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 07/07/2022

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 from 07/06/2022 through 07/07/2022. Event ID# S87711. The following intakes were investigated NC0000190605, NC00190503, NC00189651, NC00190287, NC00186734, and NC00187423. 18 of the 18 complaint allegations were not substantiated.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		7/29/22

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

Electronically Signed | 07/28/2022

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F 656	Continued From page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, observation, and record review, the facility failed to implement fall interventions per the care plan for one of two (Resident #5) residents reviewed for accidents. The findings included: Resident #5 was admitted to the facility on 6/30/21 with diagnoses that included heart failure and respiratory failure. A Care Plan dated 2/25/22 focused on falls included a goal that resident would not sustain serious injury from falls. Interventions included keep her bed in lowest position, a fall mat on floor when in bed, her call light within reach, and Resident #5 would use a scoop mattress on her bed. Resident #5's significant change Minimum Data Set (MDS) dated 3/30/22 indicated she had severe cognitive impairment and had an acute change in mental status and worsened behavioral	F 656	Carolina Rivers Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carolina Rivers Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carolina Rivers Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other	

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F 656	Continued From page 2 status. Resident #5 required extensive assistance with bed mobility and was total dependence for transfers. The MDS indicated she had not had any falls since the prior quarterly MDS. On 7/6/22 at 11:15 AM, an observation was made of Resident #5 in bed in a high position without a fall mat at bedside. Staff was not present or observed providing care. During an interview on 7/6/22 at 3:45 PM, the nurse aid (NA) #1 working with Resident #5 indicated that Resident #5's fall intervention included a scoop mattress, transfers with a mechanical lift, and fall mat. NA #1 indicated that Resident #5 was no longer trying to get out of bed and possibly did not need the fall mat anymore. She confirmed the bed should be in low position. During an interview on 7/6/22 at 3:50 PM, the Quality Assurance (QA) nursing indicated that Resident #5 no longer needed the fall mat, and it should have been removed from the Care Plan. She revealed she was responsible for removing interventions from the Care Plan. She confirmed the bed should be in low position. During an interview on 7/7/22 at 1:20 PM, the Director of Nursing (DON) revealed that the fall mat was discontinued last week and should have been removed from the Care Plan. She revealed the bed should be in low position and possibly staff had left it high after providing care. During an interview on 7/7/22 at 1:25 PM, the Administrator revealed the intervention should have been removed from the Care Plan.	F 656	administrative or legal proceeding. On 7/7/2022, the Quality Assurance Nurse (QA) Nurse updated resident #5 care plan for current fall safety interventions to include the removal of fall mat at bedside as no longer indicated. On 7/8/2022, the Minimum Data Set Nurse (MDS), Unit Coordinators, QA Nurse, and the Director of Nursing (DON), initiated an audit of care plan for all residents at risk for falls. This audit is to ensure care plan accurately reflects current safety interventions initiated for residents at risk for falls to include resident #5. The MDS Nurse, the Unit Coordinators, QA Nurse and the Director of Nursing will address all concerns identified during the audit to include updating care plan for safety interventions when indicated and education of staff. Audit will be completed by 7/29/2022. On 7/8/2022, the MDS Nurse, Unit Coordinators, QA Nurse, and the Director of Nursing, initiated an audit of residents at risk for falls. This audit is to ensure safety interventions are in place per resident care plan. The MDS Nurse, Unit Coordinators, QA Nurse, and the Director of Nursing will address all concerns identified during the audit to include implementing safety interventions when indicated, updating care plan and/or education of staff. Audit will be completed by 7/29/2022. On 7/26/2022, the Director of Nursing	

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F 656	Continued From page 3	F 656	initiated an in-service with all nurses regarding Care Plans with emphasis on ensuring care plan is resident centered and goal oriented and to ensure that the care plans reflect the resident's most current information all aspects of care to include but not limited to safety interventions. In-service will be completed by 7/29/2022. After 7/29/2022, any nurse who has not received the in-service or who has not worked will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced by the Director of Nursing during orientation regarding Care Plans. On 7/26/2022, the Director of Nursing initiated an in-service with all nurses and nursing assistants regarding Safety Interventions. Emphasis is on ensuring safety interventions are in place for residents at risk for falls per the resident care plan/care guide and notifying the nurse when interventions are not in place per care plan/care guide. In-service will be completed by 7/29/2022. After 7/29/2022, any nurse or nursing assistant who has not received the in-service or who has not worked will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced by the Director of Nursing during orientation regarding Safety Interventions. 10% of residents care planned as at risk for falls will be reviewed weekly x 4 weeks then monthly x 1 month utilizing the Care Plan/Safety Intervention Audit Tool. This audit is to ensure the care plan accurately	

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F 656	Continued From page 4	F 656	reflects safety interventions for residents at risk for falls and that the safety interventions were in place per resident care plan/care guide. The Unit Coordinators, QA Nurse and Assistant Directive of Nursing (ADON) will address all concerns identified during the audit to include updating care plan for resident safety intervention, implementing safety interventions per care plan/care guide and/or re-training of staff. The Director of Nursing will review the Care Plan/Safety Intervention Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Care Plan/Safety Intervention Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Care Plan/Safety Intervention Audit Tool 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.	