STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345072	A. BUILDING _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RIVERS NURSING AND REHABILITATION CENTER	1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted 10/01/24. Event ID #C2OJ11. The following intakes were investigated NC00221588 and NC00222553. 1 of 6 complaint allegations resulted in a deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent a resident from rolling off the bed during care which resulted in an abrasion of the posterior scalp and left ankle soft tissue swelling from a fall for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 1/3/24. Her diagnoses included hemiplegia following cerebral infarction (stroke) affecting left side. Resident #1 ' s care plan, initiated 1/3/24 had a care focus area of activities of daily living/ personal care with one of the interventions noted as totally dependent on two-person assistance for bed mobility initiated 5/27/24.	F 689	F689 Free of Accident Hazards On 8/25/24, the nurse notified the physician of resident #1 fall from bed and a dime size area to right posterior scalp with minimal bleeding. New order to transfer resident #1 to the emergency room for further evaluation and treatment with no fractures identified and computed tomography (CT) scan of the head within normal limits. Resident #1 returned to the facility on 8/25/24 with new order for pain medication as needed. On 9/4/24, the Director of Nursing verbally educated nursing assistant(NA) #1 regarding proper positioning of residents in bed, technique for turning and	10/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/15/2024

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F 689	Continued From page 1 Resident #1 ' s quarterly Minimum Data Set Assessment (MDS) dated 7/17/24 coded the resident as moderately cognitively impaired and dependent with toileting and rolling left and right in bed. Resident #1 ' s medication administration record (MAR) dated August 2024 revealed Resident #1 received acetaminophen oral suspension (325 milligram/10.15 milliliter) 20 milliliters on 8/25/24 at 4:45 PM for 4/10 pain, 8/26/24 at 10:41 AM for 2/10 pain, 8/28/24 at 9:28 PM for 5/10 pain, and on 8/30/24 at 10:14 PM for 3/10 pain level. Prior to the fall Resident #1 received acetaminophen on 8/7/24 at 12:22 AM for 3/10 pain and on 8/15/24 at 10:25 PM for 5/10 pain level. The MAR also revealed Resident #1 was on Eliquis (blood thinner) 2.5 milligram twice a day. An incident report dated 8/25/24 stated NA #1 called to Nurse #1 stating that Resident #1 had fallen out of bed while being changed. When Nurse #1 entered the room, Resident #1 was on her back on the floor between Resident #1 ' s bed and roommate's bed. Resident #1 ' s bed was at a height of 2 feet. Resident was alert and able to answer questions. Resident #1 was assessed by Nurse #1 for pain/injury. Resident reported no pain. Upon assessment Resident #1 showed no facial grimacing or verbal cue for pain. Resident #1 vital signs were obtained, and nursing staff assisted Resident #1 back to bed. Upon transfer back to the bed scant blood was observed on Resident #1 ' s bed pillow. Nurse #1 observed dime size opening to Resident ' s right posterior head and minimal bleeding noted. On call provider was notified and advised Resident #1 to be sent to the emergency department (ED) for	F 689	positioning and checking care guide for level of assistance required prior to providing care. NA #1 verbalized understanding. NA #1 no longer works at the facility. On 9/5/24, the Minimum Data Set Nurse (MDS) completed an audit of all care guides for assistance required for bed mobility. This audit is to ensure care guides accurately reflect the number of staff required for turning and repositioning resident in bed for safety. There were no additional concerns identified. On 9/5/24, the Social Worker completed interviews with all alert and oriented residents in the facility to identify any resident concerns related to turning and repositioning during care. On 10/10/24 the questionnaires were expanded to include all newly admitted alert and oriented residents from 9/5/24 to 10/10/24. Questionnaires were completed by 10/15/24 with no additional concerns identified. identified. On 9/5/24, the Staff Development Coordinator (SDC) initiated an in-service with all nursing assistants (NA) regarding Turning and Positioning during care. Emphasis on following care plan/care guide when providing care for safety to include level of assistance required, technique for turning and positioning resident when providing care, positioning resident in the center of the bed following care and when turning and positioning to prevent falls/injury. The in-service	

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F 689	Continued From page 2 further evaluation. An undated Interview statement written by Nursing Assistant #1 (NA #1) indicated alleged occurrence date: 8/25/24 and alleged occurrence time: 3:40 AM. The statement indicated NA #1 was doing her rounds and at around 3:40 AM she entered Resident #1 ' s room and Resident #1 told her she was soiled. NA #1 began performing incontinence care. Resident #1 was laying on her side facing away from NA #1 who was holding the Resident with her left hand and cleaning her with her right hand. Resident #1 tensed up which caused her to grab the side of the bed and her body to move forward and away from NA #1 and she rolled off the bed. NA #1 tried to stop the fall, but she was unable to. She immediately alerted Nurse #1 who came to assess Resident #1. Hospital discharge summary dated 8/25/24 indicated Resident #1 was seen at the emergency department (ED) on 8/25/24 for a fall after being rolled out of bed in a nursing home. The note indicated Resident #1 was complaining of right shoulder and left ankle pain. X-ray of the chest and right shoulder, computed tomography (CT) scan of the head and cervical spine completed at the ED showed no acute significant findings. X- ray of left ankle showed soft tissue swelling. Clinical impression on the discharge plan indicated acute pain of right shoulder, acute left ankle pain and fall. Resident #1 ' s ED discharge instructions dated 8/25/24 indicated Resident was seen at the ED on 8/25/24 for acute pain of right shoulder, acute left ankle pain, fall, and abrasion of scalp. The discharge instructions indicated give Tylenol/ ibuprofen every 6-8 hours for ankle pain, clean	F 689	included a return demonstration to validate staff knowledge and understanding of the education to include accessing the care guide on the iPad. On 10/7/24, the in-service and return demonstrations were expanded to include all nurses. In-service and return demonstrations will be completed by 10/15/24. After 10/15/24, any nurse or nursing assistant that has not received the in-service/return demonstration will complete it prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be in-service during orientation by the SDC regarding Turning and Positioning. On 9/23/24 the SDC initiated an in-service with all nurses and nursing assistants regarding Safe Handling with emphasis on reading the care guide prior to providing care to ensure all interventions are in place to include level of assistance required for resident safety. The in-service will be completed by 10/15/24. After 10/15/24, any nurse or nursing assistant that has not worked or received the in-service will receive it prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced by the SDC during orientation regarding Safe Handling. The Director of Nursing and/or Accounts Payable staff will mail in-services via certified mail to any nurse or nursing assistant who has not completed the education by 10/15/24 with instructions to read, sign and returned to the Director of	

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F 689	Continued From page 3 right posterior scalp abrasion with soap and water and follow up with primary care provider the next day. Facility Nurse Practitioner (NP) progress note dated 8/26/24 indicated Resident #1 was seen by the NP for assessment following return from ED consult for right shoulder/left ankle pain following fall. The note indicated Resident #1 was alert, at baseline medication (no new added medications) without signs of distress and denied pain at the time of the assessment. The note further indicated fall precautions reviewed, ED consult notes reviewed and fall precautions reiterated with Resident #1 and nursing staff. During an interview on 10/1/24 at 12:36 PM with Nurse #1, she revealed she was the primary nurse for Resident #1 when the resident fell off the bed on 8/25/24. She indicated she became aware of the fall after Nursing Assistant (NA #1) called for assistance from Resident #1's doorway. When she walked into the room, Resident #1 was on the floor between her bed and her roommate ' s bed. Resident #1 stated she was cold, her back hurt and asked to get off the floor. After they transferred Resident #1 back to bed, Nurse #1 noticed a trace amount of blood on the pillow and realized the Resident had hit her head. Nurse #1 notified the on-call physician who gave orders for Resident to be transferred to the ED for further evaluation. She called emergency services who came to transport Resident #1 to the hospital. During an observation on 10/1/24 at 2:00 PM, Resident #1 was observed in bed on a low wing mattress and her bed was noted to be in the lowest position. Resident #1 did not appear to be in any pain or distress. She denied pain when	F 689	Nursing, Assistant Director of Nursing or Administrator prior to next scheduled work shift. The letter also informs staff of the requirement to complete a return demonstration regarding turning and positioning prior to working. The Director of Nursing will monitor completion of all in-services and return demonstrations to ensure compliance with education. 10 Resident Care Audits will be completed with nurses and nursing assistants by the MDS nurse, Unit Supervisors, Assistant Director of Nursing utilizing the Resident Care Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff read the care guide on the iPad prior to providing care with activities of daily living including baths/incontinent care and turning and positioning for the level of assistance needed for resident safety. The observation also included ensuring the staff used appropriate technique when turning and positioning to include positioning in center of bed during and following care. The MDS nurse, Unit Managers and/or Assistant Director of Nursing will address all areas of concern to include re-training of staff. The DON will review the Resident Care Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Social Worker will interview 5 alert and oriented residents weekly x 4 weeks then monthly x 1 month. This audit is to identify any resident concerns related to turning and repositioning during care. The	

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F 689	Continued From page 4 asked if she was in any pain and attempts to carry on conversation were unsuccessful. Attempts to interview NA # 1 were unsuccessful. During an interview on 10/1/24 at 12:54 PM with the Assistant Director of Nursing (ADON), he indicated Resident #1 fell while being provided incontinent care by NA #1. The ADON stated Resident #1 was care planned for two-person assistance and NA #1 should have ensured there were two people in the room to provide incontinence care. The ADON indicated Resident #1 had not had a change in activity level after the fall. An interview was conducted with the Director of Nursing (DON) and the facility Administrator on 10/1/24 at 2:20 PM. The DON stated NA #1 should have had assistance in the room to provide incontinence care for Resident #1. She also stated NA #1 should have looked at the care plan because Resident #1 was care planned for two-person assist.	F 689	Social Worker will immediately notify the Director of Nursing and/or Assistant Director of Nursing of any concerns identified. The Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will address all concerns identified during the audit to include initiating interventions when indicated and/or re-training of staff. The Administrator will forward the results of the Resident Care Audit Tool and the Resident Questionnaires to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Compliance date: 10/16/24	