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	01/08/2025

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of a resident transfer for 2 of 3 residents reviewed for hospitalization (Resident #35 and Resident #11). The findings included: 1. Resident #35 was admitted to the facility on [DATE]. a. The nursing progress note dated 8/03/24 at 10:22 pm revealed Resident #35 was transferred to the hospital for further evaluation. Resident #35 was discharged from the facility on 8/03/24 and returned to the facility on [DATE]. Review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was not notified of Resident #35's transfer to the hospital on 8/03/24. b. The nursing progress note dated 9/16/24 at 4:29 am revealed Resident #35 was transferred to the hospital for further evaluation. Resident #35 was discharged from the facility on 9/16/24 and returned to the facility on [DATE]. A review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was not notified of Resident #35's transfer to the hospital on 9/16/24. A telephone interview was conducted on 1/07/25 at 9:44 am with the Ombudsman who revealed she did not receive notification from the facility of Resident #35's hospital transfers on 8/03/24 or 9/16/24. An interview was conducted with the Social Service Director on 1/07/25 at 10:06 am who revealed she started in the position in July 2024, and she stated she had been running the wrong report to send to the Ombudsman since that time. She stated when she ran the report to send to the Ombudsman, the report did not show any resident transfers or discharges from the facility. The Social Service Director stated she was recently shown how to run the correct report to send to the Ombudsman for resident transfers. (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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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	A telephone interview was conducted on 1/08/25 at 9:34 am with the Corporate Social Service Director who revealed she provided education to the current Social Service Director which included how to pull the transfer report, when to submit the report, and who to submit the report to. The Corporate Social Service Director stated she was not aware the facility's Social Service Director did not know how to pull the correct report. During an interview on 1/08/25 at 11:29 am with the Administrator she revealed she was not aware the Social Service Director did not know how to run the correct report to send to the Ombudsman, but she stated education would be provided. 45789 2. Resident #11 was admitted to the facility on [DATE]. a. The change in condition assessment dated [DATE] revealed Resident #11 was sent to the Emergency Department due to abnormal vital signs. Record review of the nursing progress notes revealed there was no documentation Resident #11's Ombudsman received written notification of the reason for transfer to the Emergency Department. b. The change in condition assessment dated [DATE] revealed Resident #11 was sent to the Emergency Department due to abnormal breathing and verbally responsive. Record review of the nursing progress notes revealed there was no documentation Resident #11's Ombudsman received written notification of the reason for transfer to the Emergency Department. An interview was conducted with the Social Services Director on 1/07/25 at 10:06 a.m. who revealed she started in the position in July 2024, and she stated she had been running the wrong report to send to the Ombudsman since that time. She stated that when she ran the report to send to the Ombudsman, the report did not show any resident transfers or discharges from the facility. The Social Service Director stated she was recently shown how to run the correct report to send to the Ombudsman for resident transfers In an interview with the Director of Nursing (DON) on 1/8/24 at 9:00 a.m. she stated it was the responsibility of the Social Services Director to send the notification of discharge for Resident #11 to the Ombudsman. She stated she was not aware the notification was not sent to the Ombudsman. During an interview with the interim Administrator on 1/8/24 at 11:38 a.m. he revealed it was the responsibility of the Social Services Director to send notification of discharges to the Ombudsman every month. He further stated the Social Services Director will receive retraining to ensure compliance with the requirement.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20710 Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment for 1 of 23 residents whose MDS assessments were reviewed (Resident #56). Findings included: Resident# 56 had been admitted to the facility on [DATE] with diagnoses of malignant neoplasm. Resident #56s admission MDS was dated 10/20/24 and identified Resident #56 as cognitively intact had a tracheotomy (a surgical opening in the neck to provide air into the lungs) and revealed she was not receiving hospice services. Review of Resident# 56's medical record revealed a Physician order dated 11/21/24 to admit resident to Hospice related to the terminal diagnosis of malignant neoplasm, if the disease runs normal course life expectancy is 6 months or less. Review of Resident# 56's medical record revealed no documentation that a MDS significant change in status assessment had been completed to reflect Resident #56 was receiving Hospice Services. An interview was conducted on 1/08/24 at 9:00 AM with the MDS Nurse #1 who stated Resident #56 should have had a significant change in status assessment completed when she began Hospice Services. An interview was conducted on 1/08/24 at 11:06 PM with the Administrator who stated the MDS Nurse should have reviewed Resident #56 for a significant change in status assessment when she elected Hospice services.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of dialysis (Resident #15 and Resident #70), use of a wander elopement alarm (Resident #57), use of hypoglycemic medication (medication that help lower blood sugar levels in people diagnosed with diabetes) (Resident #44), for 4 of 23 residents whose MDS assessments were reviewed. The findings included: 1. Resident # 15 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease and dependence on dialysis (treatment to filter wastes and water from the blood). Review of the hospital discharge summary dated 9/10/24 revealed Resident #15 was hospitalized on [DATE] for acute kidney injury. Resident #15 was seen by the Nephrology (a specialized physician focused on kidney function) and was noted to have improved kidney function and dialysis was discontinued. Resident #15 was discharged back to the facility on [DATE] with no orders for dialysis treatment. Resident #15 had an active physician order dated 9/14/24 to monitor for bruit (a whooshing sound heard at the fistula site with a stethoscope) and thrill (vibration caused by blood flow felt with fingers) to shunt every shift in right arm. A review of Resident #15's medical record revealed no physician order for dialysis. Review of the Nurse Practitioner (NP) progress note dated 10/02/24 revealed Resident #15 was hospitalized on [DATE] through 9/10/24 and was noted to have been seen by nephrology to have improved kidney function and no longer required hemodialysis. The Minimum Data Set (MDS) significant change assessment dated [DATE] and completed by MDS Nurse #1 revealed Resident #15 was coded for dialysis. An interview was conducted on 1/07/25 at 2:44 pm with MDS Nurse #1 who revealed she must have assumed Resident #15 received dialysis treatment because she saw the physician order for monitoring the shunt site. MDS Nurse #1 stated she coded Resident #15's MDS assessment in error. During an interview on 1/07/25 at 12:35 pm the Director of Nursing (DON) revealed Resident #15 had not received dialysis treatments while he resided at the facility and did not have physician orders for dialysis. An interview was conducted with the Administrator on 1/08/25 at 11:28 am who stated the MDS Nurse was responsible to ensure resident assessments were coded accurately. 2. Resident #57 was admitted to the facility on [DATE] with diagnoses which included vascular dementia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #57 had an active physician order dated 6/04/24 for wander guard alarm placement to right wrist. Review of Resident #57's Medication Administration Record (MAR) for December 2024 revealed the wander guard alarm was in place as ordered. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #57 was not coded for use of a wander or elopement alarm. An observation on 1/05/25 at 12:59 pm revealed Resident #57 was noted to have a wander guard alarm bracelet on the right wrist. An interview was conducted on 1/07/25 at 2:47 pm with MDS Nurse #1 who revealed she was aware Resident #57 was a wanderer and had a wander guard in place. MDS Nurse #1 stated she just missed it when she completed Resident #57's assessment. An interview was conducted with the Administrator on 1/08/25 at 11:28 am who stated the MDS Nurse was responsible to ensure resident assessments were coded accurately. 3. Resident #44 was admitted to the facility on [DATE] with diagnoses which included diabetes. Resident #44 had an active physician order dated 4/30/24 for insulin glargine (long-acting insulin) 100 units per milliliter (ml). Administer 24 units once a day at bedtime. Resident #44 had an active physician order dated 4/30/24 for insulin glargine100 units per ml. Administer 28 units once a day scheduled to be administered between 7:15 am through 11:00 am. Review of Resident #44's Medication Administration Record (MAR) for October 2024 revealed the insulin glargine was administered as ordered. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #44 was not coded for use of hypoglycemic medication. An interview was conducted on 1/07/25 at 2:41 pm with MDS Nurse #1 who revealed the normal process she used to complete the assessment included reviewing the medical record for pertinent information needed to code the assessment. MDS Nurse #1 stated she just missed Resident #44's hypoglycemic medication when she completed the assessment. During an interview with the Administrator on 1/08/25 at 11:28 am who stated the MDS Nurse was responsible to ensure resident assessments were coded accurately. 20710 4. Resident # 70 was readmitted to the facility on [DATE] from a hospital. His cumulative diagnosis included end stage renal dialysis with dependence on renal dialysis. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse note dated 11/29/24 revealed Resident #70 was sent to Dialysis this morning and has not returned on his usual schedule. The nurse called the hospital and found out that the resident has been transferred from dialysis and admitted to the hospital for sepsis. The physician was made aware. Resident #70 was discharged back to the facility on [DATE] with no orders for dialysis treatment. Review of Resident #70's Minimum Data Set (MDS) assessment dated [DATE] did not indicate he had end stage renal disease or was receiving renal dialysis services. An interview was conducted on 1/07/25 at 1:50PM with MDS Nurse #1 who revealed the MDS should have been coded to indicate Resident #70 was receiving dialysis. An interview was conducted on 1/07/24 at 3:33 PM with the Director of Nursing who revealed Resident #70, was listed as a resident who received Dialysis. She reported that staff failed to pull the dialysis order back up when he returned from the hospital. An interview was conducted on 1/08/24 at 11:06 PM with the Administrator who stated the MDS Nurse was responsible for ensuring resident assessments were coded accurately.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observations, record review, and staff and Responsible Party (RP) interviews, the facility failed to develop a person-centered care plan for 1 of 1resident reviewed for activities (Resident #44). The findings included: Resident #44 was admitted to the facility on [DATE] with diagnoses which included stroke and dementia. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] and completed by MDS Nurse #2 revealed Resident #44 had severe cognitive impairment. Resident #44 reported the following activity preferences were very important: books, newspapers, and magazines to read, listen to music, religious services, and be outdoors for fresh air when weather was good. Review of the Life Enrichment Record for October 2024 through January 2025 revealed Resident #44 refused participation in group activites when offered and one to one (1:1) room visits were conducted daily. Resident #44's 1:1 activities included sports and devotionals on television and listening to music. Resident #44's care plan last reviewed on 1/03/25 revealed no care plan related to activity preferences. Observations were conducted of Resident #44 on 1/05/25 at 1:46 pm, 1/06/25 at 1:14 pm, 1/07/25 at 8:07 am and 1:49 pm, and 1/08/25 at 10:30 am. Resident #44 was noted to be in the room with the television on during all observations. During an interview with Resident #44's Responsible Party (RP) on 1/05/24 at 2:41 pm she revealed she was not sure what kind of activities the facility provided for Resident #44. The RP stated she normally visited in the afternoons, and she did not observe Resident #44 involved in any activities when she was at the facility. An interview was conducted with the Activity Director on 1/06/25 at 2:59 pm who revealed she had worked at the facility for over one year. She stated she visited with Resident #44 daily and would offer to participate in the group activities but he would refuse. The Activity Director stated she completed 1:1 room visits for Resident #44 which included sports and devotionals on television, and he enjoyed music. The Activity Director stated she had not done resident care plans since she started working at the facility, but she was just shown how to create a care plan and will start doing the care plans. During an interview on 1/07/25 at 2:44 pm with MDS Nurse #2 who revealed the Activity Director was responsible for implementing the activity focused care plan for Resident #44. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 1/08/25 at 11:22 am who revealed the Activity Director was responsible for creating the activity care plan for Resident #44, but she expected the MDS Nurses to assist with care plans when needed.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observation, record review, and staff interviews, the facility failed to obtain a physician order for tracheostomy (a surgical opening through the front of the neck into the windpipe for an air passage to help breathe) care for 1 of 2 residents reviewed for tracheostomy (Resident #35). The findings included: Resident #35 was admitted to the facility on [DATE] with diagnoses which included tracheostomy. The nursing progress note dated 11/23/24 revealed Resident #35 was transferred to the hospital on 11/23/24 and returned to the facility on [DATE]. Resident #35 had a physician order dated 12/04/24 for oxygen via tracheostomy collar at 28% humification with 5 liters per minute continuously. Resident #35 had a physician order dated 12/04/24 to assess for need of suctioning tracheostomy every shift. Review of Resident #35's physician orders revealed no physician order for tracheostomy site care. Review of the Treatment Administration Record (TAR) for December 2024 and January 2025 revealed no documentation for tracheostomy site care for Resident #35. Review of the care plan last reviewed 12/11/24 revealed Resident #35 was at risk for adverse outcomes related to tracheostomy with interventions which included tracheostomy stoma care per physician orders. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #35 was coded for tracheostomy care, suctioning, and oxygen use. An observation was conducted on 1/05/25 at 11:37 am of Resident #35 who was noted to have a tracheostomy opening, without a tracheostomy tube, and oxygen at 5 liters per minute supplied via tracheostomy collar. An interview was conducted with Nurse #5 on 1/05/25 at 1:16 pm who was assigned to Resident #35. Nurse #5 revealed Resident #35 did not use a tracheostomy tube, but she has oxygen to the tracheostomy collar. Nurse #5 stated she provided tracheostomy care to Resident #35 which included cleaning around the tracheostomy site, and she stated the care was provided at least once a shift. Nurse #5 stated Resident #35 also received suctioning of the tracheostomy as needed. An interview was conducted with Nurse #3 on 1/08/25 at 9:21 am who revealed she performed tracheostomy care on her shift for Resident #35 which included cleaning the tracheostomy opening with sterile water and skin care around the tracheostomy site. Nurse #3 stated Resident #35 normally required suctioning once per shift dependent upon the amount of secretions present. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/08/25 at 10:14 am with Unit Manager #1 revealed Resident #35 received tracheostomy care once a shift. Unit Manager #1 confirmed Resident #35 did not have a physician order for the tracheostomy care but stated the order should have been entered when Resident #35 was admitted . Unit Manager #1 reported orders were reviewed in the clinical meetings, but she stated Resident #35's tracheostomy care order was just missed. An interview was conducted on 1/08/25 at 11:50 am with the Director of Nursing (DON) who revealed the Unit Manager was responsible to enter the initial admission orders and the admission packet was then reviewed in the clinical morning meeting. The DON was unable to state how Resident #35's tracheostomy care order was missed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20710 Based on record review and staff interviews, the facility failed to ensure a resident receiving dialysis had a physician's order for dialysis. This was for 1 of 2 sampled residents reviewed for receiving dialysis. (Resident #70). The findings included: Resident # 70 was admitted to the facility on [DATE] with cumulative diagnosis that included end stage renal dialysis with dependence on renal dialysis. Resident # 70's care plan dated 11/12/24 noted he had a diagnosis of chronic renal failure and has the potential for complications from hemodialysis. Staff were to provide communication with dialysis center regarding medication, diet, and lab results. Coordinate resident's care in collaboration with dialysis center, check shunt site for signs/symptoms of infection, pain, or bleeding daily and as needed, Notify MD (Medical Doctor) to absence of thrill or bruit. Review of the nurse note dated 11/29/24 revealed Resident #70 was sent to Dialysis this morning and had not returned on his usual schedule. The nurse called the hospital and found out that the resident had been transferred from dialysis and admitted to the hospital for sepsis. The physician was made aware. Resident #70's readmission orders dated 12/03/24 did not include an order for dialysis. Review of Resident #70's Minimum Data Set assessment dated [DATE] did not indicate he had end stage renal disease or was receiving renal dialysis services. Review of the nurse's note dated 12/22/24 at 12:24 PM documented Resident #70 returned from dialysis via stretcher with no distress noted. The Resident was safely put back to bed, will continue plan of care. Able to make needs known to staff. An interview with Unit Manager #1 on 1/07/24 at 3:35 PM revealed there was no order for his dialysis. She indicated Resident #70 had gone out to the hospital and on his return his dialysis order was not picked back up. An interview was conducted on 1/07/24 at 3:33 PM with the Director of Nursing who revealed Resident #70, was listed as a Dialysis resident. She reported that staff failed to pull the dialysis order back up when he returned from the hospital. An interview was conducted on 1/08/24 at 11:06 PM with the Administrator who stated staff should have seen Resident #70's physician order for dialysis.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45045 Based on observations and staff interviews the facility failed to (1) label and date an open insulin injector pen and an open albuterol inhaler (Unit 3) and failed to refrigerate a medication according to the manufacturer's recommendation (Unit 1) for 2 of 2 medications carts reviewed, and (2) failed to ensure 1 of 3 wound treatment carts were secured while unattended (Unit 3). The findings included: 1.a. During an observation of the Unit 3 medication cart with Unit Manager #1 on 1/07/25 at 2:00 pm the following was observed. Unit Manager #1 confirmed all findings before the removal of the items. One insulin lispro (rapid-acting insulin used to manage diabetes) injector pen was in the back of the top drawer, open with no open date noted and no resident identifiers. The label read expires 14-days after opening. The insulin lispro injector pen was not stored in the same location as the current residents insulin injector pens. One albuterol (a medication to relax the muscles in the airways used for asthma and chronic obstructive pulmonary disease) 90 microgram inhaler was observed open, with no open date or resident identifiers. An immediate interview was conducted with Unit Manager #1 who revealed the insulin injector pen should not have been in the medication cart without resident identification and dated when opened. Unit Manager #2 and this surveyor confirmed the insulin lispro injector pen was opened but unused with the orange stopper at the base of the pen below the beginning line of insulin. Unit Manager #1 stated the albuterol inhaler may have been brought in from a resident's home because the facility did not use that type of inhaler, but she stated it should not have been in the medication cart. An interview was conducted on 1/07/25 at 3:41 pm with Nurse #1 who was assigned to Unit 3 medication cart who revealed she did not know the medications were in the cart and she stated she did not use any medications that were not labeled with a resident name. During an interview with the Director of Nursing (DON) on 1/08/25 at 11:44 am she revealed all nurses were responsible for making sure the medication carts did not have medications without resident identifiers and that all medications required an open date. She stated the Unit Managers conduct weekly audits, and the pharmacy also conducted auditing of the medication cart, so she was unable to state how the medications were missed in the cart. b. During an observation of the Unit 1 medication cart with Unit Manager #1 on 1/07/25 at 2:20 pm the following was observed. Unit Manager #1 confirmed the finding before the removal of the item. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One squeeze bottle of netarsudil ophthalmic solution (eye drop used to lower pressure inside the eye, used treat glaucoma) unopened with a label on the container that read keep in refrigerator. The manufacturer's storage recommendations for an unopened netarsudil ophthalmic solution were to be stored in the refrigerator at 36 to 46 degrees Fahrenheit. An immediate interview was conducted with Unit Manager #1 who revealed the ophthalmic solution should have been stored in the refrigerator until it was ready to be used. During an interview on 1/08/25 at 11:44 am with the Director of Nursing she revealed the nurses were responsible for checking the medication carts to ensure all medications were stored as recommended. 2. An observation on 1/08/25 at 8:00 am on Unit 3 revealed the wound treatment cart was unattended and unlocked with the lock in the outward position. The wound treatment cart was located across from the nursing station and the facility vending machines. The Administrator and Nurse #2 were observed to be at the nursing station. The Administrator approached this surveyor, and an observation of the wound treatment cart was conducted in the presence of the Administrator. The wound treatment cart was noted to contain resident creams and ointments, medicated dressings, and treatment supplies. The Administrator stated she believed the wound treatment cart was left unlocked for the night shift in the event something was needed but she would check with the Director of Nursing. On 1/08/25 at 8:02 am the Administrator returned to the treatment cart and pushed the lock in to secure the wound treatment cart. The Administrator stated she would try to find out who left the wound treatment cart unlocked. An interview was conducted on 1/08/25 at 8:07 am with Nurse #2 who confirmed she was assigned to Unit 3 on 1/07/25 during the 7:00 pm through 7:00 am shift. Nurse #2 stated she did not use the wound treatment cart during her shift, but she stated another nurse did come over and took something from the wound treatment cart when she started her shift and must have left the cart unlocked. Nurse #2 stated had she had not gone over to the wound treatment cart during her shift and did not notice it was unlocked until reported by this surveyor. During an interview on 1/08/25 at 8:05 am the Director of Nursing (DON) stated the wound treatment cart was to be locked when unattended and all nursing staff knew to lock the cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER: Signature Healthcare of Roanoke Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20710 Based on observations, and staff interviews, the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent the potential cross contamination of food by failing to clean 1 of 1 plate dispenser and failed to clean the shelf under the steam table for 1 of 1 steam tables observed. These practices had the potential to affect food served to residents. The findings included: 1. During the lunch meal observation on 1/6/25 at 12:14 PM the tray line area was observed. The two-cylinder plate dispenser was observed with dark dried food particles in the bottom of both cylinders and the plate tray had dried liquid stains. An observation on 1/07/25 at 3:14 PM revealed the two-cylinder plate dispenser was observed in the same condition. An interview was conducted with the District Dietary Manager on 1/08/24 at 9:45 AM. She indicated that the two-cylinder plated dispenser was kept plugged in at all times and staff overlooked cleaning inside the cylinders. 2. Observations of the kitchen were conducted on 1/07/25 at 3:14 PM, and 1/08/25 at 9:34 AM, and revealed the 6-foot shelf under the steam table was observed to be covered with dark dried food particles. An interview was conducted on 1/08/25 at 9:48 AM with the Certified Dietary Manager (CDM). She stated she had a weekly cleaning schedule, and the steam table was included in that schedule. An interview was conducted with the District Dietary Manager on 1/08/24 at 9:45 AM. She indicated that the two-cylinder plated dispenser was kept plugged in at all times and staff overlooked the weekly cleaning of the plate dispenser. An interview was conducted on 1/08/25 at 11:02 AM with the Administrator. She stated the dietary staff should keep all areas in the kitchen clean and include the plate dispenser and steam table shelves to the cleaning schedule.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 20710 Based on observations, and staff interviews, the facility failed to ensure garbage was contained in a closed dumpster and doors were kept closed for 1of 2 dumpsters observed. The findings included: An observation of the dumpster area was conducted on 1/07/24 at 8:07 AM. Dumpster #1 was observed with a large bag of garbage hanging out of the dumpster lid and 2 disposable gloves were on the ground behind the dumpster. An observation of the dumpster area with the Dietary District Manager was made on 1/07/24 at 3:03 PM. Dumpster #1 lid was open, and the right-side door was open. There were 3 disposable gloves, a soda bottle and straw papers loose on the ground surrounding Dumpster #1. In an interview on 1/07/24 at 3:29 PM the Dietary District Manager revealed the dumpster area had been cleaned that morning and the Waste company had emptied the trash and not picked up what was dropped. In an interview with the Administrator on 1/08/24 at 11:10 AM revealed all staff were responsible for the dumpster area and had been educated to keep the area clean. In an interview on 1/08/24 at 1:28 PM the Corporate Administrator indicated that a staff member should be assigned to inspect the dumpster area daily to keep the area clean and the doors closed.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 45789 Based on record review and staff interviews, the facility failed to annually review and update the facility assessment, which had the potential to affect 80 of 80 residents in the facility, and to ensure the facility assessment identified and addressed the care required for the population of residents with a tracheostomy (Resident #35 and #56). The findings included: Review of the most recent facility assessment revealed the assessment period was from January 1 through December 31, 2023. This facility assessment indicated there were no residents who required tracheostomy care. A review of the medical records revealed Resident #35 and Resident #56 had tracheostomies and required tracheostomy care. The facility could not provide documents to demonstrate it had reviewed and updated the facility assessment since 2023. An interview conducted with the Administrator on 1/6/25 at 9:42 a.m. revealed it was her responsibility to ensure a review of the facility assessment was conducted annually and updated to reflect accurate information to include the care required for the resident population. She stated she was not aware the facility assessment was not current and forgot to conduct a review of the assessment in 2024.