

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345465</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Bayview Nursing &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3003 Kensington Park Drive , New Bern, North Carolina, 28560</b>	
(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
E0000	Initial Comments  An unannounced recertification and complaint survey was conducted on 11/17/25 through 11/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DB5A7-H1.	E0000		12/10/2025
F0000	INITIAL COMMENTS  A recertification and complaint investigation survey was conducted from 11/17/25 through 11/20/25. Event ID #1DB5A7-H1. The following intakes were investigated 866590, 2649791, 866596, 866592, 2563177, 2578748.  14 of the 14 complaint allegations did not result in deficiency.	F0000		12/10/2025
F0657 SS = D	Care Plan Timing and Revision  CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans  §483.21(b)(2) A comprehensive care plan must be--  (i) Developed within 7 days after completion of the comprehensive assessment.  (ii) Prepared by an interdisciplinary team, that includes but is not limited to--  (A) The attending physician.  (B) A registered nurse with responsibility for the resident.  (C) A nurse aide with responsibility for the resident.  (D) A member of food and nutrition services staff.  (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F0657	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice  During annual survey, it was determined that the facility failed to revise the comprehensive care plan to accurately reflect code status (Resident #45) and use of Assist bars (Resident #11 and Resident #40).  On 11/20/25, the Comprehensive Care Plan was updated by MDS Coordinator to reflect code status as "Do not resuscitate" for Resident #45.  On 11/20/25, Comprehensive Care Plan was updated by MDS Coordinator to reflect accuracy of utilization of assist bar relative to Resident #11 and Resident #40.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice  On 11/19/25, 100% of current residents' advance directive care plans were audited by MDS Coordinator for accuracy. Any inaccuracies noted were immediately corrected on the Comprehensive Care Plan by MDS Coordinator.	12/10/2025

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 reverse for further 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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F0657 SS = D	<p>Continued from page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review and staff interviews the facility failed to revise the comprehensive care plan to accurately reflect code status and the use of bedrails. This was for 1 of 3 residents (Resident #45) reviewed dementia care, and 2 of 2 residents (Resident #11 and Resident #40) reviewed for the use of bed rails.</p> <p>Findings included:</p> <p>1. Resident #45 was admitted to the facility on 12/9/24 with a diagnosis of dementia.</p> <p>A physician's order for Resident #45 dated 1/26/25 was Do Not Resuscitate. (DNR is the refusal of Cardio-Pulmonary Resuscitation, a lifesaving procedure performed when someone's heartbeat or breathing has stopped).</p> <p>Resident #45's current active comprehensive care plan revealed a focus area desiring Cardio-Pulmonary Resuscitation (CPR). The goal dated last revised on 11/11/25 was for Resident #45 and her family's wishes for Full Code status (Full Code status involves CPR when someone's heartbeat or breathing has stopped) to be honored through the next review. An intervention was to ensure proper documentation supporting full code status was present in Resident #45's chart.</p> <p>On 11/20/25 at 8:15 AM an interview with the Minimum Data Set (MDS) Nurse indicated she would have been responsible for ensuring the code status on Resident #45's comprehensive care plan was accurate. She reported a care plan meeting had been arranged with Resident #45 and her family because Resident #45 had been declining. She went on to say there had been paperwork that needed to be signed for a DNR code status. The MDS Nurse stated Resident #45, and her family member had wanted to think about this, so she informed Resident #45's family member to give the paperwork to the Social Worker (SW) when he was finished. She reported she had been aware that all the steps for the completion of the paperwork for a DNR code status had been completed. The MDS Nurse reported</p>	F0657	<p>Continued from page 1 On 12/8/25, 100% of current residents with assist bars, activity of daily living care plans was audited by Clinical Nurse Liaison for accuracy for the use of assist bars. Any inaccuracies noted were immediately corrected on the Comprehensive Care Plan by MDS Coordinator.</p> <p>On 11/20/25, 100% Education provided to the interdisciplinary team (Minimum Data Set Coordinator, Social Services, Activities, Dietary, Therapy, Treatment Nurse, Director of Nursing Services, and Executive Director) by Director of Clinical Reimbursement Services regarding the requirement of Comprehensive Care Plan revision timeliness and accuracy to include code status and assist bars. Education will be provided to any newly hired interdisciplinary team members.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur</p> <p>As of 12/9/25, During daily morning Clinical meeting all new orders and assist bar evaluations will be reviewed by Director of Nursing Services. Care plan will be updated to reflect any changes during this meeting by MDS Coordinator.</p> <p>As of 12/9/25, Director of Clinical Reimbursement Services has implemented a new care plan titled "Assist Bars/Bed Rails". This will be added to the comprehensive care plan for any resident requiring assist bars/bed rails by MDS Coordinator.</p> <p>As of 12/9/25, Executive Director has implemented use of new form, "Monitoring Completeness and Accuracy of Assist bar/Bed Rail Assessments" for use of revision and tracking of Comprehensive Care Plan to include assist bars. This form will be completed daily during morning clinical meeting by Director of Nursing Services or Designee.</p> <p>As of 12/9/25, Executive Director has implemented use of new form, "Code Status Audit" for use of revision tracking of Comprehensive Care Plan to include code status. This form will be completed daily during clinical meeting by Medical Records.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained</p>	

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F0657 SS = D	<p>Continued from page 2 this could have been in January 2025, although she could not recall exactly. She stated she should have updated Resident #45's comprehensive care plan immediately when the process including the obtaining of the physician's order for DNR code status was complete, but she missed it.</p> <p>On 11/19/25 at 9:15 M an interview with the Director of Nursing indicated the MDS Nurse would have been responsible for updating Resident #45's comprehensive care plan to accurately reflect Resident #45's DNR code status. She reported the MDS Nurse should have done this immediately.</p> <p>On 11/19/25 at 1:09 PM an interview with the Administrator indicated Resident #45's care plan should have been revised to accurately reflect her code status of DNR.</p> <p>2. Resident #11 was admitted to the facility on 4/19/23 with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure.</p> <p>Review of Resident #11's electronic medical record revealed an assessment titled bed rail assessment dated 5/30/25 and completed by the Director of Nursing (DON). The assessment revealed Resident #11 used bilateral side rail/assist bars on her bed.</p> <p>A care plan with the latest review date of 8/22/25 revealed no reference to use of side rails (u-shaped grab bars) for Resident #11.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated 8/22/25 revealed Resident #11 was cognitively intact. The MDS indicated Resident #11 was dependent on staff for bed mobility and was non-ambulatory. The MDS further revealed Resident #11 had impairment to her lower extremities and no impairment to her upper extremities. The MDS indicated Resident #11's u-shaped grab bars were not used as a restraint.</p> <p>An observation on 11/17/25 at 11:10 AM revealed Resident #11 lying in bed with bilateral u-shaped grab bars in the raised position.</p> <p>A follow-up observation and interview with Resident #11 was conducted on 11/18/25 at 1:55 PM. Resident #11 was observed lying in bed with bilateral u-shaped grab bars</p>	F0657	<p>Continued from page 2</p> <p>As of 12/9/25, Comprehensive Care Plans will be audited by Director of Nursing Services or Designee for accurately reflection of code status and assist bars using the "Care Plan Audit Form" for the following schedule: 100% x 4 weeks, 50% x 4 weeks, and 25% x 4 weeks.</p> <p>As of 12/9/25, Findings will be brought to the facility's Quality Assurance Committee quarterly x4 by Director of Nursing Services. Any changes will be implemented to the plan by Executive Director.</p>	

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F0657 SS = D	<p>Continued from page 3 in the raised position. Resident #11 stated she had the u-shaped grab bars since she was admitted and used them to assist with mobility and positioning in bed.</p> <p>In an interview with the MDS Nurse on 11/20/25 at 8:32 AM she stated she was responsible for creating and updating care plans. The MDS Nurse was unaware u-shaped grab bars were supposed to be included on a residents comprehensive care plan.</p> <p>In an interview with the Administrator on 11/20/25 at 8:35 AM she stated she was unaware a residents comprehensive care plan should have included u-shaped grab bars.</p> <p>In an interview with the DON on 11/20/25 at 8:43 AM she stated she was unaware u-shaped grab bars were to be included on a resident's comprehensive care plan.</p> <p>3. Resident #40 was admitted to the facility on 9/25/20 with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure.</p> <p>Review of Resident #40's electronic medical record revealed an assessment titled bed rail assessment dated 7/21/25 and completed by the Director of Nursing (DON). The assessment revealed Resident #40 used bilateral side rail/assist bars (u-shaped grab bars) on her bed.</p> <p>A care plan with the latest review date of 10/17/25 revealed no reference to use of u-shaped grab bars for Resident #40.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated 10/17/25 revealed Resident #40 was cognitively intact. The MDS indicated Resident #40 was independent with bed mobility and transfers and was ambulatory with a walker. The MDS further revealed Resident #40 had impairment to both lower extremities and one side of upper extremities. The MDS indicated Resident #40's u-shaped grab bars were not used as a restraint.</p> <p>An observation on 11/17/25 at 1:10 PM revealed Resident #40 sitting on the side of the bed with bilateral u-shaped grab bars in the raised position.</p>	F0657		

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F0657 SS = D	Continued from page 4  A follow-up observation and interview with Resident #40 was conducted on 11/18/25 at 2:22 PM. Resident #40 was observed lying in bed with bilateral u-shaped grab bars in the raised position. Resident #40 stated she had the u-shaped grab bars since she was admitted and used them to assist with positioning in bed and to help her stand when getting out of bed.  In an interview with the MDS Nurse on 11/20/25 at 8:32 AM she stated she was responsible for creating and updating care plans. The MDS Nurse was unaware u-shaped grab bars were supposed to be included on a residents comprehensive care plan.  In an interview with the Administrator on 11/20/25 at 8:35 AM she stated she was unaware a residents comprehensive care plan should have included u-shaped grab bars.  In an interview with the DON on 11/20/25 at 8:43 AM she stated she was unaware that u-shaped grab bars were to be included on a resident's comprehensive care plan.	F0657		
F0700 SS = D	Bedrails  CFR(s): 483.25(n)(1)-(4)  §483.25(n) Bed Rails.  The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.  §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F0700	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.  During annual survey it was identified that facility failed to assess entrapment risk and attempt interventions prior to installation of assist bars and include the details on care plan for Resident #11 and Resident #40.  On 11/20/25, Director of Nursing Services completed "Assist bar Audit" to identify residents currently using Assist bars.  On 11/20/25, Director of Nursing Services completed "Assist Bar Use Evaluation" on Resident #11 and Resident #40.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  As of 12/8/25, 100% of residents will have "Assist Bar Use Evaluation" completed by Director of Nursing	12/09/2025

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F0700 SS = D	<p>Continued from page 5 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, staff and resident interviews the facility failed to assess entrapment risk and failed to attempt alternatives prior to siderail use for 2 of 2 residents (Resident #11, Resident #40) reviewed for side rails.</p> <p>Findings included:</p> <p>1. Resident #11 was admitted to the facility on 4/19/23 with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure.</p> <p>Review of Resident #11's electronic medical record revealed an assessment titled bed rail assessment dated 5/30/25 and completed by the Director of Nursing (DON). The assessment revealed Resident #11 used bilateral side rail/assist bars (u-shaped grab bars) on her bed. The bed rail assessment noted that Resident #11 used the u-shaped grab bars as an enabler to promote independence and that she expressed desire to have the u-shaped grab bar. The bed rail assessment did not include an entrapment risk evaluation or if any alternatives were attempted before installation of the u-shaped grab bars.</p> <p>A care plan with the latest review date of 8/22/25 revealed no reference to use of u-shaped grab bars for Resident #11.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated 8/22/25 revealed Resident #11 was cognitively intact. The MDS indicated Resident #11 was dependent on staff for bed mobility and was non-ambulatory. The MDS further revealed Resident #11 had impairment to her lower extremities. The MDS indicated Resident #11's u-shaped grab bars were not used as a restraint.</p> <p>An observation on 11/17/25 at 11:10 AM revealed Resident #11 lying in bed with u-shaped grab bars in the raised position. The bars were white, metal and about 8 inches wide x 16 inches tall. They were attached to the frame of the bed.</p>	F0700	<p>Continued from page 5 Services or Designee, to include current and new admissions. Assessment to include entrapment risk and interventions attempted prior to application of assist bar, as well as risk and benefits for utilization.</p> <p>As of 12/8/25, Care plan will be updated by MDS Coordinator to reflect interventions, and documentation of assist bars if applicable to resident.</p> <p>As of 12/8/25, "Informed Consent for use of Positioning/Mobility Assistive Device" will be completed by Director of Nursing Services or Designee prior to application of assist bars.</p> <p>As of 12/10/25, 100% of Interdisciplinary team and Nurses received education by Executive Director or Designee regarding requirement of regulation to include assessment for entrapment risk and attempt of interventions prior to installation of assist bars and care planning as appropriate. All newly hired employees will be educated at orientation.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 11/20/25, Director of Nursing Services has implemented use of new forms, "Assist Bar Use Evaluation" and "Informed Consent for use of Positioning/Mobility Assistive Device" to all residents prior to installation of assist bars.</p> <p>As of 12/8/25, Care plan will be updated by MDS Coordinator to reflect interventions, and documentation of assist bars if applicable to resident.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained</p> <p>As of 12/8/25, Director of Nursing Services or Designee will utilize the "Assist bar Process Audit" for New Admission, Re-Admission, Quarterly assessment, Yearly Assessments and Significant Change assessment. 100% x 4 weeks, 50% x 4 weeks, 25% x 4 weeks or until substantial compliance achieved</p> <p>As of 12/8/25, Results of audit will be reported in QAPI monthly x 3 by Director of Nursing Services. This plan will be reviewed and revised as needed by the Executive Director.</p>	

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F0700 SS = D	<p>Continued from page 6</p> <p>A follow-up observation and interview with Resident #11 was conducted on 11/18/25 at 1:55 PM. Resident #11 was observed lying in bed with bilateral u-shaped grab bars in the raised position. Resident #11 stated she had the u-shaped grab bars since she was admitted and used them to assist with positioning in bed.</p> <p>In an interview with the DON on 11/18/25 at 2:30 PM she stated she was the staff member who conducted Resident #11's side rail assessment on 5/30/25 and that the facility referred to them as u-shaped grab bars. The DON revealed that staff did not conduct an entrapment risk assessment or attempt alternative interventions before using side rails. The DON further stated she was unaware that alternatives needed to be tried and documented and that an entrapment risk evaluation needed to be conducted before using u-shaped grab bars. The DON indicated that the MDS Nurse often conducted the quarterly side rail assessments.</p> <p>In an interview with the MDS Nurse on 11/18/25 at 2:40 PM she stated she often conducted quarterly side rail assessments for the use of the u-shaped grab bars. The MDS Nurse further stated she was unaware an entrapment risk evaluation needed to be conducted and alternatives to u-shaped grab bars needed to be tried and documented.</p> <p>In an interview with the Administrator on 11/18/25 at 3:46 PM she stated that the therapy department assessed residents for entrapment risk when using the u-shaped grab bars when they did their bed mobility evaluation.</p> <p>An interview was conducted with the Rehabilitation Manager on 11/18/25 at 3:54 PM. She stated therapy did not conduct entrapment risk evaluations. The Rehabilitation Manager further stated that when therapy conducted an evaluation regarding bed mobility and they felt the resident could use side rails to help, they would verbally inform that residents charge Nurse and Maintenance to have the side rails put on the bed if they don't already have them.</p> <p>In a follow-up interview with the Administrator on 11/18/25 at 4:02 PM, she indicated nursing staff used the side rail assessment tool that the corporate clinical team provided to the facility. The Administrator stated she was unaware that an entrapment</p>	F0700		

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F0700 SS = D	<p>Continued from page 7 risk evaluation needed to be done and that alternatives needed to be tried and documented before the use of u-shaped grab bars.</p> <p>2. Resident #40 was admitted to the facility on 9/25/20 with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure.</p> <p>Review of Resident #40's electronic medical record revealed an assessment title bed rail assessment dated 7/21/25 and completed by the Director of Nursing (DON). The assessment revealed Resident #40 used bilateral side rail/assist bars (u-shaped grab bars) on her bed. The bed rail assessment noted that Resident #11 used the u-shaped grab bars as an enabler to promote independence and that she expressed desire to have the u-shaped grab bar. The bed rail assessment did not include an entrapment risk evaluation or if any alternatives were attempted before installation of the u-shaped grab bars.</p> <p>A care plan with the latest review date of 10/17/25 revealed no reference to use of u-shaped grab bars for Resident #40.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated 10/17/25 revealed Resident #40 was cognitively intact. The MDS indicated Resident #40 was independent with bed mobility and transfers and was ambulatory with a walker. The MDS further revealed Resident #40 had impairment to both lower extremities and one side of upper extremities. The MDS indicated Resident #40's u-shaped grab bars were not used as a restraint.</p> <p>An observation on 11/17/25 at 1:10 PM revealed Resident #40 sitting on the side of the bed with u-shaped grab bars in the raised position. The bars were white, metal and about 8 inches wide x 16 inches tall. They were attached to the frame of the bed.</p> <p>A follow-up observation and interview with Resident #40 was conducted on 11/18/25 at 2:22 PM. Resident #40 was observed lying in bed with u-shaped grab bars in the raised position. Resident #40 stated she had the u-shaped grab bars since she was admitted and used them to assist with positioning in bed and to help her stand when getting out of bed.</p>	F0700		

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NAME OF PROVIDER OR SUPPLIER <b>Bayview Nursing &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3003 Kensington Park Drive , New Bern, North Carolina, 28560</b>	
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F0700 SS = D	<p>Continued from page 8</p> <p>In an interview with the DON on 11/18/25 at 2:30 PM she stated she was the staff member who conducted Resident #11's side rail assessment on 5/30/25 and that the facility referred to them as u-shaped grab bars. The DON revealed that staff did not conduct an entrapment risk assessment or attempt alternative interventions before using side rails. The DON further stated she was unaware that alternatives needed to be tried and documented and that an entrapment risk evaluation needed to be conducted before using u-shaped grab bars. The DON indicated that the MDS Nurse often conducted the quarterly side rail assessments.</p> <p>In an interview with the MDS Nurse on 11/18/25 at 2:40 PM she stated she often conducted quarterly side rail assessments for the use of the u-shaped grab bars. The MDS Nurse further stated she was unaware an entrapment risk evaluation needed to be conducted and alternatives to u-shaped grab bars needed to be tried and documented.</p> <p>In an interview with the Administrator on 11/18/25 at 3:46 PM she stated that the therapy department assessed residents for entrapment risk when using the u-shaped grab bars when they did their bed mobility evaluation.</p> <p>An interview was conducted with the Rehabilitation Manager on 11/18/25 at 3:54 PM. She stated therapy did not conduct entrapment risk evaluations. The Rehabilitation Manager further stated that when therapy conducted an evaluation regarding bed mobility and they felt the resident could use side rails to help, they would verbally inform that residents charge Nurse and Maintenance to have the side rails put on the bed if they don't already have them.</p> <p>In a follow-up interview with the Administrator on 11/18/25 at 4:02 PM, she indicated nursing staff used the side rail assessment tool that the corporate clinical team provided to the facility. The Administrator stated she was unaware that an entrapment risk evaluation needed to be done and that alternatives needed to be tried and documented before the use of u-shaped grab bars.</p>	F0700		