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	05/07/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of the use of an anticoagulant medication for 1 of 30 residents whose MDS assessments were reviewed (Resident #17).The findings included:Resident #17 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident (CVA). Resident #17 had an active physician order dated 4/17/26 for dabigatran (an anticoagulant medication) 150 milligram (mg) capsule; give one capsule twice a day by mouth. The order was noted as on hold for 4/18/26 and 4/19/26. The Medication Administration Record for April 2026 revealed the anticoagulant medication was administered to Resident #17 as ordered twice a day on 4/20/26, 4/21/26, 4/22/26, and 4/23/26. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #17 was not coded for the use of an anticoagulant medication during the 7-day look back period. A telephone interview was conducted with MDS Nurse #2 on 5/07/26 at 10:23 am. MDS Nurse #2 reviewed the electronic health record and confirmed that Resident #17 had been administered the anticoagulant medication during the 7-day look back period of the admission assessment. MDS Nurse #2 stated when she completed the MDS assessment for Resident #17 she missed the use of the anticoagulant medication and did not code the assessment accurately for the use of the medication. The Administrator was interviewed on 5/07/26 at 2:31 pm. The Administrator stated MDS Nurse #2 was responsible for making sure Resident #17's MDS assessment was coded correctly when it was completed.

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 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** Based on observations, record review, and staff interviews the facility failed to post cautionary and safety signs indicating the use of supplemental oxygen for 2 of 3 residents reviewed for respiratory care (Resident #1 and Resident #17). The findings included:During the survey entrance conference with the Administrator on 5/04/26 at 10:10 am the Administrator reported the facility was a smoking facility.1. Resident #1 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease and dependence on supplemental oxygen. Resident #1 had a physician order dated 4/21/26 for oxygen therapy; oxygen via nasal cannula (NC) at 3 liters per minute continuous every shift for hypoxia (low levels of oxygen in the body tissue). Resident #1's census history revealed a room change had occurred on 4/26/26.Observations were conducted on 5/04/26 at 10:46 am and 2:37 pm of Resident #1. Resident #1 was observed in bed with supplemental oxygen in place. Resident #1 did not have the cautionary and safety signage posted that indicated supplemental oxygen was in use.During an interview on 5/07/26 at 9:37 am with Unit Manager #2 confirmed she was responsible for Resident #1's unit. Unit Manager #2 revealed that all residents that used supplemental oxygen should have the safety oxygen in use sign posted on the door frame. Unit Manager #2 stated any staff member was able to put the oxygen in use signage up on Resident #1's door when supplemental oxygen was used. Unit Manager #2 stated that Resident #1 had a recent room change and the safety signage must not have been moved to the new room when the room change was completed. The Director of Nursing (DON) was interviewed on 5/07/26 at 2:03 pm. The DON stated that Resident #1's oxygen in use signage must have been missed when the room change occurred.During an interview on 5/07/26 at 2:29 pm with the Administrator she revealed that when a resident was admitted to the facility and required supplemental oxygen the safety signage should be posted on the residents door. The Administrator stated that nursing administration should follow up and ensure the oxygen in use signs were posted on Resident #1's door. 2. Resident #17 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and dependence on supplemental oxygen.Resident #17 had a physician order dated 4/17/26 for oxygen therapy; oxygen at 2 liters per minute via nasal cannula continuous every shift for hypoxia (low levels of oxygen in the body tissue). Resident #17's census history revealed a room change had occurred on 4/29/26. An observation was conducted on 5/04/26 at 1:51 pm of Resident #17 who was observed to be in bed with supplemental oxygen in place. Resident #17 did not have the cautionary and safety signage posted that indicated supplemental oxygen was in use. An observation and interview were conducted on 5/07/26 at 9:03 am with Unit Manager #1 of Resident #17's room. Unit Manager #1 confirmed the oxygen in use signage was not posted to indicate supplemental oxygen was in use. Unit Manager #1 stated she was not responsible for unit that Resident #17 resided on but she stated that any nurse was able to put the oxygen in use signage on the door when it was needed. During an interview on 5/07/26 at 9:37 am with Unit Manager #2 confirmed she was responsible for Resident #17's unit. Unit Manager #2 revealed that all residents that used supplemental oxygen should have the safety oxygen in use sign posted on the door frame. Unit Manager #2 stated any staff member was able to put the oxygen in use signage up on Resident #17's door when supplemental oxygen was used. Unit Manager #2 stated that Resident #17 had recent room change and the safety signage must not have been moved to the new room when the change was completed. The Director of Nursing (DON) was interviewed on 5/07/26 at 2:03 pm. The DON stated that Resident #17's oxygen in use signage must have been missed when the room change occurred.During an interview on 5/07/26 at 2:29 pm with the Administrator she revealed that when a resident was admitted to the facility and required supplemental oxygen the safety signage should be posted on the residents door. The Administrator stated that nursing administration should follow up and ensure the oxygen in use signs were posted on Resident #17's door.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, manufacturer recommendations, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 39 opportunities, resulting in a medication error rate of 7.69% for 2 of 4 residents observed during the medication administration observations (Resident #6 and Resident #26).The findings included:1. Resident #26 was admitted to the facility on [DATE] with diagnoses that included vitamin D deficiency and hyperlipidemia (condition of high cholesterol or fats in the blood).A review of Resident #26's current physician's orders revealed a medication order was initiated on 3/25/26 for cholecalciferol (a vitamin supplement to replace Vitamin D) 25 micrograms (mcg) one tablet by mouth one time a day for vitamin deficiency and a medication order initiated on 3/25/26 for fenofibrate 40 milligram (mg) to be given as one tablet by mouth one time a day for hyperlipidemia (condition of high cholesterol or fats in the blood).A review of Resident #26's May 2026 Medication Administration Record (MAR) revealed that the Cholecalciferol and Fenofibrate were scheduled to be administered daily between 7:00 AM and 11:00 AM. On 5/6/26 at 9:03 AM, Nurse #1 was observed as he prepared and administered nine (9) medications to Resident #26. The medications administered to the resident did not include cholecalciferol and Fenofibrate. An interview was conducted on 5/6/26 at 9:22 AM with Nurse #1 with the Assistant Director of Nursing (ADON) present. During the interview, Nurse #1 pulled up Resident #26's May 2026 MAR and reviewed her physician's order for the cholecalciferol and fenofibrate. At that time, Nurse #1 confirmed the order indicated Resident #26 was supposed to receive cholecalciferol 25 mcg once daily and confirmed the order indicated Resident #26 was supposed to receive fenofibrate 40 mg tablet once daily. Nurse #1 stated the stock medication bottle contained cholecalciferol 20 mcg, so he did not administer the cholecalciferol medication. Nurse #1 further stated that the fenofibrate medication was not available for administration and he would follow up with pharmacy to see when medication would be delivered. The ADON stated she would review the orders with the provider for further instructions. An interview was conducted on 5/7/26 at 2:03 PM with the facility's Director of Nursing (DON). The DON stated that staff were to follow up with the pharmacy when medications were not available for administration. The DON stated she expected the staff to notify the provider to see what recommendations they had for the medication order. The DON also stated that she expected staff to notify her of the missing medication, the steps they took, and document that the medication was not given on the MAR.An interview conducted with the Administrator on 05/07/2026 at 2:40 PM revealed medication errors were to be managed by Nursing administration and the DON. The Administrator stated she expected the DON and Nursing administration to ensure medications were available and administered as ordered. The Administrator further stated she expected staff would notify the DON, Unit Manager, and Pharmacy when medications were not available. 2. Resident #6 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe).Fluticasone propion-salmeterol 500-50 micrograms (mcg)/dose is an aerosol powder for inhalation used for the management of chronic obstructive pulmonary disease (COPD) and/or asthma. The manufacturer's Full Prescribing Information that was undated for the Fluticasone propion-salmeterol inhaled medication included Administration Information. These instructions read, in part: After inhalation, the patient should rinse his/her mouth with water without swallowing to prevent thrush (a yeast infection of the mouth). A review of Resident #6's current orders revealed a medication order was initiated on 1/16/26 for 500-50 mcg per actuation of Fluticasone propion-salmeterol aerosol powder to be given as one puff by mouth twice a day for COPD. There was no notation included in the order to rinse mouth and spit after use. On 5/6/26 at 10:11AM, Nurse #6 was observed as she prepared and administered Fourteen (14) medications to Resident #6. The medications administered to the resident included 500-50 micrograms (mcg) per actuation of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluticasone propion-salmeterol powder given as one puff by mouth. After Resident #6 inhaled one puff of the Fluticasone propion-salmeterol, Nurse #6 collected the inhaler and walked out of the room back to the medication cart. Nurse #6 did not prompt the resident to rinse his mouth with water and then spit the water out after using the inhaled medication. An interview was conducted on 5/6/26 at 10:24 AM with Nurse #6. During the interview, Nurse #6 reviewed the manufacturer's instruction and confirmed the manufacturer's instruction read, in part: After inhalation, the patient should rinse his/her mouth with water without swallowing after use of Fluticasone propion-salmeterol. Nurse #6 pulled up Resident #6's May 2026 Medication Administration Record (MAR) and reviewed his physician's order for the Fluticasone propion-salmeterol. When asked, Nurse #6 stated Resident #6 knew that she was supposed to rinse her mouth out after the Fluticasone propion-salmeterol was administered. Nurse #6 acknowledged she did not prompt Resident #6 to rinse and spit the water out. Nurse #6 stated she would go remind Resident #6 to rinse/spit after using the Fluticasone propion-salmeterol. An interview was conducted on 5/7/26 at 2:03 PM with the facility's Director of Nursing (DON). The DON reported she would expect the nursing staff administering a steroid inhaler to remind the resident to rinse and spit the water out after administering the inhaler.An interview conducted with the Administrator on 05/07/2026 at 2:40 PM revealed medication errors were to be managed by Nursing administration and the DON. She stated she expected the DON and Nursing administration to ensure medications were available and administered as ordered.