26, showed that all 28 doses were used and none were returned. The second of the two Controlled Drug records for Resident # 2's Oxycontin included a pharmacy sticker which included information that 28 doses were filled on 2/28/26 under the same prescription number for Resident # 2, which left four tablets left as available to be filled on the prescription. A nurse's signature, which was not clear, showed these 28 tablets of Oxycontin were received on 2/19/26 by the facility (which was before the pharmacy sticker's fill date.) The Controlled Drug Record for the Oxycontin, which was filled on 2/28/26, showed that 17 doses remained after Resident # 2 was discharged and were returned to the pharmacy on 3/9/26. According to the Corporate Nurse Consultant during an interview on 3/26/26 at 11:55 AM all of Resident # 2's unused Oxycontin was returned upon the resident's discharge, and it did not make sense that the pharmacy's internal records would show the facility returned 17 doses on 2/28/26 when their records showed those 17 doses were used for the resident. According to the Corporate Nurse Consultant, the form showing the return of 17 doses on 3/9/26 was directly taken from the pharmacy's system which they (the facility) could access. The Corporate Nurse Consultant did not understand why the Pharmacist in charge thought that there were still remaining doses of Resident # 2's Oxycontin to be returned since the facility's records showed they had returned all of them and she did not know why the records between the pharmacy and the facility could not be reconciled. 4. Resident # 4 was admitted to the facility on [DATE] and had a diagnosis of vertebrae osteomyelitis (bone infection) and low back pain. Review of orders revealed an order dated 1/1/26 for Oxycontin 10 mg every twelve hours. Resident # 4 also had an order, dated 2/6/26, for oxycodone 5 mg every six hours as needed for breakthrough pain. a. A review of Resident # 4's March 2026 Medication Administration Record (MAR) and Oxycontin Controlled Drug Record revealed on 3/2/26 Nurse # 13 initialed Resident # 4 received his Oxycontin scheduled 10:00 AM dose. A review of Resident # 4's Controlled Drug Record revealed no Oxycontin was signed out of the resident's storage for the administration of the 10:00 AM dose on 3/2/26. Nurse # 13 was interviewed on 3/25/26 at 1:30 PM and reported the following information. She had not administered the 10:00 AM dose of Oxycontin on 3/2/26. The resident appeared sedated. She had already signed on the MAR before she determined it needed to be held and not administered. She was new to the facility's electronic medical system and had been unsure of how to correct MAR to reflect the dose was not actually administered. b. On 3/20/26 at 7:57 PM Nurse # 14 documented on Resident # 4's March 2026 MAR that she administered oxycodone 5 mg per the resident's as needed order. On 3/20/26 Nurse # 14 initialed on Resident # 4's MAR by the 10:00 PM dose of Oxycontin with an asterisk indicating a comment about administration was documented. The comment entered by Nurse # 14 was RC. A review of Resident # 4's Controlled Drug Record revealed no Oxycontin was signed out of the resident's storage for the administration of the 10:00 PM dose on 3/20/26. Nurse # 14 was interviewed on 3/26/26 at 9:10 PM and reported RC meant resident care and did not provide an explanation for why this comment was documented related (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the administration or lack thereof of Oxycontin. She recalled that on the evening of 3/20/26 Resident # 4 had complained of pain and she did not realize he had Oxycontin ordered and gave him a dose of Oxycodone which he had ordered as needed. Therefore, she had not administered the Oxycontin but had not entered an explanation to why in the record. During an interview with the DON (Director of Nursing) on 3/25/26 at 7:56 PM, the DON reported she did not know what RC meant under the administration of Resident # 4's 10:00 PM Oxycontin dose on 3/20/26 and did not know by the documentation if the dose had or had not been administered. c. On 3/22/26 Nurse # 15 initialed on Resident # 4's March 2026 MAR by the 10:00 AM dose of Oxycontin that the dose was administered. A review of Resident # 4's Oxycontin Drug Control Record did not reveal a dose of OxyContin was removed from Resident # 4's drug supply for the administration of this dose. Nurse # 15 was interviewed on 3/25/26 at 7:05 PM and reported she could not recall why the MAR reflected that the dose was administered and the Drug Control Record did not reflect it was removed for administration. During an interview with the DON (Director of Nursing) on 3/24/26 at 7:10 PM, the DON reported the following. She would expect that the documentation of removal of controlled substances from locked storage should coincide with documentation of administration to a resident on the MAR.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the accuracy and completeness of documentation related to bowel movements and/or medication administration. This was for 2 of 4 residents whose medical records were reviewed for documentation of bowel movements and/or medication administration (Residents # 1 and # 4). The findings included:1a. Resident # 1 was admitted to the facility on [DATE] with a diagnosis of Stage IV basal cell carcinoma.A review of Resident # 1's bowel movements which were documented in the resident's medical record revealed three bowel movements during Resident # 1's nineteen-day residency of 3/5/26 through 3/18/26. A medium bowel movement was documented on 3/6/26, a small bowel movement on 3/13/26, and a small bowel movement on 3/18/26.Nurse # 1 was interviewed on 3/24/26 at 1:52 PM and reported the following information. She had routinely cared for Resident # 1, and the medical record was not accurate in reflecting the number of bowel movements Resident # 1 had while he resided at the facility. The system would flag when a resident went without a bowel movement for three days in order that nursing staff administer a medication if needed. She had checked with Resident # 1, and he had more bowel movements than were documented in the medical record. Nurse # 1 specifically remembered Resident # 1 had a large bowel movement she thought on 3/17/26 which was not documented.The DON was interviewed on 3/24/26 at 7:10 PM regarding documentation of only three bowel movements during the resident's residency. The DON reported the resident was at risk for constipation due to pain medications he received for his cancer diagnosis. The DON further reported Resident # 1's record was not complete and did not accurately reflect his status in that the resident had more bowel movements than were documented. The DON reported the number of bowel movements in the medical record should be accurately reflected.1b. Review of orders revealed Resident # 1 had an order, dated 3/6/26, for hydrocodone 5-325 mg (milligrams) every four hours as needed for pain.Review of Resident # 1's March 2026 Medication Administration Record (MAR) revealed no documentation that hydrocodone-acetaminophen was administered to Resident # 1 on 3/6/26 at 2:00 PM, 3/9/26 at 9:00 AM, 3/9/26 at 2:00 PM, 3/10/26 at 8:30 AM, 3/10/26 at 2:30 PM, 3/13/26 at 9:00 AM, and 3/13/26 at 2:00 PM although Nurse # 1 signed for the removal of Resident # 1's hydrocodone-acetaminophen on those dates and times on Resident # 1's Controlled Drug Record.Nurse # 1 was interviewed on 3/25/26 at 12:40 PM and validated Resident # 1's medical record was incomplete because she had given the hydrocodone-acetaminophen on all the dates and times she had removed the hydrocodone-acetaminophen from storage, but she had not documented the administration of the hydrocodone-acetaminophen on the resident's MAR in the resident's record.Review of Resident # 1's March 2026 MAR revealed no documentation that Resident # 1 received hydrocodone-acetaminophen on 3/10/26 at 1:08 PM although there was documentation of its removal from drug storage by Nurse # 6 on this date and time. Nurse # 6 was interviewed on 3/26/26 at 1:08 PM regarding Resident # 1's dose of hydrocodone-acetaminophen she had removed from controlled drug storage on 3/10/26 at 1:30 AM without documentation of administration to Resident # 1. Nurse # 6 reported she had administered the hydrocodone-acetaminophen but had forgotten to sign for the administration on Resident # 1's MAR. Review of orders revealed additionally Resident # 1 was ordered oxycodone 10 mg every six hours as needed for pain. This was originally ordered on 3/6/26.Review of Resident # 1's March 2026 MAR revealed no documentation that oxycodone was administered to Resident # 1 on 3/6/26 at 2:00 PM, 3/9/26 at 10:15 AM, 3/9/26 at 4:20 PM, 3/10/26 at 11:00 AM. 3/13/26 at 6:00 PM, 3/15/26 at 10:00 AM, and 3/16/26 at 1:35 PM although Nurse # 1 signed for the removal of Resident # 1's oxycodone on those dates and times on Resident # 1's Controlled Drug Record.Nurse # 1 was interviewed on 3/25/26 at 12:40 PM and validated Resident # 1's medical record was incomplete because she had given the oxycodone on all the dates and times (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she had removed the oxycodone from storage, but she had not documented the administration of the oxycodone on the resident's MAR in the resident's record.Interview with the interim Administrator on 3/26/26 at 3:50 PM revealed she expected that medical records would be complete regarding the documentation of bowel movements and the administration of controlled medications.2. Resident # 4 was admitted to the facility on [DATE] and had a diagnosis of vertebrae osteomyelitis (bone infection) and low back pain. Review of orders revealed an order dated 1/1/26 for Oxycontin 10 mg every twelve hours. Resident # 4 also had an order, dated 2/6/26, for oxycodone 5 mg every six hours as needed for breakthrough pain. A review of Resident # 4's March 2026 Medication Administration Record (MAR) and Oxycontin Controlled Drug Record revealed on 3/2/26 Nurse # 13 initialed Resident # 4 received his Oxycontin scheduled 10:00 AM dose. Nurse # 13 was interviewed on 3/25/26 at 1:30 PM and reported the following information. She had not administered the 10:00 AM dose of Oxycontin to Resident #4 on 3/2/26 because the resident appeared sedated. She explained she had already signed on the MAR before she determined it needed to be held and not administered. Nurse # 13 indicated she was new to the facility's electronic medical system and had been unsure of how to correct the MAR to reflect that the dose of Oxycontin was not actually administered. Therefore, Nurse # 13 validated the medical record was not accurate. Interview with the interim Administrator on 3/26/26 at 3:50 PM revealed she expected that medical records would be complete regarding the administration of controlled medications.