STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramseur Rehabilitation and Healthcare Center	7166 Jordon Road Ramseur, NC 27316

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Physician interviews, the facility failed to notify the Physician when a STAT (immediately or urgently) x-ray was not completed as ordered for a resident that had right hip pain after a fall on 2/22/25. The order for the x-ray was called to the mobile x-ray provider the evening of 2/22/25. The nurse assigned to the resident on 2/23/25 contacted the mobile x-ray provider to follow up about the STAT x-ray order around 5:00 PM but did not notify the Physician the STAT x-ray had not been completed. Another nurse contacted the mobile x-ray provider on 2/24/25 and the x-ray was completed that afternoon and noted Resident #90 had a displaced right femoral neck fracture (a break in the upper part of the femur [thigh bone], near the hip joint, where broken bone fragments have moved out of their normal alignment). The lack of notification resulted in a delay of an evaluation at the hospital for stabilization or surgery for the fracture until 2/24/25. The deficient practice occurred for 1 of 4 residents reviewed for notification of changes (Resident #90).Findings included:Resident #90 was admitted to the facility on [DATE] with diagnoses that included dementia, hypertension and protein calorie malnutrition.Resident #90's admission Minimum Data Set (MDS) dated revealed he had cognitive impairment.A review of Resident #90's fall report dated 02/22/25 read in part, Resident was ambulating unassisted and lost his balance and fell landing on their right side, range of motion completed and movement of extremities without difficulty. The report read further Resident complained of (c/o) right hip pain.A review of Nurse #1's progress note dated 02/22/25 read in part, Nurse Practitioner (NP) notified at 10:24pm. Received new order for x-ray 2 view right hip STAT x-ray order through mobile company at 10:30pm.On 07/30/25 at 1:39 pm an interview was conducted with Nurse #1 (worked 7p-7a on 02/22/25) and she indicated Resident #90 had a fall on 02/22/25 that was witnessed. She indicated, Resident complained by moaning of right hip pain, however he was able to move all extremities without difficulty, and when she called the NP, she received an order to do a STAT x-ray of right hip. Nurse #1 stated, I did report off to oncoming nurse of fall, pain in his hip, and not getting the x-ray, and called the x-ray company with the order. Nurse #1 indicated the portable/mobile x-ray company did not come during her shift. A review of Nurse #2's progress noted dated 02/23/25 read in part, Resident status post (S/P) fall with no injures, c/o right hip area pain, awaiting on portable x-ray for 2 view x-rays of right hip area, in bed resting with eyes closed, respirations even with no distress noted, continue to monitor.An interview was conducted with Nurse #2 (worked 7a-7p shift on 02/23/25) on 07/29/25 at 3:28 pm. Nurse #2 indicated the 3rd shift nurse had called the portable/mobile x-ray company on the night of 02/22/25. She indicated she had contacted the portable/mobile company for the x-ray on 02/23/24 around 5 pm because they had not arrived and the representative that she spoke with stated the dispatcher would call her back to give the time they would arrive to perform the x-ray. Nurse #2 reported she was not aware the order for the x-ray was STAT and did not receive a return call from the portable/mobile x-ray company. Nurse #2 indicated she did not notify the Physician/NP that the STAT order had not been performed as she was waiting for a return call from the dispatcher from the portable/mobile company. A review of Nurse #3's progress note dated 02/24/25 read in part. Resident has been in bed this am resting, and staff went to get him out of bed (OOB) he grimaced with pain. The writer spoke with portable/mobile about stat x-ray, and they stated it depends on quality and severity of STAT x-ray, and they will continue to reschedule. She informed me of estimated time of arrival (ETA) time today is between 1-3 pm. Resident was administered acetaminophen for pain and discomfort. Staff will continue to monitor.A review of the radiology results report dated 02/24/25 revealed findings as follows: fracture of the right femoral neck (right hip bone) with displacement of the distal fragment. Femoral head appropriately positioned Conclusion: acute, displaced right femoral neck fracture as noted.On 07/30/25 at 1:07 pm an interview was conducted with Nurse #3 (worked 02/24/25 7a-7p shift) and she indicated Resident #90's x-ray had not been performed and she called the portable/mobile x-ray company to see why it had not been done. She stated the x-ray representative she spoke with indicated they would be out that day to perform the x-ray. Nurse #3 indicated the portable/mobile x-ray company arrived around 2:30 pm and performed the x-ray and it was revealed Resident had a fracture to his right hip. She stated she called and informed the Nurse Practitioner and received orders to send Resident out to the hospital due to the x-ray results. Nurse #3 stated she also informed the Residents' responsible party of x-ray results and the order to send him to the hospital.An interview was conducted with a Representative from the portable/mobile x-ray company on 07/31/25 at 9:54 am and she indicated the turn around time for a STAT x-ray was 4 to 6 hours

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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 - Potential for minimal harm Residents Affected - Some	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 Minimum Data Set (MDS) assessments for 2 of 23 residents reviewed for MDS accuracy (Resident #8 and Resident #14).The findings included: a. Resident #8 was admitted to the facility 11/2/2024 with diagnoses including schizoaffective disorder, bipolar type. Review of the physician orders for Resident #8 included an order dated 12/31/24 Haloperidol (an antipsychotic medication) 100 milligrams (mg) to be administered intramuscularly (injection into the muscle) one time per month. Review of the medication administration record revealed Resident #8 received Haloperidol in June and July 2025. The quarterly MDS assessment dated [DATE] documented Resident #8 did not take antipsychotic medications. b. Resident #14 was admitted to the facility 10/30/24 with diagnoses including obesity. Review of the physician orders for Resident #14 included an order dated 3/14/25 for semaglutide (a medication used to facilitate weight loss) weekly subcutaneously (into the fatty tissue). This order was modified on 6/9/25 to administer 1 mg every Monday for weight loss. Review of the medication administration record revealed Resident #14 received the semaglutide injection every Monday in June and July 2025 as ordered. The quarterly MDS dated [DATE] documented Resident #14 received 1 injection of insulin in the 7-day look-back period. Review of the physician orders for Resident #14 revealed no orders for insulin. The MDS coordinator (MDS Nurse #1) was interviewed on 7/30/25 at 2:29 PM. MDS Nurse #1 reviewed the assessments for Resident #8 and Resident #14 and agreed that Resident #8 should have been coded for antipsychotic medications, and Resident #14 should not have been coded for insulin. MDS Nurse #1 reported that MDS Nurse #2 had completed those assessments for Resident #8 and Resident #14. An attempt was made to interview MDS Nurse #2, but no response was received from voice messages or text messages sent. The Administrator was interviewed on 7/30/25 at 2:40 PM and she reported she did not know why the MDS for Resident #8 and Resident #14 were coded incorrectly, and she expected all MDS assessments to be accurate.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Physician interviews, the facility failed to provide immediate medical evaluation and treatment when Resident #90 fell and complained of right hip pain on 2/22/25. Nurse #1 notified the Nurse Practitioner and received an order for a STAT (immediately or urgently) of the right hip on 2/22/25. The x-ray was not completed until 2/24/25 and the results revealed a displaced right femoral neck fracture (a break in the upper part of the femur [thigh bone], near the hip joint, where the broken bone fragments have moved out of their normal alignment). In addition, nurses failed to document thorough ongoing assessments of the resident's condition and staff continued to turn and reposition the resident in the bed which was painful for the resident. Resident #90 was sent to the hospital for an evaluation on 2/24/25 and x-rays confirmed the displaced right femoral neck fracture. Initially the Orthopedic surgeon considered operating on Resident #90 but then further evaluating determined Resident #90 was a very high risk for surgery and would not do well postoperatively due to his significantly worsening dementia, severe protein calorie malnutrition, and already having frequent falls. After having long conversation with the family member hospice was consulted and Resident #90 was transferred to hospice services from the hospital on 2/27/25. The deficient practice occurred for 1 of 4 residents reviewed for falls (Resident #90). Findings included:Resident #90 was admitted to the facility on [DATE] with diagnoses that included dementia, hypertension and protein calorie malnutrition.Resident #90's admission Minimum Data Set (MDS) dated revealed he had severe cognitive impairment and needed partial/moderate assistance with eating, substantial/maximum assistance with toileting hygiene assistance, shower/bath, personal hygiene, substantial/maximum assistance to dependent assistance with transfers, dependent with walking, and supervision/touching assistance with bed mobility. A review of Resident #90's care plan last revised 02/20/25 revealed Resident was at risk for falls. The goal was Resident would be free from falls and free of minor injuries. The Interventions read in part, Resident would be kept in areas of observation while awake, anticipate and meet the Resident's needs, prompt response to requests for assistance, nonskid strips to be applied to left side of bed on floor, keep bed in lowest position, staff to offer toileting assistance during periods of restlessness, offer toileting prior to meals and bedtime, ensure proper footwear (nonskid socks/shoes) in place while awake, anti-rollbacks to wheelchair, bariatric bed with bolster, dycem (non-slip material) to wheelchair, provide diversional activities during periods of restlessness. A review of Resident #90's fall report dated 02/22/25 read in part, Resident was ambulating unassisted and lost his balance and fell landing on their right side, range of motion completed and movement of extremities without difficulty. The report read further residents complained of (c/o) right hip pain. A review of Nurse #1's progress note dated 02/22/25 at 10:40 pm read in part, Resident noted on the floor laying on his right side at 10:00pm. Fall was witnessed. Resident was noted ambulating unassisted and lost his balance and fell landing on his right side. The Resident did not hit his head. The Resident assisted off the floor x 2 staff. Resident c/o right hip pain. Temperature 97.3, respiration 18, blood pressure 144/94, pulse 60, oxygen saturation 94% on room air. Resident assisted to bed x 2 staff. As needed (PRN) acetaminophen administered 325 milligrams (mg) x 2 tablets administered for pain. Nurse Practitioner notified at 10:24pm. Received new order for X-ray 2 view right hip STAT. X-ray order through mobile company at 10:30 pm. Resident responsible party notified at 10:35 pm. No signs or symptoms (s/s) of acute distress noted. Will continue to monitor. Call light within reach. A review of Nurse #1's progress note dated 02/23/2025 at 4:58 am read in part, Resident status post (s/p) witnessed fall. No pain or discomfort. No apparent injuries noted. Able to move all extremities without any difficulty. Will continue to monitor.On 07/30/25 at 1:39 pm an interview was conducted with Nurse #1 (worked 7:00 pm to 7:00 am on 02/22/25) and she indicated Resident #90 had a fall on 02/22/25 that was witnessed. She indicated, Resident complained by moaning of right hip pain, however he was able to move all extremities without difficulty, and she administered acetaminophen as ordered for the pain in right hip after the fall. Nurse #1 indicated she called the NP and received an order to do a STAT x-ray of right hip. Nurse #1 stated, I did report off to oncoming nurse of fall, pain in his hip, and not getting the x-ray, and called the x-ray company with the order. Nurse #1 indicated the portable/mobile x-ray company did not come during her shift. Unable to contact Nursing Assistant #3 (NA) (worked 02/22/25 7p-7a).A review of the electronic medication administration record (EMAR) revealed Resident #90 received acetaminophen tablet 325 mg 2 tablets by mouth for s/s of pain/discomfort to right hip/leg on 2/23/2025 at 8:10 am.A review of Nurse #2's progress