	-	ID HUMAN SERVICES				RM APPROVED
				PLE CONSTRUCTION		NO. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	G		TE SURVEY MPLETED
			A. DOILDING	J		С
		345234	B. WING			4/10/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		4/10/2023
				1555 WILLIS AVENUE		
HARBOR\	IEW LUMBERTON			LUMBERTON, NC 28358		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	ULD BE	COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	1		-			
F 000			– – –			
E 000	Initial Comments		E 00	JU		
	•	ered the facility on 03/31/25				
	to conduct a recertific	•				
		and exited on 04/03/25. h was obtained on 04/10/25.				
		ite was changed to 04/10/25.				
		The facility was found in				
		requirement CFR 483.73,				
	Emergency Prepared	•				
F 000	INITIAL COMMENTS	;	F 00	00		
	The survey team ent	ered the facility on 03/31/24				
	to conduct a recertific	-				
	investigation survey a	and exited on 04/03/25.				
		n was received on 04/10/25.				
		te was changed to 04/10/25.				
	Event ID# WCHO11.					
	The following intakes	were investigated:				
		218989, NC00220798, and				
	NC00222844.	10000, 11000220700, and				
	6 of the 12 complain	t allegations resulted in				
	deficiency.					
F 580		jury/Decline/Room, etc.)	F 58	30		4/23/25
SS=D	CFR(s): 483.10(g)(14	l)(i)-(iv)(15)				
	\$400.40/m)/(4) Notifi	action of Changes				
	§483.10(g)(14) Notifie	ediately inform the resident;				
		ent's physician; and notify,				
		her authority, the resident				
	representative(s) whe	•				
		ving the resident which				
		as the potential for requiring				
	physician interventior					
		ge in the resident's physical,				
	mental, or psychosod					
	deterioration in health	n, mental, or psychosocial				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					04/25/2025

Electronically Signed

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.

PRINTED: 05/13/2025

	-	D HUMAN SERVICES				FORM	: 05/13/2025 APPROVED
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	LETED
		345234	B. WING		_	04/ [,]	C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	VIEW LUMBERTON			555 WILLIS AVENUE UMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	clinical complications) (C) A need to alter trea a need to discontinue treatment due to advec commence a new forr (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section. (iv) The facility must r update the address (n phone number of the representative(s). §483.10(g)(15) Admission to a composi- that is a composite dis §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9).	reatening conditions or); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and resident besite distinct part. A facility stinct part (as defined in e in its admission agreement ion, including the various se the composite distinct y the policies that apply to en its different locations T is not met as evidenced	F 580	Based on record r	eview, staff and the		

Facility ID: 953293

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ С 345234 B. WING 04/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1555 WILLIS AVENUE** HARBORVIEW LUMBERTON LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 580 Continued From page 2 F 580 Wound Care Physicians interviews, the facility Wound Care Physician interviews, the failed to notify the Wound Care Physician for facility failed to notify the Wound Care evaluation and treatment of a Stage IV (full Physician for evaluation and treatment of thickness skin and tissue loss with exposed a Stage IV (full thickness skin and tissue muscle, tendon, ligament or bone)pressure loss with exposed muscle, tendon, wound on the left trochanter (bonev protrusion on ligament or bone) pressure wound on the the femur bone) that was present on admission. left trochanter (boney protrusion on the This occurred for 1 of 1 resident reviewed for femur bone) that was present on wound care (Resident #1). admission. This occurred for 1 of 1 resident reviewed for wound care Findings included. (Resident #1). Resident #1 was admitted to the facility on 3/8/25 Resident #1 was seen by the wound care with diagnoses including a Stage IV pressure physician on 4/3/25. No other residents wound to the left trochanter, protein calorie were identified at this time as needing to malnutrition, and anemia. be evaluated by the wound care physician. The wound care nurse was An admission note dated 3/8/25 at 3:01 PM educated on 4/3/25 by the Director of documented by Nurse #11 revealed in part; Nursing and Administrator on ensuring that the wound care physician is notified Resident #1 admitted to the facility from the hospital on 3/8/25 at 12:18 AM. Resident #1 was of any resident needing to be added to the non-verbal and required total care. Contractures next physician's assessment list. noted of all extremities. Wounds to the left hip All residents have the potential to be and sacrum were noted, with dressings clean, dry and intact. affected by this practice. A physicians order dated 3/8/25 for Resident #1 The Director of Nursing or Assistant revealed calcium alginate with silver every day Director of Nursing in collaboration with shift for wound care. Cleanse the area to the left the wound care nurse will review all new hip with normal saline, place alginate with silver to wounds and new admissions with wounds the wound bed then cover with foam border 5 times weekly to discuss if the resident dressing. needs to be assessed by the wound care physician. Any deficiencies found with the A progress note dated 3/10/25 documented by audits will be corrected immediately and the Nurse Practitioner revealed in part; Resident re-education done as necessary by the #1 with a stage four pressure ulcer. She is Director of Nursing. receiving nutrition via a gastrostomy tube (feeding tube) with continuous feedings. Pressure ulcer of The Director of Nursing will review and unspecified part of back, Stage II. Implement the discuss the audit result in the QAPI

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		MEDICAID SERVICES				<u> 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY PLETED
					с	
		345234	B. WING		04	/10/2025
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	e 3	F 580			
		including regular dressing		meeting monthly for the next thre	e months	
	changes and pressur	re relief measures. Consult		to determine if additional training		
	the wound care spec	ialist for advanced		required.		
	management.					
	A weekly wound eval	luation dated 3/14/25				
	completed by the Wo	ound Treatment Nurse for				
		Stage IV left trochanter				
		The wound measured 1.0 cm x 0.8 cm., with no				
	. ,	wound extends deep creating				
	a tunnel causing incr	eased risk of infection and				
	impedes wound heal	U ,				
	(separation of the wo	bund edges from the tissue creating a pocket				
		d healing). Moderate serous				
		drainage) was noted. The				
		nema (redness) noted, with				
		sue. Surrounding tissue with				
	-	eatment included collagen alginate with silver dry				
	-	igned and dated by the				
	wound treatment nur					
	Deview of Desident 4	411- al-atravia madiaal				
		*1's electronic medical rough 4/2/25 revealed no				
		he Wound Care Physician				
		age IV left hip wound.				
	An interview was can	nducted on 04/03/25 at 9:19				
		Care Physician. She stated				
		ent #1 today for the first time.				
	She stated Resident	#1 had a Stage IV to the left				
		n x 0.7 cm x 0.7 cm (depth),				
		6:00 o'clock measuring 2.5				
		100% granulation with inage. She stated she was				
		ent #1's stage IV hip wound				
	1	S 1	1	1		1

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/13/2025 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF PF	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	•	
HARBOR	IEW LUMBERTON			555 WILLIS AVENUE UMBERTON, NC 28358	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	facility so that she cou wound and that did no stage IV hip wound hat the last documented r An interview was con- with the Wound Treat was not in the facility and was working out I was only in the facility when she was not her responsible for the wo the Wound Care Physi	/ upon admission to the uld evaluate and treat the ot occur. She stated the ad decreased in size since	F 580				
F 684 SS=E	PM with the Director of Administrator. The DC aware that the Wound been notified upon ad stage IV pressure wor and DON stated the V should have been not stage IV wound. The education would be p Quality of Care CFR(s): 483.25 § 483.25 Quality of car Quality of care is a fur applies to all treatment facility residents. Base assessment of a reside that residents receive accordance with profe	ducted on 04/03/25 at 4:00 of Nursing (DON) along with DN stated she was not d Care Physician had not mission of Resident #1's und. Both the Administrator Vound Care Physician ified on admission of the Administrator stated rovided.	F 684				4/25/25

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COI	MPLETED
		345234	B. WING			C 4/10/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		4/10/2025
				1555 WILLIS AVENUE		
HARBOR	IEW LUMBERTON			LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	5	F 68			
1 004			FOC	04		
	care plan, and the res	is not met as evidenced				
	by:					
	-	iew, and staff, Registered		Based on record review,	and staff,	
		e Physician, and the Medical		Registered Dietician, Wo		
	Director's interviews t	the facility failed to 1a.)		Physician, and Medical D	Director's	
	implement treatment	orders on admission and		interviews, the facility fail	ed to:	
	• •	reatments as ordered for a				
		7) with a chronic venous		1a.) Implement treatment		
		er extremity. b.) obtain daily		admission and provide da	•	
		or Resident #17 who had a		treatments as ordered for		
		ve heart failure and on fluid		(Resident #17) with a chr wound on the left lower e		
	, .	ide treatments as ordered erial ulcers (Resident #24).		obtain daily weights as of	. ,	
		ghts as ordered for Resident		Resident #17 who had a		
	, .	l retention and an elevated		congestive heart failure a	-	
		tide (BNP) level (a blood		restrictions.		
		luid volume status that				
	when elevated is a st	rong indicator of heart or		2a.) Provide treatments a	as ordered for a	
	kidney failure or infec	tion) and required close		resident with arterial ulce	ers (Resident	
	monitoring and treatm			#24). b.)obtain weekly we	-	
		emove excess fluid. 3.)		for Resident #24 with ede		
		reatments to non pressure		retention and an elevated		
		dent #93). This occurred for		Peptide (BNP) level (a bl		
		were reviewed for wound itoring (Resident #17,		monitor fluid volume state		
	Resident #24, Reside			elevated is a strong indic kidney failure or infection		
		ла <i>т</i> эој.		close monitoring and trea		
	Findings included.			diuretic, a medication use		
				excess fluid.		
	1a.) Resident #17 wa	is admitted to the facility on				
	1/3/25 with diagnosis	including congestive heart		3. Provide daily wound tr		
		chronic venous wound		non-pressure related wou		
		od circulation problems that		#93). This occurred for 3		
	damage your veins) t	o the left lower extremity.		who were reviewed for w		
	A			weight monitoring (Resid	ents #17, #24,	
	u caro plan dated 1/2		1	1 77(1.2)		1
		3/25 revealed Resident #17 lated to a venous stasis		#93).		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ С 345234 B. WING 04/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1555 WILLIS AVENUE** HARBORVIEW LUMBERTON LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 6 F 684 included to evaluate the wound for size, depth, treatment orders 3/4/25. margins, exudate (discharge), edema, b.)Resident #17 daily weight order was granulation (pink-red moist tissue that fills an discontinued per MD order open wound, when it starts to heal), and infection. 3/25/25. 2 a.)Resident #24 received treatment Document the progress of wound healing on an ongoing basis. Notify the physician as indicated. orders 4/1/25. Observe for signs of infection and provide b.)Resident #24 weighed 4/3/25 with treatments as ordered. result provided to Registered Dietician and Nurse Practitioner with no new Review of Resident #17's admission skin orders. 3. Education initiated with licensed assessment dated 1/3/25 documented by Nurse #4 revealed venous statis ulcer to the front left nurses, CNA IIs, and CMAs that if the lower extremity. There was no assessment of the wound care nurse is unavailable, the wound to include wound size, depth, exudate, assigned nurse is ultimately responsible edema, or granulation. There was no wound for ensuring the completion of the wound treatment initiated on 1/3/25. care. During a phone interview on 4/10/25 at 2:15 PM All residents have the potential to be Nurse #4 stated she was the admission nurse on affected by this practice. 1/3/25 and completed an initial skin assessment on Resident #17. She stated a venous ulcer was 1a.)New, full-time treatment nurse has observed on the front left lower extremity, the been hired and begins 4/21/25. Extensive area was nickel size and looked like a blister that new hire education will take place for her had ruptured and dried. She stated there was no role. drainage and Resident #17 had no dressing on 1b.)Daily weight orders reduced per IDT the area when she was admitted. She stated review with MD and RD to enable better since the area appeared dry with no drainage and no dressing she did not initiate any type of wound compliance with orders. treatment. She indicated she did not recall seeing any other wounds on the left lower extremity. 2a.)New, full-time treatment nurse hired and to begin 4/21/25. Extensive new hire A physicians order for Resident #17 was initiated education will take place for her role. on 1/8/25 for calcium alginate with silver to the left lower leg daily for wound care. Cleanse the 2b.)Admission/Readmission weight area with normal saline, apply calcium alginate tracking tool revised to allow closer with silver, apply gauze pads, and wrap with monitoring of compliance with new kerlix. admission weights. The Minimum Data Set (MDS) admission 3.New, full-time treatment nurse hired

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 05/13/2025

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SURVEY	8-039 ⁄
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					С	
		345234	B. WING		04/10/202	5
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	PCODE	
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPL D THE APPROPRIATE DAT	ETIO
F 684	Continued From page	e 7	F 68	4		
	assessment dated 1/was cognitively intact	9/25 revealed Resident #17 She had a venous wound mity. She had no rejection of		and to begin 4/21/25. Ext education will take place		
	care.	vsician's initial evaluation		On 4/17/25 all nurses we the Staff Development Co Director of Nursing, and A	oordinator,	
	dated 1/9/25 revealed	d Resident #17 was wound of the left lower		if the wound care nurse is assigned nurse is ultimat for the completion of the	s unavailable, the ely responsible	
	measured 8.7 centim cm (depth). The surfa	eters (cm) x 6.5 cm x 0.4 ace area measured 56.55 ation tissue, and heavy		newly hired nurses will be this practice during their	e educated on	
	serosanguinous exuc a combination of sero	late (wound drainage that is ous fluid and blood). The be present on admission.		Starting the week of 4/28 or Nursing or Assistant D will conduct an audit of a admissions/readmissions	irector of Nursing Il new	
	completed by the Tre 1/10/25. The wound of	the same as the Wound		week to ensure weights a obtained weekly x 4 wee be conducted for 12 wee deficiencies found with th corrected immediately an	are being ks. This audit will ks. Any ne audits will be	
	Review of the Treatm	ent Administration Record 17 dated January 2025		done as necessary by the Nursing or Assistant Dire	e Director of	
	revealed calcium algi leg daily for wound ca 1/8/25. Cleanse the apply calcium alginat pads, and wrap with administration betwee	nate with silver to left lower are with a start date of area with normal saline, e with silver, apply gauze		The Director of Nursing v discuss the audit result d meeting monthly for 3 mo determine if additional tra necessary.	uring the QAPI onths to	
		ent order implemented to the om 1/3/25 through 1/8/25.				
	nurse was Nurse #4	s administered, the assigned s administered, the assigned				

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	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345234	B. WING			-		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
HARBOR	VIEW LUMBERTON				555 WILLIS AVENUE .UMBERTON, NC 28358	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	nurse was Nurse #5 1/14/25: not signed as nurse was Nurse #4 1/17/25: not signed as nurse was Nurse #2 1/24/25: not signed as nurse was Nurse #2 During an interview of Nurse #2 the assigned 1/24/25 stated she wa provide care for Reside not do daily wound ca Treatment Nurse was care. She reported she dressing change on R extremity at times and the days she did the w stated that if she did r she did not do the wo thought the wound nurse treatments. During a phone interv Nurse #4 stated if she then she did not comp stated the wound nurse treatments. During a phone interv Nurse #5 stated she w #17 on 1/11/25 but it v reported on weekends that completed wound	s administered, the assigned s administered, the assigned s administered, the assigned n 04/03/25 at 10:16 AM d nurse on 1/17/25, and as routinely assigned to dent #17. She stated she did are, and she thought the s responsible for wound he had completed the Resident #17's lower d signed off on the TAR on wound treatments. She hot sign off on the TAR then bund care because she urse had done the treatment. We won 4/10/25 at 2:15 PM e did not sign off on the TAR plete the treatment. She se was responsible for the triew on 4/10/25 at 3:05 PM was assigned to Resident was a Saturday. She s there was a treatment aide d care. we won 4/10/25 at 4:30 the hide stated she called out on ave been the nurses	F	584				

Facility ID: 953293

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING					C 10/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
HARBOR	VIEW LUMBERTON				555 WILLIS AVENUE LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	(TAR) for Resident #1 revealed Calcium algi leg daily for wound ca normal saline, apply of apply gauze pads, an Scheduled for admini- until 3:00 PM and was administered on the for 2/07/25: not signed as nurse was Nurse #2 2/14/25: not signed as nurse was Nurse #2 2/19/25: not signed as nurse was Nurse #2 2/21/25: not signed as nurse was Nurse #2 2/28/25: not signed as nurse was Nurse #2 2/28/25: not signed as nurse was Nurse #10 During an interview of Nurse #2 stated she w the February dates lis treatment nurse comp An attempt was made 4/10/25 at 4:50 PM, th Record review reveals hospitalized on 2/26/2 failure and unrelated to readmitted to the facil There was no treatment left lower extremity for	ent Administration Record 17 dated February 2025 inate with silver to left lower are. Cleanse the area with calcium alginate with silver, id wrap with kerlix. stration between 7:00 AM is not signed off as ollowing dates: is administered, the assigned is administered is administered in the isode the wound care. She lity on 2/28/25. The order implemented to the isode 2/28/25 through 3/7/25. The administration Record	F	684				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING _			_		C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	IEW LUMBERTON				555 WILLIS AVENUE	0		
					UMBERTON, NC 2835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	leg daily for wound ca 3/7/25. Cleanse the a apply calcium alginate pads, and wrap with k administration betweed and was not signed or following dates: 3/10/24: not signed as nurse was Nurse #2 3/11/25: not signed as nurse was Nurse #2 3/12/25: not signed as nurse was Nurse #2 3/12/25: not signed as nurse was Nurse #2 3/25/25: not signed as nurse was Nurse #2 3/27/25: not signed as nurse was Nurse #2 3/28/25: not signed as nurse was Nurse #2 3/28/25: not signed as nurse was Nurse #2 3/30/25: not signed as nurse was Nurse #2 3/31/25: not signed as nurse was Nurse #2 3/31/25: not signed as nurse was Nurse #2 3/31/25: not signed as nurse was Nurse #2 During an interview of Nurse #2 stated she w the March dates listed nurse completed the w	hate with silver to left lower ire with a start date of rea with normal saline, a with silver, apply gauze serlix. Scheduled for an 7:00 AM until 3:00 PM iff as administered on the a administered, the assigned a administered, the assigned	F	\$84		SEFICIENCY)		
	did not sign off on the the treatment. She sta	es. She indicated that if she TAR then she did not do ated the wound nurse also reatments. She stated if she						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING					C 10/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE	E, ZIP CODE		
HARBOR	/IEW LUMBERTON				555 WILLIS AVENUE LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	must have thought the treatment. Review of the Treatm (TAR) for Resident #1 calcium alginate with for wound care with a Cleanse the area with calcium alginate with and wrap with kerlix. S between 7:00 AM unt signed off as administ 4/02/25: not signed as nurse was Nurse #2 4/05/25: not signed as the weekend Treatme 4/06/25: not administe number 8 by Nurse #7 During an interview of Nurse #2 stated she w 4/02/25 but thought th completed the wound During a phone interv Nurse #7 stated the T responsible for wound not complete it. She s provide wound care of refused at that time. S attempt to try again af	ent at any time then she e wound nurse did the ent Administration Record 17 dated April 2025 revealed silver to left lower leg daily e start date of 3/7/25. In normal saline, apply silver, apply gauze pads, Scheduled for administration il 3:00 PM and was not tered on the following dates : is administered, the assigned is administered, the assigned to ent Aide ered, signed with chart code 7 in 04/03/25 at 10:16 AM was the assigned nurse on the treatment nurse is care. view on 04/10/25 at 4:20 PM freatment Aide was d care on 4/5/25 so she did stated she attempted to on 4/6/25 but Resident #17 She indicated she did not t a later time. view on 4/10/25 at 4:30 PM ent Aide stated she left early d not do the treatment. She been the nurses	F	684				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	: 12	F 684				
	dated 4/3/25 document chronic venous wound calf. The wound was a wound treatment usin wound had been press days and had failed to over 30 days despite Management has incl two-layer compressio and pressure off-load management of any s vascular disease. Cor regimen has been obs signs of infection or or Review of the progress 4/6/25 revealed no ac wound care was comp An interview was comp with Resident #17. Sh person, place, and sit received wound care stated she would not An interview was comp with the Wound Treat was not in the facility was working out her r only in the facility 2-3 she was not here the responsible for the wo was a second nurse w unless she had a resi treatment aide did wo She stated some days	served. The wound has no steomyelitis. as notes from 1/3/25 through Iditional documentation that pleted for Resident #17. ducted on 4/3/25 at 2:00 PM ne was alert and oriented to uation. She stated she but not every day. She refuse wound care. ducted on 4/3/25 at 1:30 PM ment Nurse. She stated she daily; she had resigned and notice. She stated she was days per week and when					

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						D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDIN	NG		
		345234	B. WING			C
	ROVIDER OR SUPPLIER	040204		STREET ADDRESS, CITY, STATE, Z		/10/2025
NAME OF F	ROVIDER OR SUFFLIER			1555 WILLIS AVENUE	IF CODE	
HARBOR	VIEW LUMBERTON			LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	e 13	F 6	584		
		onsible. She stated Resident				
		and the admission nurse				
		the initial skin assessment.				
		d Care Physician evaluated				
		25. The first documented				
	assessment with a we	-				
		ing admission in January				
		the wound nurse was on				
		ledged that treatment orders mity venous wound were not				
		hich was 5 days after				
		ated she was not working on				
		mission and could not say				
	why no treatment was	s started. She stated she				
		were doing the wound care.				
		ered the treatment on 1/8/25				
		17 admitted from another				
	nursing facility and th					
		e stated Resident #17 was				
	2/28/25 but stated sh	and returned to the facility				
		nplement the treatment				
		mitted because that would				
		sion nurse. She did not say				
		der was not started until				
	3/7/25 which was 7 d	ays after readmission to the				
	facility. She stated if	she had completed the				
	treatment it would be	signed off on the TAR.				
	During a phone inter	/iew on 4/10/25 at 3:00 PM				
		sician stated she was in the				
		irsdays. She stated she				
		om her previous facility and				
		care at the previous facility.				
	She stated she was a	ware of the transfer and last				
		other facility on 12/31/24 and				
		d measured 8.7 centimeters				
		m, and it was present on				
	admission on 1/3/25	She stated she had spoken	1			1

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 05/13/2025 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345234	B. WING				(04/	C 10/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STAT	FE, ZIP CODE		
	/IEW LUMBERTON			1	1555 WILLIS AVENUE			
HARDUR				L	UMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	with the Wound Treat her the treatment order treatment with calcium 1/3/25. She stated shi treatment order was r the daily treatments w consistently. She was treatment was not sta following hospitalizatio 2/28/25. She reporter getting smaller each w evaluated the wound okay, but it has looked progressed and was I 4.2 cm x 2.1 cm x 0.2 completing daily treat cause this wound to d worsened this week. An interview was comp PM with the Director of Administrator. The DO nurses were responsi here, otherwise the as responsible. She state nurse or the assigned completing an initial a wound description wit admission and docum medical record and en were implemented. She treatment nurse only w had hired a new treatu training. The DON state daily treatments were Administrator and DO	ment Nurse and had given ers prior to admission so the n alginate would start on e was not aware that the not started on 1/3/25 or that vere not being done a not aware that the rted back until 3/7/25 on and readmission on d the wound had been week until recently. She today and stated it looked d better, and it had arger this week measuring cm. She stated not ments as ordered would leteriorate and it had ducted on 04/03/25 at 4:00 of Nursing (DON) along with DN stated the treatment ble for wound care when ssigned nurse was ed either the treatment i nurse was responsible for ssessment that included a h measurements on nent the assessment in the nsuring treatment orders he stated the current worked part time, but they ment nurse who was in ted she was not aware the not getting done. Both the N stated wound care should daily as ordered. The	F	684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
HARBOR	/IEW LUMBERTON			555 WILLIS AVENUE .UMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 15	F 684				
	the Medical Director s multiple comorbidities managed by the Wou stated she expected t implemented and follo During an interview of Director of Nursing st there was a delay in s on admission 1/3/25 of She stated they were with wound care and nurse would be startin 1b.) A care plan dated #17 was at risk for im related to congestive Interventions included report any significant A physician's order da #17 to maintain 1500 shift: 720 milliliters fro from nursing for chror congestive heart failu A physicians order da was to obtain daily we heart failure. Review of the Medica (MAR) dated March 2 revealed the following	n 4/10/25 at 5:00 PM the ated she was not aware that starting the treatment orders or on readmission 2/28/25. working to resolve the issue indicated the new wound ng soon. d 1/10/25 revealed Resident paired cardiovascular status heart failure (CHF). d to monitor weights and changes. ated 2/26/25 for Resident milliliter fluid restrictions per om dietary, and 780 milliliters nic systolic and diastolic re. ted 3/1/25 for Resident #17 eights due to congestive					
		lbs. documented by Nurse					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345234	B. WING		_	(04/) 10/2025	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	8			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	3/09/25 weight 292 lb 3/15/25 weight 292 lb 3/16/25 weight 292 lb 3/17/25 weight 292 lb 3/22/25 weight 292 lb 3/23/25 weight 292 lb Further review of Res medical record reveal recorded that was not 3/6/2025 weight 295.0 Restorative Aide. The physicians order #17 to obtain daily we heart failure was disc Review of Resident # 3/1/25 through 3/25/2 weights recorded. During an interview o Registered Dietitian s obtaining weights was weight meeting the D gave her a copy of the then sent the orders of the Restorative Aide x member who was ass She indicated Reside weights due to conge the weight orders sho During an interview o Restorative Aide state	s. documented by Nurse #7 s. documented by Nurse #7 ident #17's electronic led the following weight t included on the MAR. 6 lbs. documented by the dated 3/1/25 for Resident eights due to congestive ontinued on 3/25/25. 17's progress notes from 5 revealed no other daily n 04/03/25 at 9:59 AM the tated the facility process for s that after the weekly irector of Nursing (DON) e current weight orders and but to the staff. She stated was the primary staff signed to obtain the weights. nt #17 was to receive daily stive heart failure and that	F 684					

Facility ID: 953293

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 05/13/2025 APPROVED	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345234	B. WING		_	(04/	C 10/2025	
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
HARBOR	/IEW LUMBERTON			555 WILLIS AVENUE .UMBERTON, NC 2835	8			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	the weekly meetings, to let her know what t which residents need She stated she was a aide on the floor some transport residents to which made it difficult unable to gets the we During a phone interv Nurse #7 stated that of Resident#17's weight Administration Record previous weight that se record. She stated that daily weights that she 3/01/25 through 3/23/ obtained any weights she was not sure how obtained Resident #1 Restorative Aide used mechanical lift to get to knew that was wrong obtained the weight a weights. During an interview of Nurse #2 stated she w Resident #17. She state was responsible for o indicated she had not Resident #17. An interview was cont PM with the Director of the Administrator. The Restorative Aide was	are plan meetings. During the DON will give her a list he weight orders were, and ed daily or weekly weights. Iso assigned as a nurse e days and assigned to appointments at times to do weights and she was ights done at times. iew on 04/03/25 at 1:19 PM when she recorded s on the Medication d MAR) she used the the found in the medical at she did not obtain the recorded on the MAR from 25. She stated she had not on Resident #17 because the Restorative Aide 7's weight and whether the the wheelchair or the the weight. She stated she and she should have and documented accurate the 04/03/25 at 2:00 PM vas routinely assigned to ated the Restorative Aide bataning the weights. She obtained weights on	F 684					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	list of residents that merights. She indicates was not available to gresident the assigned getting the weights. Sorders should be followed their process for obtains staff education. During a phone intervet the Physician stated Fe daily weights due to commonitor fluid retentions worsening heart failur extremity edema and stated the goal of care asymptomatic. She in change in condition refution the order of the daily weights which incluse expected the daily we according to the order of the daily we discharged the and readmitted on 3/3 knee amputation. The hospital discharge infection of the bone to underwent left above #24's discharge summof right foot chronic ost the order of the state that Resider infection of the bone to underwent left above #24's discharge summof right foot chronic ost the order of the state that Resider infection of the bone to underwent left above #24's discharge summof right foot chronic ost the order of the state the state of the state that Resider infection of the bone to underwent left above #24's discharge summof right foot chronic ost the state of the state that Resider infection of the state the state of the	eetings and she was given a eeded daily or weekly d that if the Restorative Aide get the daily weight for a nurse was responsible for he stated the physicians wed, and they would review ining weights and provide riew on 04/03/25 at 5:11 PM Resident #17 was ordered congestive heart failure to which was an indicator of re. She had bilateral lower received diuretics. She e was to keep her dicated there had been no eported to her and Resident ymptomatic. She stated she eights to be completed	F 684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 05/13/2025 RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	NO. 0938-0391 ATE SURVEY DMPLETED
		345234	B. WING			C 04/10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
HARBOR	/IEW LUMBERTON			555 WILLIS AVENUE UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	Resident #24's care p 3/3/25 care plan of re- impairment to the skir of the right foot with a ulcers caused by poor and heel with treatme the right foot. The go will maintain or develo Interventions indicated ordered. Physician orders date indicated: -Apply betadine to right distal foot (the outer etheel to the little toe) to wound care and wrap -Apply calcium alginate every day shift for word -Apply betadine to the gauze every day shift. Review of Resident # Minimum Data Set (M the resident had mild no episodes of rejection had 2 venous and arto of the foot, and had an ointments/medications application of dressing Resident #24's Treatm (TAR) revealed no do application of betading lateral distal foot, and the calcium alginate b	blan dated 3/3/25 included a sident had actual in integrity with osteomyelitis interial wounds (wounds or r circulation) to the right foot ent in between the toes on al indicated Resident #24 op intact skin by next review. d providing treatment as ed 3/7/25 for Resident #24 ht 2nd toe and right lateral edge of the foot from the opically every day shift for with gauze. te in between the right toes und care. e right heel and wrap with 24's significant change IDS) dated 3/9/25 indicated cognitive impairment with on of care. Resident #24 erial ulcers, had an infection pplication of s other than to the feet and g to the feet. ment Administration Record	F 684			

Facility ID: 953293

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING					C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZI	IP CODE		
	/IEW LUMBERTON			1	555 WILLIS AVENUE			
HANDON				L	UMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI		(X5) COMPLETION DATE
F 684	The facility's daily ass 3/11/25, 3/14/25, 3/25 revealed there was no An interview was cond 4/2/25 at 10:15 AM. It assigned to Resident familiar with her care. was assigned to Resi 3/11/25, 3/14/25, 3/27 stated there was a We supposed to complete however she had rece decreased her hours stated the floor nurses complete the ordered Nurse #5 stated it was residents' ordered me ordered wound care t indicated that wound electronic TAR that we	ignment sheet for 3/10/25, i/25, 3/27/25 and 3/31/25 o assigned treatment nurse. ducted with Nurse #5 on Nurse #5 stated she was #24 regularly and was Nurse #5 verified that she dent #24 on 3/10/25, i/25 and 3/31/25. Nurse #5 ound Care Nurse who was the wound care treatments e the wound care treatments e the worked. Nurse #5 is were often required to wound care treatments. is hard to administer the edications and complete the	F	684	DEFICIE	ENCY)		
	that she did not electr ordered wound care t did not complete the of A wound care observa Resident #24 with the 4/2/25 at 2:00 PM. Th #24's foot was comple wounds did not have the skin surrounding t redness. An interview was complex Nurse on 4/2/25 at 3:0 Nurse stated she had	a assigned to Resident #24 onically sign the TAR for the reatments indicated that she ordered care. ation was conducted for wound Care Nurse on he wound care to Resident eted as ordered and the any signs of infection and he wounds did not have any ducted with the Wound Care turned in her resignation part time until her last day.						

Facility ID: 953293

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		D HUMAN SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345234	B. WING					C 10/2025	
NAME OF PROVI	IDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZI	P CODE	-		
HARBORVIEV	V LUMBERTON			1	555 WILLIS AVENUE				
HARBORNET	Lowberton			L	UMBERTON, NC 28358				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BI		(X5) COMPLETION DATE	
Th nu ord an Th aw co an the An Nu 2:5 tha res to co sta sci nu tre inc co sta sci nu tre inc co sta sci nu tre tha co co sta sci nu tre tha co co sta sci nu tha co co sta sci nu tha co co sta sci nu tha co co sta sci nu tha co co sta sci nu tha co co sta sci nu tha co co sta sci nu tre co co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci nu tre co sta sci sci sci sci sci sci sci sci sci sci	Irses were responsited dered wound care were dered wound care were and there was not an a see Wound Care Nurse ware of any problems impleted on the days deside hit not review e ordered treatments in interview was concerned ursing (DON) and Act 50 PM. The DON and at the Wound Care I signation in January work a few days per- build be hired. The D ated that when a wo heduled, it was the fa- trese to complete the eatments. The DON dicated that they exp impleted as ordered of review the TARs a oblems with the com- tre treatments. In interview was concerned actitioner on 4/3/25 dicated that she exp impleted as ordered esident #24 was sev ultiple risk factors, a portant for wound cared. b.) Review of Reside	se indicated that the floor ole for completing the when she was not working assigned treatment nurse. Se stated she was not s with wound care not being s that she was not working, with TARs for completion of s. ducted with the Director of dministrator on 4/3/25 at and Administrator indicated Nurse had turned in her but had agreed to continue r week until a replacement OON and Administrator und care nurse was not responsibility of the floor ordered wound care and Administrator bected wound care to be . The DON stated she did and was not aware of any apletion of the daily wound ducted with the Nurse at 3:45 PM. The NP ected wound care to be . The NP stated that rerely debilitated with and this made it even more are to be completed as	F	684					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING			_		C 10/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
HARBORV	IEW LUMBERTON				555 WILLIS AVENUE UMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	22	F	684				
	Review of Resident # electronic health reco	24's weights listed in the rd revealed:						
	2/3/25 157 pounds (lb hospitalization and an 3/5/25 184.7 lb. recor Nursing (DON) 3/14/25 164.7 lb. reco 3/20/25 No weight wa 3/21/25 No weight wa 3/28/25 No weight wa	nputation) ded by the Director of orded by the DON is recorded is recorded						
	progress note dated 3 by the Assistant Direct the interdisciplinary te Resident #24 for weig Registered Dietitian p significant weight gain re-weight was conduct above knee amputation hospitalization with al time. The note indicate expected due to the a continues to receive to Tube feeding will be a Resident #24 will be a fluctuations. Review of Resident # Minimum Data Set (M 3/9/25 indicated resid weighed 185 lb. with the	eted. Resident #24 had an on during recent I over body swelling at this red weight loss was imputation. Resident ube feeding as ordered. adjusted as needed and						
		cian orders indicated an ndicated give furosemide, a						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345234	B. WING				(04/) 10/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP COD	Ε		
HARBOR	/IEW LUMBERTON				555 WILLIS AVENUE UMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 684	fluid used to treat con hypertension, heart fa causing edema 20 m via gastrostomy tube for elevated BNP leve a blood test that mease blood released when such as from heart or A 3/11/25 Nurse Prace indicated Resident #2 elevated BNP level of Resident #24's physic order dated 3/11/25 fo (mg) twice per day via days for edema (the construction welling with abnormative the body's tissues). To on 3/13/25. A 3/13/25 Nurse Prace indicated Resident #2 edema with weight gat of 12, 383. The plant to receive furosemide until 3/20/25. The not was to be monitored fi crackles in the lungs of provider if needed. Resident #24's physic order dated 3/13/25 for per day for 7 days for Review of Resident #2 on 3/17/25 indicated a	ation that removes excess ditions such as illure and fluid retention illigrams (mg) give 3 tablets STAT (as soon as possible) I (Brain Natriuretic Peptide, sures a hormone in the the heart is under stress kidney failure or infection) . titioner progress note 4 was evaluated due to an 15, 751. tian orders indicated an or furosemide 40 milligrams a gastrostomy tube for 5 condition characterized by a accumulation of fluid in the order was discontinued titioner progress note 4 was evaluated due to in and elevated BNP level indicated Resident #24 was 40 milligrams twice per day the indicated Resident #24 for respiratory distress, for wheezing and contact the chan orders indicated an or furosemide 40 mg. twice edema. 24's care plan last revised	F	584				

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	-					FORM	D: 05/13/2025
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345234	B. WING		_		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	58		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	The interventions incl ordered and monitorin A 3/20/25 Nurse Prace revealed Resident #2 The assessment and weights with the first of due to an elevated BN Review of Resident # electronic health reco weight was recorded. A Registered Dietitian note dated 3/21/25 at Resident # 24 was ref warning with a curren note indicated Reside an above knee amput edema. Resident's ef weight trending back indicated to continue Review of Resident # revealed an order dat policy. Review of Resident # electronic health reco 3/21/25 No weight wa 3/28/25 No weight wa An interview was con Administrator on 4/3/2 Administrator stated t obtained weekly for 4 or readmission. After	ipheral vascular disease. Juded obtain weights as ang for increased edema. Stitioner progress note 4 had decreased edema. plan indicated that daily one now were to be obtained NP. 24's weights listed in the ord revealed: 3/20/25 No A (RD) nutrition progress 11:55 AM indicated that viewed due to a weight at weight of 164.7 Lb. The ent #24 was readmitted after tation and had significant dema was improving with to baseline. The plan to monitor weights weekly. 24's physician orders ted 3/21/25 for weights per 24's weights listed in the ord revealed: as recorded as recorded ducted with the	F 684	4			

Facility ID: 953293

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	-					FORM	05/13/2025 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		345234	B. WING			04/ [,]	C 10/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			1	555 WILLIS AVENUE			
HARBOR	VIEW LUMBERTON			UMBERTON, NC 28358	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	physician. The Admin weights were to be ob documented in the ele An interview was con Dietitian (RD) on 4/3/3 stated that new admis were to be weighed a readmission date as p 4 weeks. The RD ind weights recorded twid 3/3/25 and she should for 4 weeks. The RD to have accurate weig and according to the recommendations. T weights were a clinical important for monitori The RD stated that R BNP and had change weights were necessa condition. The RD stated the provider requeste but the weights should the provider's recomm An interview was con Nursing Assistant (NA Restorative NA indical obtaining all resident stated she was assign floor at times and she residents at times, so the weights. Restora a backup system to e obtained as required. there was not a syste informed of admission	nistrator indicated that balaned as ordered and ectronic health record. ducted with the Registered 25 at 10:00 AM. The RD asions and readmissions is close to the admission or bossible and then weekly for licated Resident #24 had be since readmission on d have been weighed weekly indicated it was important ghts, to obtain weights timely provider's he RD indicated that al indicator and were ng the resident's condition. esident #24 had an elevated us to her diuretic order and ary for monitoring her ated she was not aware that d daily weights on 3/20/25 d have been obtained per	F 684				

Facility ID: 953293

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	: 05/13/2025 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE SURVE COMPLETED	
		345234	B. WING			(04/	; 10/2025
NAME OF P	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 283	58		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	looked on the hallway admission or readmis weight. Restorative N were to be weighed w as ordered. Restorat Resident #24 was rea obtained her readmiss did not recall who. Re someone, she did not obtain a reweigh on F gain. Restorative NA reweight on 3/5/25 an she obtained was a si she rechecked it. Re gave both the weights to the DON to record. recall what the 2 weight that she obtain stated she did not kno obtained Resident #2 3/21/25 or 3/28/25 bu because she was ass go out to appointment not able to obtain the stated the DON gave week and how often t An interview was com Nursing (DON) on 4/3 stated that she expect were obtained and rea four weeks after admi unless otherwise spec Nurse Practitioner.	Restorative NA stated she vs and if she saw a new sion, then she obtained the VA stated that all residents veekly for 4 weeks and then ive NA stated when admitted, someone else sion weight, although she estorative NA stated recall who, asked her to Resident #24 due to weight stated she obtained the vd observed that the weight ignificant weight gain, so storative NA stated she s that she obtained on 3/5/25 The Restorative NA did not whts were but recalled that same or close to the initial ned. The Restorative NA pow why she had not	F 68				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 05/13/2025 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345234	B. WING		_	04/ [,]	C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	IEW LUMBERTON			555 WILLIS AVENUE UMBERTON, NC 2835	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	stated that weekly we admission or readmiss The NP indicated that and required monitori indicator of resident's indicated the BNP wa resident's fluid volume weight and fluid a resistated she planned or monitoring but then do weekly weights. Weig monitoring. An interview was cond 4/3/25 at 5:05 PM. The facility's responsite weights for 4 weeks for readmission and then physician stated that monitoring the residen 3.) Resident #93 was diagnosis of sacral und peripheral vascular di Review of a care plan potential for pressure to impaired mobility, in treatment to the sacrum was revised on 4/1/25 change to the left med included administer tr observe for effectiven Review of a Wound C	ted that weights were nts as specified. The NP ights for 4 weeks following sion were to be obtained. Resident #24 had edema ng of weights as an health status. The NP s used to determine the e status and how much ident was retaining. The NP n ordering daily weights for ecided to continue with ghts should be obtained for ducted with the Physician on ne Physician stated it was bility to obtain weekly ollowing admission or as indicated. The weights were important for nt's health status. admitted on 3/17/25 with cer, diabetes, stroke and sease.	F 684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 05/13/2025 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345234	B. WING				_ 10/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 684	medial (the back and partial thickness wour centimeters (cm.) in le cm depth. a non-pressure wour partial thickness wour length, 3.0 cm width a a non-pressure wour outer area) thigh full t in length and 1.0 cm w A physician order date calcium alginate and lateral thigh once per A physician order date zinc paste to the left r posterior thigh once p Review of Resident # Data Set (MDS) dated was cognitively intact and application of oin other than to feet. Review of Resident # Administration Record wound care treatment dressing to right latera not signed as comple	d on the right posterior outer side of the leg) thigh nd measuring 4.5 ength, 8.0 cm width and 1 d to the left medial sacrum nd measuring 5.0 cm in and 0.1 cm depth d to the right lateral (the hickness measuring 0.7 cm width and 0.2 cm depth. ed 3/21/25 indicated to apply dry dressing to the right day. ed 3/21/25 indicated to apply medial sacrum and right per shift. 93's admission Minimum d 3/23/25 indicated resident , had no pressure ulcers, tments and medications 93's electronic Treatment d revealed the ordered t calcium alginate and dry al thigh once per day was ted on 3/27/25 , 3/28/25 and	F 684		ICIENCY)		
	paste to the sacrum a per shift was not sign evening shift, 3/22/25	I wound care treatment zinc and right posterior thigh once ed as completed on 3/22/25 night shift, 3/23/25 evening ift, 3/27/25 day shift, 3/28/25 shift.					

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	MENT OF HEALTH AN						FORM	: 05/13/2025 APPROVED . 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		SURVEY LETED
		345234	B. WING				C 04/1	; 10/2025
NAME OF P	PROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE			
HARBOR	VIEW LUMBERTON				1555 WILLIS AVENUE LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE		(X5) COMPLETION DATE
F 684	Continued From page	≥ 29	F	684	4			
	4/2/25 at 9:55 AM. Na supposed to be a woult reatments, but the cur resigned and was not schedule. Nurse #4 s not a wound care nurse expected to complete treatments. Nurse #4 complete the ordered her other scheduled ta she did not recall anyth having any wound car was not aware of her If the electronic Treatments was blank for the order stated she did not cor An interview was cond Specialist Physician of Wound Care Specialist initiated care with the regarding wounds on posterior thigh, and sa Specialist indicated the completed daily and the wound Care Specialist Resident #93's wound posterior thigh are large treatments were chan the wounds. The Wound Physician stated wound be completed daily as breakdown and worse	urrent treatment nurse t working her regular stated that when there was see the floor nurses were a the ordered wound care 4 stated it was hard to 1 wound care in addition to casks. Nurse #4 indicated thing about Resident #93 re treatments ordered and having any skin breakdown. ment Administration Record ered wound care, Nurse #4 mplete it. ducted with the Wound Care on 4/3/25 at 9:20 AM. The st Physician stated she resident on 3/20/25 the right lateral thigh, right acrum. The Wound Care nat the treatments should be that she expected that the e completed as ordered. The st Physician stated that ds to the sacrum and the rger today and the nged due to the worsening of ound Care Specialist nd care treatments need to s ordered to prevent further ening of the wounds. quire consistent care and						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	ECONSTRUCTION	COMPLETED
					с
		345234	B. WING		04/10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 684	Attempts were made phone with messages return call was receive to Resident #93 on th	e 30 to interview Nurse #6 via s left x 2 on 4/3/25. No ed. Nurse #6 was assigned e 3:00 PM to 11:00 PM shift 7:00 AM shifts on 3/22/25	F 684		
F 686 SS=D	Practitioner on 4/3/25 indicated that she exp would be completed a	bected that wound care as ordered. event/Heal Pressure Ulcer	F 686		4/25/25
	resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indivi- demonstrates that the (ii) A resident with pre- necessary treatment a with professional stan promote healing, prev- new ulcers from deve	re ulcers. hensive assessment of a bust ensure that- care, consistent with s of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent idards of practice, to vent infection and prevent			
	Based on observatio Wound Care Physicia Director's interviews t conduct an initial wou admission for a Stage tissue loss with expos ligament or bone) left	he facility failed to 1.) nd assessment on e IV (fullthickness skin and		 Based on observation, record review staff, wound care physician, and the medical director's interviews, the facili failed to 1.)Conduct an initial wound assessme on admission for a Stage IV (full thick skin and tissue loss with exposed must be addressed as a statement of the skin and tissue loss with exposed must be addressed as a statement of the skin and tissue loss with exposed must be addressed as a statement of the skin and tissue loss with exposed must be addressed as a statement of the skin and tissue loss with exposed must be addressed as a statement of the skin as a statement of the skin and tissue loss with exposed must be addressed as a statement of the skin and the skin as a skin and the skin a	ity ent ness

Event ID: WCHO11

Facility ID: 953293

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				5.001/07/01/07/01/		NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	OATE SURVEY OMPLETED
			A. BUILDING			
		345234	B. WING		С	
	ROVIDER OR SUPPLIER	545254		STREET ADDRESS, CITY, STATE, ZIP COL		04/10/2025
	ROVIDER OR SUFFLIER		1555 WILLIS AVENUE			
HARBOR	VIEW LUMBERTON			LUMBERTON, NC 28358		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLETIO DATE
F 686	Continued From pag	e 31	F 68	6		
		surements and perform daily		tendon, ligament or bone) lef	t trochanter	
	wound care treatmer			(bony protrusion on the femu		
		a resident (Resident #1)		wound to include the wound		
	admitted with a stage	e IV pressure wound and		with measurements and perfe	orm daily	
	-	ge II (partial thickness skin		wound care treatments accor	-	
		rmis) pressure wound on the		physicians orders for a reside		
		ick following admission. 2.)		#1)admitted with a stage IV p		
		care to a stage IV pressure		wound on the sacrum and low	wer back	
		 This occurred for 2 of 2 Resident #71) reviewed 		following admission.		
	for pressure wound of			2.)Provide daily wound care	to a stage IV	
				pressure wound (Resident #7		
				occurred for 2 of 2 residents		
	Findings included.			Resident #71) reviewed for p wound care.	•	
	1.) Resident #1 was	admitted to the facility on				
		s including a Stage IV		Wound assessments comple	ted on	
		ie left trochanter, protein		Resident #1 3/14/25.		
	calorie malnutrition, a			Education initiated with licens CNA IIs, and CMAs that if the	e wound care	
		ated 3/8/25 at 3:01 PM		nurse is unavailable, the assi	•	
		e #11 revealed in part;		is ultimately responsible for e		
		to the facility from the		completion of the wound care	ð.	
	· ·	12:18 AM. Resident #1 was red total care. Contractures		All residents with wounds have	ve the	
	-	es. Wounds to the left hip		potential to be affected by thi		
		ted, with dressings clean dry		potential to be alleoted by the	o practice.	
	and intact.	,		New, full-time treatment nurs	e hired and	
				to begin 4/21/25. Extensive n		
		ated 3/8/25 for Resident #1		education will take place for I		
		jinate with silver every day				
		Cleanse the area to the left		On 4/17/25 all nurses were in		
		e, place alginate with silver to		the Staff Development Coord		
		cover with foam bordered		Director of Nursing, and Adm when the the wound care nur		
	dressing.			unavailable, the assigned nu		
	A physicians order da	ated 3/8/25 for Resident #1		ultimately responsible for ens		
	revealed Calmosepti			completion of wound care. Al		
		pl-Zinc Oxide) Apply to		nurses will be educated on th		

Facility ID: 953293

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			0.00			0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPL			
				с				
		345234	B. WING		04/1	04/10/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE			
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	(X5) COMPLETION DATE		
F 686	Continued From page	e 32	F 68	36				
	sacrum topically ever protection.	y day and evening for		their orientation.				
	record from 3/8/25 th documentation of a w stage IV left hip or sa description and meas Attempts were made 4:50 PM to contact N nurse on 3/8/25, there A progress note date the Nurse Practitione #1 with a stage four p receiving nutrition via tube) with continuous unspecified part of ba	on 4/03/25 at 4:00 PM and urse #11 the admission		Starting the week of 4/2 of Nursing or Assistant will conduct an audit of admissions/readmission week for 12 weeks to en wound assessment is o admission/readmission wound description with The Director of Nursing Director of Nursing will audit of all TARs 5 times weeks to ensure that we being followed. Any def with the audits will be co immediately and re-edu necessary by the Direct	Director of Nursing all new ns 5 times per nsure that an initial btained on to include the measurements. or Assistant also conduct an s per week for 12 ound orders are iciencies found orrected totation done as tor of Nursing.			
	-	e relief measures. Consult		discuss the audit finding QAPI meeting for 3 mor any changes need to be	gs in the monthly nths to determine if			
	was severely cognitiv	14/25 revealed Resident #1 vely impaired. Her weight the stage IV wound was						
	had the potential for p related to impaired m She was admitted wit to the left hip and mo to the lower back. Ob any changes in skin s	4/25 revealed Resident #1 pressure ulcer development poblity, and incontinence. th a Stage IV pressure ulcer isture associated dermatitis pserve, document, and report status: appearance, color, of infection, wound size,						

Facility ID: 953293

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 APPROVED 0: 0938-0391	
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345234	B. WING			(04/	C 10/2025	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
HARBORV	VIEW LUMBERTON			555 WILLIS AVENUE .UMBERTON, NC 2835	i8			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	33	F 686					
	revealed the following	n on 3/8/25 through 4/2/25 g weekly wound evaluations:						
	Resident #1 revealed identified on 3/8/25. M (cm) x 0.6 cm x 0.8 cm	uation dated 3/14/25 for Stage IV left trochanter Aeasuring 1.0 centimeters m. No tunneling (when the						
	increased risk of infect	creating a tunnel causing ction and impedes wound ng (separation of the wound						
	creating a pocket white Moderate serous exust	ch impedes wound healing). date (thin watery drainage). nema. 100% granulation						
	tissue. Surrounding tis treatment collagen po with silver dry dressin	ssue with erythema. Current wder and calcium alginate g. This was signed and						
	A weekly wound evalu	Treatment Nurse on 3/14/25.						
	the lower back measu cm. The wound was is	moisture related wound to uring 3.0 cm x 1.0 cm x 0.1 dentified 3/8/25. Moderate						
	drainage) . Tender to tissue. Surrounding tis							
	and zinc paste. Treati	eatment collagen powder ment ordered 3/14/25. This d by the wound treatment						
	Resident #1 revealed identified on 3/8/25. M (cm) x 1 cm x 0.8 cm.	uation dated 3/21/25 for Stage IV left trochanter Aeasuring 2.0 centimeters No tunneling or te serous exudate. Wound						
		edness). 100% granulation						

Facility ID: 953293

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		D HUMAN SERVICES				FORM): 05/13/2025 APPROVED 0. 0938-0391
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVE COMPLETED	
		345234	B. WING		_	(04/	C 10/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	/IEW LUMBERTON			555 WILLIS AVENUE UMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	tissue. Surrounding ti- treatment collagen po- with silver dry dressin dated by the wound tr A weekly wound evalue Resident #1 revealed the lower back measu cm. The wound was is serosanguineous exu 20 % granulation tissue erythema. Current tre zinc paste. Treatment signed and dated by to on 3/21/25. A weekly wound evalue of 3/25/25 for Resider trochanter identified of centimeters (cm) x 1.2 or undermining. Mode Wound bed with eryth tissue. Surrounding ti- treatment collagen po- with silver dry dressin dated by the wound tr and entered into the e 4/2/25. A weekly wound evalue of 3/25/25 for Resider moisture-related woun measuring 3.5 cm x 3 was identified 3/8/25. exudate. Tender to to tissue. Surrounding ti- treatment collagen po- Treatment ordered 3/	ssue with erythema. Current wder and calcium alginate g. This was signed and reatment nurse on 3/21/25. Juation dated 3/21/25 for moisture-related wound to uring 3.5 cm x 3.5 cm x 0.1 dentified 3/8/25. Moderate date. Tender to touch with ue. Surrounding tissue with atment collagen powder and to ordered 3/14/25. This was the wound treatment nurse uation with an effective date th #1 revealed Stage IV left on 3/8/25. Measuring 2.0 2 cm x 0.7 cm. No tunneling erate serous exudate. hema. 100% granulation ssue with erythema. Current wder and calcium alginate g. This was signed and reatment nurse on 4/2/25 electronic medical record on uation with an effective date th #1 revealed nd to the lower back .4 cm x 0.1 cm. The wound Moderate serosanguineous uch with 20 % granulation ssue with erythema. Current	F 686				

Facility ID: 953293

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/13/2025 APPROVED D: 0938-0391
STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		SURVEY PLETED
		345234	B. WING				
NAME OF PROVIDER	R OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARBORVIEW LU	UMBERTON				555 WILLIS AVENUE UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
and e 4/2/25 A wou 3:37 F #12 rd to the order woun Woun Periw Dress pink v intact woun serou o'cloc well. I was r hip m media 0.1 cr A care actua press press incluc obser Revie (TAR) revea shift f hip w woun	5. und evaluation p PM for Resident evealed the wou e sacrum. Medi h red daily. The dre id bed was pink v red daily. The dre id bed was pink v vound (skin surro sing changed to l with scant serous t. Dressing was c id bed was pink v is drainage. Und ck and 9 o'clock a No signs of pain repositioned usin heasured 0.9 cm al lower back me m. re plan dated 4/1, al pressure ulcer sure ulcer of the l sure ulcer of the l sure ulcer of the l sure ulcer of the sided to administer rve for effectiven ew of the Treatme) for Resident #1 aled: Calcium alg for wound care. C rith normal saline ad bed then cove sing with a start of	electronic medical record on rogress note dated 4/1/25 at #1 documented by Nurse and treatment was changed honey and foam dressing essing was applied. The with scant serous drainage. with dry, peeling skin. bunding the wound) intact. lower back with wound bed is drainage. Periwound was changed to the Left hip. The with a small amount of dermining was noted at 12 areas. Resident #1 tolerated or discomfort. Resident #1 ag pillows. The stage IV left x 0.6 cm x 1.2 cm. The easured 0.8 cm x 0.9 cm x /25 for Resident #1 revealed development. Stage II lower back, and stage II sacrum. Interventions r treatments as ordered and	F	686			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED	
		345234	B. WING			C 04/10/2025		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
	//=!				1555 WILLIS AVENUE			
HARBOR	IEW LUMBERTON				LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 686	on the following dates	5:	F	686	6			
	nurse was Nurse #2. 3/14/25: not signed as nurse was Nurse #2 3/27/25: not signed as	s completed, the assigned s completed, the assigned s completed, the assigned						
	nurse was Nurse #2	s completed, the assigned s completed, the assigned						
	(TAR) for Resident #1 revealed: Calmosepti 0.44-20.6 % (Menthol sacrum topically ever Protection with a start scheduled to be comp	ne External Ointment I-Zinc Oxide) Apply to y day and evening shift for t date of 3/8/25 and Deted between 7:00 AM Dund care was not signed off						
	nurse was Nurse #2. 3/14/25: not signed as nurse was Nurse #2 3/27/25: not signed as nurse was Nurse #2 3/28/25: not signed as nurse was Nurse #2	s completed, the assigned s completed, the assigned s completed, the assigned s completed, the assigned s completed, the assigned						
	(TAR) for Resident #1 revealed: Collagen po dressing to open area	ent Administration Record dated March 2025 owder, zinc paste, and dry a located on lower back und care. Cleanse area with						

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PRINTED: 05/13/2025

		D HUMAN SERVICES					FORM): 05/13/2025 MAPPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345234	B. WING _			_		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	IEW LUMBERTON			15	555 WILLIS AVENUE			
HARBORY				Ll	UMBERTON, NC 28358	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 686	and dry dressing start scheduled to be comp until 3:00 PM. The wo as completed on the f 3/27/25: not signed as nurse was Nurse #2 3/28/25: not signed as nurse was Nurse #2 3/31/25: not signed as nurse was Nurse #2 Review of the Treatm (TAR) for Resident #1 wound care to the sta and stage II lower bac ordered. During an interview of Nurse #2 stated she w provide care for Resident # She reported she had change on Resident # off on the TAR on the treatments. She state on the TAR then she of because she thought	collagen powder, zinc paste, c date 3/15/24 and bleted between 7:00 AM bound care was not signed off following dates: a completed, the assigned a completed, the assigned bleted April 2025 revealed: ge IV hip, stage II sacrum, ck were completed as a n 04/02/25 at 3:33 PM vas routinely assigned to dent #1. She stated she did are, and she thought the responsible for wound care. I completed the dressing at once or twice and signed days she did the wound d that if she did not sign off did not do the wound care the wound nurse had done	F6	86	D	EFICIENCY)		
	Resident #1 had a sta she knew she had the area on her lower bac aware it was a stage An interview was cond AM with Nurse #12. S	ated she was not aware age II on her sacrum, but a Stage IV on her hip and an sk but reported she was not II. ducted on 04/02/25 at 10:04 she stated she typically did y but was brought in this						

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING			_		C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				1	555 WILLIS AVENUE			
HARBOR	IEW LUMBERTON			L	UMBERTON, NC 28358	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	week to assist with we Resident #1 had a Sta small but deep. She s wound care the previo clean, with no slough, iodoform packing strip lower back wound wa wound. The treatment powder with dry dress also had a stage II pre- that developed since ordered on 4/1/25 to t with foam dressing ar the wounds on her low started as excoriation admission but now ha pressure wounds. A wound observation at 10:04 AM with Nurs were stage IV left hip, II lower back. The sta area, with no exudate noted. The wound wa packing strips. Medi h sacrum and collagen applied to lower back concerns with the wound During a phone interv Nurse #13 stated she at times. She stated s weekends. She stated s weekends. She stated s would have signed it o she had a resident as	bund care. She stated age IV hip wound that was tated she completed the bus day and the area was The order was to pack with bs daily. She reported the s now a stage II pressure t ordered was collagen sing. She stated Resident #1 essure wound to the sacrum admission. The treatment he sacrum was Medi honey ad change daily. She stated wer back and sacrum (raw irritated skin) on ad developed into stage II was conducted on 04/02/25 se #12. The areas observed stage II sacrum and stage ge IV wound was a small , no odor, with undermining s packed with iodoform oney applied to stage II powder with dry dressing wound. There were no und care observation. iew on 04/02/25 at 3:08 PM did assist with wound care	F	686				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_	04/ [,]	C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HARBOR	/IEW LUMBERTON			555 WILLIS AVENUE .UMBERTON, NC 2835	58		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page treatments.	: 39	F 686				
	PM Nurse #7 stated s on Saturday 3/8/25 fr She stated she did sk not complete wound a description of the wou stated the wound treat	und or measurements. She					
	with the Wound Treat was not in the facility was working out her r only in the facility 2-3 she was not here the responsible for the wo was a second nurse w unless she had a resi treatment aide would weekends. She stated facility for charting an the assigned nurse w stated she did an initia #1's wounds to the left measurements and a on 3/14/25. When as assessment with meas completed until 3/14/2 she did not give an ar did not enter the would with measurements u left early that day and measurements. She s an area of excoriation calmoseptine until this	bund care. She stated there who did wound care at times dent assignment, and a complete wound care some d at times she may be in the d not doing wound care and ould be responsible. She al assessment of Resident ft hip and lower back with description of wound status ked why the initial asurements was not 25, 6 days after admission, nswer. When asked why she and evaluation on 3/25/25 ntil 4/2/25 she stated she in never entered the stated the sacrum was only					

Facility ID: 953293

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/13/2025 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		345234	B. WING			(04/	; 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
HARBOR	/IEW LUMBERTON			555 WILLIS AVENUE			
	I		<u> </u>	UMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page to the sacrum was ch	e 40 anged to Medi honey. She	F 686				
	stated if she had com	pleted any of the wound have signed it off on the					
	AM Medication Aide # weekends and was or wound treatments. Sh Resident#1's wound t admission. She recall to her left hip and stat had a wound on her le did not do wound ass and that was the resp treatment nurse. An interview was con-	tiew on 04/03/25 at 11:50 t1 stated she only worked hly assigned to complete he stated she recalled doing reatment on the day of ed applying calcium alginate ted she thought she also ower back. She stated she essments or measurements ionsibility of the wound ducted on 04/03/25 at 9:19					
	she evaluated Resider She stated Resident # hip measuring 0.7 cm undermining at 6:00 c	care Physician. She stated ent #1 today for the first time. #1 had a Stage IV to the left x 0.7 cm x 0.7 cm., with o'clock measuring 2.5 cm.					
	The wound had 100% serous drainage. She treatment to the stage continue iodoform par the second area was lower back measuring with light serous drain collagen powder appl third area was a Stag sacrum measuring 3.1 light serous drainage. was started 2 days ag it then reevaluate nex not notified of Reside until today. She stated	granulation with moderate					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING			04/	C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	04/	10/2020
				1555 WILLIS AVENUE			
HARBOR	IEW LUMBERTON			LUMBERTON, NC 2835	58		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	facility so that she cou wound and that did no stage IV hip wound hat the last documented r An interview was come PM with the Director of Administrator. The DO nurses were responsi- they were here, other was responsible. She nurse or the assigned completing an initial a wound description with admission and docum medical record. She se nurse only worked pa new treatment nurse DON stated she was treatments were not g not aware that the Wo been notified upon ad stage IV wound. Both stated wound care sh daily as ordered, an in measurements compl medical record and the notified of the wound. education would be p During a phone intervi the Medical Director se admitted with a stage left hip and multiple of required a high level of feedings and had bee Resident #1 was at hid development and the	Id evaluate and treat the bet occur. She stated the ad decreased in size since measurements. ducted on 04/03/25 at 4:00 of Nursing (DON) along with DN stated the treatment ble for wound care when wise the assigned nurse stated either the treatment in urse was responsible for assessment that included a h measurements on bent the assessment in the stated the current treatment rt time, but they had hired a who was in training. The not aware the daily jetting done, and she was bund Care Physician had not mission of Resident #1's the Administrator and DON ould have been completed hitial evaluation with eted and documented in the ted and to the ted and the ted and the ted and term is the ted and term is the ted and term is the term is th	F 68	16			

Facility ID: 953293

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 05/13/2025 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING			_	(04/	C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	/IEW LUMBERTON				555 WILLIS AVENUE UMBERTON, NC 2835	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	wounds that develope back were unavoidab expect that wound ca 2.) Resident #71 was diagnoses which inclu diabetic neuropathy. Resident #71's care p problem dated 12/13/. impairment to skin int Stage 4 (full-thickness sacrum and an unstag (dead skin tissue due blood supply) to the ri potential for further pr related to impaired mo malnutrition and histo goal indicated that the skin by the next review included administer tr observe effectiveness Resident #71's quarter (MDS) dated 12/27/24 severe cognitive impa pressure ulcer which admission, entry or re and pressure reducing coded. Physician's orders dat indicated: - apply calcium algina dressing once per day - apply skin prep (a tree	ed on the sacrum and lower le. She stated she did re orders were followed. admitted on 1/27/23 with ided dementia, diabetes and lan included a care plan 24 which indicated actual egrity with pressure ulcer is skin and tissue loss) to the geable ulcer due to necrosis to injury, infection or lack of ght second toe with essure ulcer development obility, incontinence, ry of pressure ulcers. The e resident would have intact w date. Interventions eatments as ordered and a. erly Minimum Data Set 4 indicated the resident had irrment and one Stage 4 was present upon entry. Pressure ulcer care g device for the bed were ted 3/7/25 for Resident #71 te to the sacrum and a dry y for wound care eatment used to provide a ver the skin) to the right	F	686				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/13/2025 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345234	B. WING					C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE	, ZIP CODE		
HARBOR	VIEW LUMBERTON				1555 WILLIS AVENUE LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 686	Resident #71's Marcl Administration Record documentation of the alginate to the sacrum application of skin pre 3/10/25 and 3/11/25. The facility's daily ass and 3/11/25 revealed treatment nurse and N assigned to Resident to oversee Medication The Wound Care Spe documentation dated following measureme pressure ulcers: - Stage 4 pressure ulc (cm), width 4.1 cm, ar - Unstageable deep ti second toe: length 0.3 Resident #71's Marcl documentation of the alginate to the sacrum application of skin pre 3/14/25. The facility's daily ass revealed there was no and that Medication A	h 2025 Treatment d (TAR) revealed no application of calcium n and a dry dressing or the ep to the right second toe on signment sheet for 3/10/25 there was no assigned Medication Aide #1 was #71 with Nurse #4 assigned n Aide #1. ecialist Physician 3/13/25 indicated the ents of Resident #71's cer: length 4.8 centimeters nd depth 1.1 cm issue injury to the right 3 cm, width 0.3 cm h 2025 TAR revealed no application of calcium n and a dry dressing or the ep to the right second toe on signment sheet for 3/14/25 o assigned treatment nurse, Nide #1 was assigned to urse #4 assigned to oversee ecialist Physician 3/20/25 indicated the	F	686				

Facility ID: 953293

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/13/2025 M APPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345234	B. WING			C / 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARBOR	/IEW LUMBERTON		1	555 WILLIS AVENUE		
			L	UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 686	Continued From page - Stage 4 pressure uld cm, and depth 1.1 cm - Unstageable deep ti second toe: length 0.3 The Wound Care Spe documentation dated following measureme pressure ulcers: - Stage 4 pressure uld cm, and depth 1.0 cm - Unstageable deep ti second toe: length 0.3 Resident #71's March documentation of the alginate to the sacrun application of skin pre 3/25/25, 3/27/25, and The facility's daily ass 3/27/25, and 3/31/25 assigned treatment m Aide #1 was assigned #4 assigned to overse An interview was com 4/2/25 at 9:55 AM. N Monday through Frida PM shift and was ass the 700 hall and was medication aide on 50 #71 resided on. Nurs	e 44 cer: length 5.1 cm, width 4.0 issue injury to the right 5 cm, width 0.5 cm ecialist Physician 3/25/25 indicated the ents of Resident #71's cer: length 5.0 cm, width 3.1 issue injury to the right 3 cm, width 0.3 cm a 2025 TAR revealed no application of calcium in and a dry dressing or the ep to the right second toe on 3/31/25. signment sheet for 3/25/25, revealed there was no urse, and that Medication d to Resident #71 with Nurse ee the Medication Aide. ducted with Nurse #4 on urse #4 stated she worked ay on the 7:00 AM to 3:00 igned to the 800 hall, part of assigned to oversee the 00 hall, the hall that Resident se #4 stated she was aware f the Wound Care Nurse or	F 686			
	care for her assigned the Wound Care Nurs	letion of the ordered wound residents. Nurse #4 stated se frequently was not is no assigned treatment				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	05/13/2025 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345234	B. WING		_	(04/ [,]	C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	58		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Medication Aide comp care for her assigned Care Nurse was not w assigned treatment nu did not complete the w Resident #71 when sl the Medication Aide o 3/25/25, 3/27/25, and An interview with Medic conducted with on 4/3 Medication Aide #1 in Monday through Frida PM shift and was assis Medication Aide #1 st Care Nurse was not w an assigned treatment overseeing her was re- the ordered wound care. She assumed that Nu ordered wound care. She assumed that Nu ordered wound care of Care Nurse was not w An interview was comp Nurse on 4/2/25 at 3:0 Nurse stated she had and was only working The Wound Care Nur- nurses were responsi- ordered wound care w and there was not an The Wound Care Nur-	ed she did not know if the bleted the ordered wound residents when the Wound vorking and there was no urse. Nurse #4 stated she wound care treatments for he was assigned to oversee in 3/10/25, 3/11/25, 3/14/25, 3/31/25. dication Aide #1 was 8/25 at 12:30 PM. dicated that she worked ay on the 7:00 AM to 3:00 igned to Resident #71. ated that when the Wound vorking and there was not it nurse, the nurse that was esponsible for completion of are treatments. Medication urse #4 had not notified her bleted Resident #71's Medication Aide #1 stated rse #4 completed the on the days that the Wound vorking. ducted with the Wound Care 100 PM. The Wound Care	F 680				

Facility ID: 953293

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF PR	ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBORV	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 46	F 686				
	Specialist Physician of Wound Care Specialis been seeing Resident pressure ulcer to the Specialist Physician s extensive wound to the the muscle. The Wou indicated Resident #7 had the potential for m breakdown of the skin exposure to moisture) and worsening of the Specialist indicated the completed daily and t wound care would be Wound Care Specialis Resident #71's wound completed daily as or wound care treatment #71's sacrum and toe worsening of the wou were currently stable. consistent care and m worsening and further An interview was com Nursing (DON) and A 2:50 PM. The DON a that the Wound Care resignation in January to work a few days per	1's wounds were stable but naceration (a softening and n tissue due to prolonged), further skin breakdown wound. The Wound Care hat the treatments should be hat she expected that the completed as ordered. The st Physician stated that d treatments were to be dered. Not completing the ts as ordered to Resident had the potential to cause nds, however the wounds Wound treatments required nonitoring to prevent					
	scheduled, it was the nurse to complete the treatments. The DOM	ound care nurse was not responsibility of the floor ordered wound care I and Administrator stated on Aide was assigned to a					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/13/2025 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345234	B. WING _				C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARBOR	/IEW LUMBERTON				555 WILLIS AVENUE UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 F 692 SS=D	resident with an order was the responsibility Medication Aide to co The DON and Admini- expected wound care ordered. The DON sta TARs and was not aw the completion of the treatments. An interview was comp Practitioner on 4/3/25 indicated that she exp completed as ordered Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric both percutaneous endosc enteral fluids). Based comprehensive assess ensure that a resident §483.25(g)(1) Maintai of nutritional status, s desirable body weight balance, unless the re- demonstrates that this preferences indicate of §483.25(g)(2) Is offeren- maintain proper hydra §483.25(g)(3) Is offeren-	red wound care treatment it of the nurse overseeing the mplete the wound care. strator indicated that they to be completed as ated she did not review the vare of any problems with daily wound care ducted with the Nurse at 3:45 PM. The NP bected wound care to be l. atus Maintenance (3) nutrition and hydration. c and gastrostomy tubes, idoscopic gastrostomy and opic jejunostomy, and l on a resident's esment, the facility must te- ns acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when roblem and the health care		592			4/24/25

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(PRINTED: 05/13/2025 FORM APPROVED DMB NO. 0938-0391 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G		COMPLETED
		345234	B. WING		-	04/10/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIAT DEFICIENCY)	DATE
F 692	Continued From page This REQUIREMENT by:	e 48 is not met as evidenced	F 6	92		
	Based on observation and the Physician's in obtain weekly weights (Resident #1) who wa	ns, record review, and staff nterviews, the facility failed to s as ordered for a resident as a new admission and lings (tube feeding). This sidents reviewed for		and staff and the Pl the facility failed to as ordered for a res who was a new adr enteral feedings (tu	tions, record review, hysician's interviews obtain weekly weigh sident (Resident #1) nission and receiving be feeding). This residents reviewed fo	ts g
	with diagnoses includ	itted to the facility on 3/8/25 ing Stage IV pressure protein calorie malnutrition,				ts
	was severely cognitiv rejection of care. The care plan dated 3 #1 received enteral to	14/25 revealed Resident #1 ely impaired. She had no 8/18/25 revealed Resident ibe feedings and was at risk		ensure that weights ordered or at least v	ssion weight I which was revised t s are being obtained weekly x 4 weeks.	-
	observe, document, a symptoms of dehydra	ventions included in part to and report signs or tion or sudden weight loss. 25 for Resident #1 revealed		Nursing in collabora restorative aide will times weekly to ens obtained as ordered	or Assistant Director ation with the monitor weights 5	٢4
	Review of Resident # record revealed the for 3/08/25 no admission 3/13/25 the weight wa	ollowing: weight was recorded as 89.0 pounds (lbs.)		education/corrective Director of Nursing	ed immediately and e action done by the as appropriate.	
	3/21/25 there was no 3/28/25 the weight wa	-		Director of Nursing	vill be reported by the during the monthly months to determine	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION		(X3) DATE COMP	LETED
		345234	B. WING		_	(04/	_ 10/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	58		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Registered Dietitian s to weigh new admissi monthly if there were facility process in obta the weekly weight me (DON) gave her a cop orders and then sent She stated the Restor staff member who wa weights. She indicate receive weekly weigh admission and receive indicated it was impor weights to determine ensure she was recei stated the weekly weigh obtained. During an interview of Restorative Aide state for obtaining all reside attended the weekly of the weekly meetings, to let her know what t which residents need She stated new admis weekly weights and if observed on the hall t and not on her list she She stated she was a aide on the floor some transport residents to which made it difficult unable to get the weig stated she would weig	n 04/03/25 at 9:59 AM the tated the facility policy was ons weekly for 4 weeks then no concerns. She stated the aining weights was that after beting the Director of Nursing by of the current weight the orders out to the staff. rative Aide was the primary s assigned to obtain the d Resident #1 was to ts due to being a new ing tube feedings. She trant to obtain weekly her nutritional status to ving adequate intake. She ghts should have been n 04/03/25 at 10:35 AM the ed that she was responsible ent weights. She stated she care plan meetings. During the DON will give her a list he weight orders were, and ed daily or weekly weights. ssions were to receive there was a resident that was new to the facility e would obtain the weight. Iso assigned as a nurse e days and assigned to appointments at times to do weights and she was ghts done at times. She gh Resident #1 today.	F 65	22 changes need to b	be made.		
	the Restorative Aide s						

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	-					FORM	D: 05/13/2025 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358	8		
			ID	-	PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 692	Continued From page	• 50	F 692	2			
	AN OF CORRECTION IDENTIFICATION NUMB 345234 OF PROVIDER OR SUPPLIER BORVIEW LUMBERTON DID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT 692 Continued From page 50 Resident #1's weight today and it was 89 pc During an interview on 04/03/25 at 2:00 PM Nurse #2 stated she was routinely assigned Resident #1. She stated the Restorative Aid responsible for obtaining the weights. She indicated she had not obtained weights on Resident #1. An interview was conducted on 04/03/25 at PM with the Director of Nursing (DON) along the Administrator. The DON stated the facili policy included to obtain weekly weights for new admissions and the Restorative Aide we responsible for obtaining weights. She state Restorative Aide attended the weekly weigh meetings and she was given a list of resider that needed daily or weekly weights. She indicated that if the Restorative Aide was no available to get the weight for a resident the assigned nurse was responsible for making the weight should have been obtained on day o admission then weekly. She stated they wou review their process for obtaining weights an provide staff education. During a phone interview on 04/03/25 at 5:1 the Physician indicated Resident #1 require weekly weights as a new admission receivir tube feedings. She stated weekly weights sh have been obtained. Tog Regimen Review, Report Irregular, Ac			-			
	Nurse #2 stated she w Resident #1. She stat responsible for obtain indicated she had not	was routinely assigned to ed the Restorative Aide was ing the weights. She					
	PM with the Director of the Administrator. The policy included to obtain new admissions and to responsible for obtain Restorative Aide atter meetings and she way that needed daily or wiindicated that if the Re available to get the way assigned nurse was re the weights were don weight should have be admission then week review their process for	of Nursing (DON) along with a DON stated the facility ain weekly weights for all the Restorative Aide was ing weights. She stated the nded the weekly weight s given a list of residents weekly weights. She estorative Aide was not eight for a resident the esponsible for making sure e. She indicated that a een obtained on day of y. She stated they would or obtaining weights and					
F 756 SS=D	the Physician indicate weekly weights as a r tube feedings. She sta have been obtained. Drug Regimen Review CFR(s): 483.45(c)(1)(§483.45(c) Drug Regi §483.45(c)(1) The dru	ed Resident #1 required new admission receiving ated weekly weights should w, Report Irregular, Act On (2)(4)(5) men Review. ug regimen of each resident	F 75				4/23/25

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 05/13/2025 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345234	B. WING			04/*	; 10/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
				1555 WILLIS AVENUE			
HARBORV	VIEW LUMBERTON			LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 756	of the resident's media §483.45(c)(4) The pha irregularities to the att facility's medical direct and these reports mus- (i) Irregularities included drug that meets the ca (d) of this section for a (ii) Any irregularities in during this review mus- separate, written repor- attending physician and director and director of minimum, the residen and the irregularity the (iii) The attending phy- resident's medical rect irregularity has been taken be no change in the in physician should door the resident's medical §483.45(c)(5) The fact maintain policies and drug regimen review to limited to, time frames	view must include a review cal chart. armacist must report any rending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. toted by the pharmacist st be documented on a art that is sent to the nd the facility's medical of nursing and lists, at a t's name, the relevant drug, e pharmacist identified. sician must document in the ford that the identified reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in	F 756		FICIENCY)		
	when he or she identi requires urgent action This REQUIREMENT by: Based on record revi Consultant Pharmacis	fies an irregularity that to protect the resident. is not met as evidenced ew, and staff, Physician and		Based on record rev Physician and Consu interviews, the Pharn	ultant Pharmacist's		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345234 B. WING 04/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1555 WILLIS AVENUE** HARBORVIEW LUMBERTON LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 756 Continued From page 52 F 756 the monthly medication regimen reviews that a identify and address during the monthly resident's Midodrine 10 mg (milligrams) medication regimen reviews that a prescribed for hypotension was administered resident's Midodrine 10 mg (milligrams) outside of the set parameters 38 times during prescribed for hypotension was administered outside of the set January 2025, 44 times in February 2025 and 15 times in March 2025 when the Consultant parameters 38 times during January Pharmacist completed her monthly March review 2025, 44 times in February 2025 and 15 on 03/14/25. This occurred for 1 of 1 resident times in March 2025 when the Consultant (Resident #95) reviewed for medication Pharmacist completed her monthly March administration. Resident #95 experienced no review on 03/14/25. This occurred for 1 of 1 resident (Resident #95) reviewed for significant outcome. medication administration. Resident #95 Finding included: experienced no significant outcome. Resident #95 was admitted to the facility on Resident #95 was assessed by NP in 04/12/24 with diagnoses that included house with no significant effects noted. NP ordered to discontinue Midodrine as hypotension. resident's blood pressure had been Record review revealed the following active stable. The pharmacy consultant orders: completed the required monthly drug regimen review and noted on a nursing Midodrine 10 mg give 1 tablet by mouth one time recommendation in February that it had a day every Monday, Wednesday, Friday for been administered outside of parameters. hypotension hold if sys (systolic) > (greater than) The pharmacy consultant report did not 120 or dys (diastolic) > 80; Start date 01/08/25. identify this as a medication error. Midodrine 10 mg give 1 tablet by mouth three All residents have the potential to be times a day every Tuesday, Thursday, Saturday, affected by this deficient practice. and Sunday for hypotension hold if sys > 120 or dys > 80; Start date 01/08/25. An audit was conducted on 4/1/25 of all pharmacy recommendations from the Review of the January 2025 Medication month of February with all Administration Record (MAR) revealed that the recommendations being addressed and medication Midodrine was given in error a total of scanned into the documents section of the 38 times, in February 2025 the medication medical record with the exception of the Midodrine was given in error a total of 44 times one for resident #95. Discussion with and in March 2025 the medication Midodrine was Pharmacy Consultant, Administrator, and given in error a total of 35 times to Resident #95. Director of Nursing took place on 4/14/25 regarding facility expectations along with

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PRINTED: 05/13/2025

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ С 345234 B. WING 04/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1555 WILLIS AVENUE** HARBORVIEW LUMBERTON LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 756 Continued From page 53 F 756 Review of the Pharmacist Recommendations to regulatory expectations. The Administrator the Nursing Staff dated 02/14/25 revealed the and Director of Nursing expect that they pharmacist noted the medication Midodrine had be notified by separate email of any been administered when the systolic blood observations noted by the pharmacist of pressure was >120 on 2/1/25, 2/2/25, 2/4/25, medications being administered outside of 2/6/25. 2/8/25. 2/13/25 and 2/20/25 in relation to parameters. The Pharmacy Consultant the Midodrine order for Tuesday, Thursday, will also draft a new separate document of Saturday and Sunday. The Monday, Wednesday, any recommendations not addressed Friday Midodrine order was not acknowledged in from the previous month. the report. There were no recommendations made to nursing regarding Midodrine medication The administrator will review the individual errors in January 2025 or March 2025 for resident recommendations from the Resident #95. monthly drug regimen review as well as the summary to validate whether there The Consultant Pharmacist Summary dated as of were observations of medications being 1/13/2025 provided to the facility documented, administered outside of ordered "Medication errors were not noted during my parameters, beginning with the April 2025 review this month." Consultant Pharmacy Summary. The Consultant Pharmacist Summary dated as of The administrator will report the findings 2/10/2025 provided to the facility documented, to QAPI monthly x 3 months to determine "Medication errors were not noted during my if there are any additional training review this month." opportunities identified. The Consultant Pharmacist Summary dated as of 3/10/2025 provided to the facility documented, "Medication errors were not noted during my review this month." A telephone interview was conducted with the facility Consultant Pharmacist on 04/01/25 at 10:18 AM. She stated she had not notified the facility that the Midodrine had been given in error in January 2025 because she had not seen a trend and didn't think that giving this medication to Resident #95 when his blood pressure was outside of the parameters was of clinical significance. She reported that she had recommended to the nursing staff on 02/14/25

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PRINTED: 05/13/2025

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING			-		C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
HARBOR	/IEW LUMBERTON				1555 WILLIS AVENUE LUMBERTON, NC 28358	3		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	ix.	PROVIDER'S (EACH CORREC	PLAN OF CORRECTION CTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	6		ICED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
F 756	error when the systoli but only listed a small enough to show a treat the medication was gi 2025. She stated she errors continued to or she had been told that educated (when she fi regarding the Februar March 10, 2025) and re-education would "ta An interview was com- Nursing on 04/02/25 a she received the mon- recommendations and Unit Manager. She not were documented on reports. She explaine February 2025 Pharm Nursing Staff that lister medication errors. Sh medication errors in J 2025, or March 2025. should have been not even one medication during the monthly re- shocked when she for medication administra aware of any education the nursing staff related parameters. She stated	ad been administered in c blood pressure was >120 sample of dates, just nd, but not all the dates that iven in error in February did not alert the facility that cour in March 2025 because at the nurses had been followed up with the facility ry recommendation on she thought the ake a while." ducted with the Director of at 11:30 AM. She stated that thly pharmacy d distributed them to the oted no medication errors the monthly summary d she had not seen the nacy Recommendation to ed a portion of the e was not aware of any anuary 2025, February She stated that the facility ified by the pharmacist if error had been discovered views. She noted she was und out about the Midodrine ation errors. She was not on that had been provided to ed to medication ed she had not told the st that the nursing staff had	F	756)EFICIENCY)		
	An interview was con Manager on 04/02/25	ducted with the Unit						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	/IEW LUMBERTON		1	555 WILLIS AVENUE			
HARDOR			L	UMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	seen the February 20 Recommendation to M portion of the medication no medication errors of January 2025 through she never told the Co- nursing staff had been medication errors or p An interview was come Development Nurse of stated she had not pre- nursing staff regarding and had not been ask been aware of the me today. She stated she Pharmacist that education with parar An interview was come Administrator on 04/0 stated she was not aw errors that had occurr January 2025 and Ma because she signed of reports and/or reprima would have known. S surprised when she le of medication errors to explained that the Co- documented on the me	nd acted on the ne stated she had never 25 Pharmacy Nursing Staff that listed a ion errors. She explained had been noted between n March 2025. She stated nsultant Pharmacist that n educated regarding parameters. ducted with the Staff on 04/02/25 at 1:23 PM. She povided any education to the g medication parameters i.ed to do so. She had not edication errors prior to a had not told the Consultant ation had been provided to rding the administration of	F 756		DEFICIENCY)		
	errors. She stated the	e had been no medication facility should have been nly one medication error during the monthly					

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-				FOR	D: 05/13/2025 MAPPROVED O. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DAT	E SURVEY PLETED
	345234	B. WING		04	C // 10/2025
ROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIF		
		1	555 WILLIS AVENUE		
		L	UMBERTON, NC 28358		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
		F 756			
Medical Director on 0 stated she would have Pharmacist to report to facility beginning in Ja that the Consultant PH reported any medicati it was discovered. She no significant outcome errors. Residents are Free of CFR(s): 483.45(f)(2) The facility must ensue §483.45(f)(2) Residen medication errors. This REQUIREMENT by: Based on record revia and the Consultant PH facility failed to hold the when Resident #95 's above 120 mm Hg (m give the medication w pressure was less that #95 experienced no s occurred for 1 of 1 res medication administrat Findings included: Resident #95 was adm 04/12/24 with diagnos hypotension.	4/03/25 at 4:36 PM. She e expected the Consultant he medication errors to the anuary 2025. She concluded harmacist should have on error to the facility when e noted Resident #95 had e related to the medication ⁷ Significant Med Errors ⁸ Significant Med Errors ⁹ If that its- the are free of any significant is not met as evidenced ew, and staff, Physician, harmacist interviews, the he medication Midodrine systolic blood pressure was illimeters of mercury) or hen the systolic blood in 120 mm Hg. Resident ignificant outcome. This sident reviewed for tion.	F 760	Midodrine when Residen blood pressure was above give the medication when blood pressure was less MD was notified immedia #95 suffered no ill effect the medication. The medication. The medication. The medication is the discontinued due to reside stable blood pressures. If use of Midodrine was init licensed nurses and certinaides. All residents who are ord have the potential to be a deficient practice. On 4/1	at # 95s systolic /e 120mmHg or In the systolic than 120 mmHg. ately. Resident from receiving lication has been dent #95 having Education on the tiated on 4/3/25 to ified medication lered Midodrine affected by this //25, current	4/23/25
Record review reveale	ed the following active		-		
	S FOR MEDICARE & M DEDEFICIENCIES CORRECTION ROVIDER OR SUPPLIER MEW LUMBERTON SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page pharmacy medication A telephone interview Medical Director on 00 stated she would have Pharmacist to report tf facility beginning in Ja that the Consultant PH reported any medication it was discovered. Sho no significant outcome errors. Residents are Free of CFR(s): 483.45(f)(2) The facility must ensure §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on record revia and the Consultant PH facility failed to hold th when Resident #95 's above 120 mm Hg (m give the medication w pressure was less that #95 experienced no s occurred for 1 of 1 resis medication administration Findings included: Resident #95 was addr 04/12/24 with diagnosis hypotension.	CORRECTION IDENTIFICATION NUMBER: 345234 ROVIDER OR SUPPLIER IDENTIFICATION NUMBERTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 56 pharmacy medication reviews. A telephone interview was conducted with the Medical Director on 04/03/25 at 4:36 PM. She stated she would have expected the Consultant Pharmacist to report the medication errors to the facility beginning in January 2025. She concluded that the Consultant Pharmacist should have reported any medication error to the facility when it was discovered. She noted Resident #95 had no significant outcome related to the medication errors. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- \$483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician, and the Consultant Pharmacist interviews, the facility failed to hold the medication Midodrine when Resident #95 's systolic blood pressure was less than 120 mm Hg. Resident #95 experienced no significant outcome. This occurred for 1 of 1 resident reviewed for medication administration. Findings included: Resident #95 was admitted to the facility on 04/12/24 with diagnoses that included	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING_ 345234 B. WING	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING	WENT OF HEALTH AND HUMAN SERVICES FOR SE COR MEDICARE & MEDICALD SERVICES OMB N or prediction (x1) PROVERISUPPLENCIAN (x2) DAT advice R supplicer 346234 (x2) DAT advice R supplicer 346234 (x2) DAT advice R supplier 346234 (x3) DAT advice R supplier 346234 (x3) DAT advice R supplier STREET ADDRESS, CITY, STATE, 2P CODE (x3) DAT rew LUMBERTON DESCRETADDRESS, CITY, STATE, 2P CODE (x4) DAT rew LUMBERTON, NUST RE PROCEEDED AY FULL PROVIDERS IN AV CORRECTION (x4) DAT read Lip Contained From page 56 F 756 PROVIDERS IN AV CORRECTION (x4) DAT Continued From page 56 F 756 F 756 PROVIDER SUPPLIENT DERCIENCY) Continued From page 56 F 756 F 760 F 760 F 760 F 760 CFR(s): 433,45(f)(2) The facility beginning in January 2025. She concluded that the Consultant Pharmacist should have reported any medication on root to the facility when it was discovered. She noted Resident #95 She systolic blood pressure was less than 120 mmHg. Midodrine when Resident #95 Systolic blood pressure was less than 120 mmHg. Methandigitant outoome related to the medication fidodrine w

Event ID: WCHO11

Facility ID: 953293

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	· /	3	COMPLETED			
					С			
		345234	B. WING		04/10/2025			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLET THE APPROPRIATE DATE			
F 760	Continued From page	e 57	F 76	50				
	orders:	lligrams) give 1 tablet by		reviewed with no addition	al issues found.			
	mouth one time a day			All licensed nurses and co				
		or hypotension hold if sys		medication aides have be				
	(systolic) > (greater t 80; Start date 01/08/2	han) 120 or dys (diastolic) >		on the use of Midodrine a				
		25. Iligrams) give 1 tablet by		significant medication error during survey. Newly hire				
	mouth three times a			nurses and certified medi				
		and Sunday for hypotension		be educated on the use o	f Midodrine as			
	hold if sys > 120 or d	ys > 80; Start date 01/08/25.		well as administering med	dications with			
				parameters during orienta	ation.			
		ation Administration Records						
	revealed Resident #9	od pressure reading > 120		Beginning the week of 4/2 Director of Nursing, Assis				
		eceive Midodrine with a		Nursing, or Staff Develop				
	-	ng < 120 mm Hg on Monday,		audit MARs for administra				
		lay on the following dates:		medications with paramet				
		blood pressure 118/61 mm		weekly with re-education				
		ne was held by Medication		necessary. Additionally,				
	Aide (MA) #1	blood procedure 114/55 mm		administration observation				
		blood pressure 114/55 mm ne was held by MA #1		residents receiving medic parameters will randomly				
		blood pressure 113/51 mm		times weekly. The Directo				
	Hg, 10 mg of Midodri	ne was held by MA #1		report these findings to th	5			
		blood pressure 153/74 mm		Assurance Performance I	-			
		ne was given by MA #1		meeting monthly x 3 mon				
		blood pressure 131/65 mm		if additional changes are	necessary.			
		ne was given by MA #1 blood pressure 136/72 mm						
		ne was given by MA #1						
		blood pressure 128/56 mm						
		ne was given by MA #1						
		blood pressure 130/64 mm						
		ne was given by MA #1						
		blood pressure 124/66 mm ne was given by MA #1						
		blood pressure 121/54 mm						
		ne was given by MA #1						
		blood pressure 135/69 mm						

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
						С
		345234	B. WING		0	4/10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE		
-				LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	e 58	F 76	0		
	-	ne was given by MA #1				
	02/14/25 at 7:30 AM	blood pressure 129/70 mm				
		ne was given by MA #1				
		blood pressure 159/87 mm ne was given by MA #1				
		blood pressure 129/64 mm				
		ne was given by MA #1				
		blood pressure 129/64 mm				
02/24 Hg, 7		ne was given by MA #1				
		blood pressure 140/70 mm ne was given by MA #1				
		blood pressure 140/55 mm				
		ne was given by MA #1				
		blood pressure 130/74 mm				
		ne was given by MA #1				
		blood pressure 123/67 mm ne was given by MA #1				
		blood pressure 147/73 mm				
		ne was given by MA #1				
		blood pressure 132/72 mm				
		ne was given by MA #1				
		blood pressure 121/57 mm				
		ne was given by MA #1 blood pressure 134/79 mm				
		ne was given by MA #1				
		blood pressure 127/73 mm				
		ne was given by MA #1				
		blood pressure 136/62 mm				
		ne was given by MA #1 blood pressure 130/72 mm				
		ne was given by MA #1				
		blood pressure 132/71 mm				
		ne was given by MA #1				
		blood pressure 127/60 mm				
	Hg, 10 mg of Midodri	ne was given by MA #1				
	Review of the Medica	tion Administration Records				
	revealed Resident #9					
		d pressure reading > 120	1			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	IO. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	IPLETED
		345234	B. WING			C 4/10/2025
NAME OF P	ROVIDER OR SUPPLIER	010201		STREET ADDRESS, CITY, STATE, ZIP CODE		4/10/2025
				1555 WILLIS AVENUE		
HARBOR	IEW LUMBERTON			LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	5 9	F 76	0		
1 / 00	-	eceive Midodrine with a				
	blood pressure reading					
	Tuesday, Thursday, S	Saturday, and Sunday on the				
	following dates:					
		blood pressure 112/59 mm				
		ne was held by MA #1 I blood pressure 116/58 mm				
		ne was held by MA #1				
		blood pressure 122/82 mm				
		ne was given by MA #5				
		l blood pressure 128/60 mm				
		ne was given by MA #1 blood pressure 144/68 mm				
		ne was given by MA #1				
		blood pressure 139/73 mm				
	Hg, 10 mg of Midodri	ne was given by MA #3				
		1 blood pressure 139/73 mm				
		ne was given by MA #3				
		blood pressure 124/72 mm ne was given by MA #1				
		1 blood pressure 136/66 mm				
		ne was given by MA #1				
		blood pressure 126/62 mm				
		ne was given by MA #1				
		blood pressure 147/72 mm				
		ne was given by Nurse #1 I blood pressure 140/76 mm				
		ne was given by Nurse #1				
		blood pressure 122/67 mm				
		ne was given by MA #6				
		blood pressure 132/66 mm				
		ne was given by MA #4				
		1 blood pressure 132/66 mm ne was given by MA #4				
		blood pressure 116/60 mm				
		ne was held by MA #4				
		blood pressure 140/80 mm				
	Hg, 10 mg of Midodri	ne was given by MA #4				
	01/21/25 at 7:30 AM					1

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		MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
						С
		345234	B. WING		04	4/10/2025
NAME OF PF	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL		
				1555 WILLIS AVENUE		
HARBORV				LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 760	Continued From page	a 60	F 76	0		
1 700			F /0	0		
		ne was given by MA #1 I blood pressure 130/68 mm				
		ne was given by MA #1				
		blood pressure 136/72 mm				
		ne was given by MA #1				
		1 blood pressure 136/68 mm				
		ne was given by MA #1				
		blood pressure 125/65 mm				
		ne was given by MA #1				
Hg,		1 blood pressure 132/74 mm				
		ne was given by MA #1				
		blood pressure 127/67 mm				
		ne was given by MA #1 I blood pressure 138/74 mm				
		ne was given by MA #1				
		blood pressure 103/52 mm				
		ne was held by MA #2				
		blood pressure 147/62 mm				
	Hg, 10 mg of Midodri	ne was given by MA #1				
		1 blood pressure "X", 10 mg				
	of Midodrine was held					
		blood pressure 118/58 mm				
		ne was held by MA #2				
		blood pressure 158/80 mm				
		ne was given by MA #4				
		1 blood pressure 147/77 mm ne was given by MA #4				
		blood pressure 147/77 mm				
		ne was given by MA #4				
	0. 0	1 blood pressure 134/80 mm				
		ne was given by MA #4				
		blood pressure 157/75 mm				
		ne was given by MA #4				
		blood pressure 130/70 mm				
		ne was given by MA #1				
		1 blood pressure 160/80 mm				
		ne was given by MA #4				
	02/04/25 at 7.00 FW	blood pressure 112/58 mm				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						С
		345234	B. WING		0,	4/10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE		
	1			LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	e 61	F 76	n		
1 100	-	blood pressure 135/69 mm				
		ne was given by MA #1				
		1 blood pressure 138/72 mm				
	Hg, 10 mg of Midodri	ne was given by MA #1				
		blood pressure 128/78 mm				
		ne was given by MA #2				
		blood pressure 128/66 mm				
	0, 0	ne was given by MA #1 I blood pressure 136/74 mm				
		ne was given by MA #1				
		1 blood pressure 128/76 mm				
		ne was given by MA #1				
		blood pressure 142/83 mm				
		ne was given by MA #3				
		blood pressure 139/75 mm				
		ne was given by MA #1 blood pressure 138/76 mm				
		ne was given by MA #1				
		1 blood pressure 136/74 mm				
		ne was given by MA #1				
	02/15/25 at 7:30 AM	blood pressure 138/76 mm				
		ne was given by MA #4				
		blood pressure 1139/67				
		lodrine was given by MA #4 blood pressure 105/60 mm				
		ne was held by MA #4				
		1 blood pressure 105/60 mm				
		ne was held by MA #4				
		blood pressure 130/79 mm				
		ne was given by MA #4				
		blood pressure 132/72 mm				
		ne was given by Nurse #2				
		1 blood pressure 132/72 mm ne was given by MA #1				
		blood pressure 136/74 mm				
		ne was given by MA #1				
		blood pressure 123/68 mm				
	Hg, 10 mg of Midodri	ne was given by MA #1				
	02/20/25 at 7:00 DM	blood pressure 123/68 mm				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		O. 0938-039 E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	PLETED		
345234					С			
		B. WING			/10/2025			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2020		
	HARBORVIEW LUMBERTON			1555 WILLIS AVENUE				
HARBOR	VIEW LUMBERTON			LUMBERTON, NC 28358				
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
	1			DEFICIENCY;				
F 760	Continued From page	- 60		20				
F 700			F 76	50				
		ne was given by MA #3						
		1 blood pressure 124/66 mm ne was given by MA #1						
	0. 0	5,						
	02/22/25 at 7:00 PM blood pressure 146/82 mm Hg, 10 mg of Midodrine was given by MA #6							
		blood pressure 144/70 mm						
		ne was given by MA #5						
		1 blood pressure 124/61 mm						
		ne was given by MA #5						
		blood pressure 136/72 mm						
		ne was given by MA #7						
		blood pressure 142/68 mm						
		ne was given by MA #1						
		1 blood pressure 136/72 mm						
		ne was given by MA #1						
		blood pressure 113/60 mm						
		ne was held by MA #2						
		blood pressure 122/65 mm						
		ne was given by MA #1						
		blood pressure 118/70 mm						
		ne was held by MA #4						
	0. 0	1 blood pressure 129/65 mm						
		ne was given by MA #4						
		blood pressure 113/60 mm						
		ne was held by MA #4						
		blood pressure 133/62 mm						
		ne was given by MA #4						
		1 blood pressure 135/69 mm						
		ne was held by MA #4						
		blood pressure 139/77 mm						
		ne was given by MA #3						
		1 blood pressure 136/74 mm						
		ne was given by MA #1						
		blood pressure 136/74 mm						
		ne was given by MA #3						
		blood pressure 125/70 mm						
		ne was given by MA #1						
		blood pressure 132/70 mm						
	Hg, 10 mg of Midodri							

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED
245924		B. WING			С	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COI		4/10/2025
				1555 WILLIS AVENUE	DE	
HARBORVIEW LUMBERTON				LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AI DEFICIENCY) DEFICIENCY)			N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 760	Continued From page	- 62		<u></u>		
F 700	Continued From page		F 7	60		
		l blood pressure 139/63 mm ne was given by MA #1				
		U				
		03/11/25 at 7:00 PM blood pressure 132/66 mm Hg, 10 mg of Midodrine was given by MA #1				
		blood pressure 138/74 mm				
	Hg, 10 mg of Midodrine was given by MA #1					
		1 blood pressure 136/68 mm				
	0. 0	ne was given by MA #1				
		blood pressure 112/60 mm				
		ne was held by MA #4 I blood pressure 141/80 mm				
		ne was given by MA #4				
		blood pressure 130/60 mm				
	Hg, 10 mg of Midodri	ne was given by MA #4				
		1 blood pressure 141/70 mm				
		ne was given by MA #4				
		blood pressure 136/68 mm ne was given by MA #1				
	0. 0	1 blood pressure 132/66 mm				
		ne was given by MA #1				
		blood pressure 129/67 mm				
		ne was given by MA #1				
		blood pressure 136/76 mm				
		ne was given by MA #1				
		blood pressure 128/68 mm				
		ne was given by MA #1 blood pressure 122/68 mm				
		ne was given by MA #1				
		blood pressure 138/76 mm				
		ne was given by MA #1				
		blood pressure 132/74 mm				
		ne was given by MA #1				
		blood pressure 122/70 mm				
		ne was given by MA #1 blood pressure 130/72 mm				
		ne was given by MA #1				
		blood pressure 134/72 mm				
		ne was given by MA #1				
	03/27/25 at 12:00 PM		1			1

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_	(04/	C 10/2025
NAME OF PF	ROVIDER OR SUPPLIER		- i	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	IEW LUMBERTON			1555 WILLIS AVENUE			
HANDON				LUMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	03/27/25 at 7:00 PM k Hg, 10 mg of Midodrin 03/29/25 at 7:00 PM k Hg, 10 mg of Midodrin 03/30/25 at 12:00 PM	ne was given by MA #1 blood pressure 138/72 mm ne was given by MA #1 blood pressure 110/60 mm ne was held by MA #4 blood pressure 101/70 mm	F 760				
	04/01/25 at 7:30 AM t Hg, 10 mg of Midodrir 04/01/25 at 12:00 PM Hg, 10 mg of Midodrir	ne was held by MA #4 blood pressure 128/72 mm ne was given by MA #1 blood pressure 133/66 mm ne was given by MA #1					
	through 04/01/25 for I	ss notes from 01/08/25 Resident #95 revealed no e medication Midodrine was n on the dates listed.					
	time on the 100 hall a She acknowledged th parameters attached parameters popped u confirmed if there was Medication Administra that she had administ stated she did not kno caused her to give the	She stated she worked full nd cared for Resident #95. at this medication order had to it because the p automatically. She s a check mark on the ation Record (MAR) it meant ered the medication. She bw what had happened that a medication in error.					
	04/01/25 at 3:00 PM. with Resident #95. Sh with the medication M used to increase the b	ication.					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_	(04/	C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HARBOR\	IEW LUMBERTON			555 WILLIS AVENUE .UMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	04/01/25 at 3:11 PM v worked on the weeke Resident #95. She sta medication Midodrine pressure by raising th the medication had pa that if she documente that she had administ thought she may have A telephone interview on 04/02/25 at 10:28 v worked at the facility f with Resident #95. Sh understood that the m used for orthostatic hy up his blood pressure of the parameters and if the systolic blood pr concluded she must h error because she als medications on the 50 assignment chaotic. An interview was com 04/02/25 at 11:10 AM worked on the 300 ha pulled to pass medica stated she had admin Resident #95 in error. An interview was com 04/02/25 at 4:17 PM. at the facility for 2 yea Resident #95. She ind the medication on the administered the drug looked at the parameter	via phone. She stated she nds and was familiar with ated she knew the was used to treat low blood e blood pressure. She knew arameters. She confirmed d a check mark on the MAR ered the medication. She e documented incorrectly. was conducted with MA #6 AM. She stated that she had for 4 years and was familiar ne explained that she hedication Midodrine was ypotension and would bring . She stated she was aware d would hold the medication ressure was > 120. She have made a documentation to had to also pass 00 hall which made the ducted with MA #5 on . She stated that she usually Il but was occasionally tions on the 100 hall. She istered the medication to Aducted with MA #3 on She stated she had worked ars and was familiar with dicated that if she signed off MAR that she had to. She stated she had not	F 760				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	G	COMPLETED
345234 B. WING		C 04/10/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HARBORVIEW LUMBERTON	1555 WILLIS AVENUE LUMBERTON, NC 28358	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	D 475
F 760 Continued From page 66 F 76	60	
A phone interview was conducted with MA #2 on 04/02/25 at 4:39 PM. She stated that she had worked at the facility for 3 years and was familiar with Resident #95. She noted she usually worked as a nurse aide but did pass medications occasionally. She recalled the parameters on the Midodrine order for Resident #95 and stated she had always taken his blood pressure before administering the drug. She stated she may have misunderstood the order and had given the medication in error. A telephone interview was conducted with Nurse #1 on 04/02/25 at 4:52 PM. She stated that she was familiar with Resident #95. She explained that the medication Midodrine was used for hypotension. She was not sure why she gave the medication when the systolic blood pressure was > 120. She thought she may have interpreted the order to instruct her to hold the medication if the systolic reading was < 120. She confirmed that if there was a check mark on the MAR that she had given the medication. An interview was conducted with the Staff Development Coordinator (SDC) Nurse on 04/03/25 at 8:59 AM. She stated she was familiar with the medication Midodrine and that it was used to bring up a low blood pressure. She explained she had not noticed the order had parameters set and had given the medication in error. A telephone interview was conducted with MA #7 on 04/03/25 at 11:15 AM. She stated she was familiar with Resident #95 but usually di not work the 100 hallway. She explained she did not know why she gave the medication in error. She		

Facility ID: 953293

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 05/13/2025 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING		_		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	100 hall was very bus passed medication or constantly being inter approaching her for p described the assignr Unsuccessful attempt made on 04/02/25 at AM and 04/03/25 at 4 on each attempt. An interview was com Director of Nursing or stated she was familia had administered the him in error. She state nurse in the past and be given if the diastoli low, so she had given in the morning in an e pressure and wasn't p parameters that had a thought the diastolic p She stated she had m thought it read "dys hor read "dys hold if > 80" the diastolic blood pre giving the medication systolic parameter wa gave it either because previous dialysis expen- A telephone interview facility Consultant Pha 10:18 AM. She stated facility that the Midod in January 2025 beca	the resident. She noted the y and the whole time she in the 100 hall she was rupted by residents ain medications. She nent as hectic. s to contact Nurse #3 were 10:40 AM, 04/03/25 at 9:15 :22 PM. A message was left ducted with the Assistant 04/01/25 at 4:30 PM. She ar with Resident #95 and medication Midodrine to ed she had been a dialysis knew that dialysis would not c blood pressure was too the Midodrine on 01/27/25 ffort to raise his diastolic baying attention to the been ordered. She had pressure of 68 was too low. hisunderstood the order and old if < 80" when it actually ' and she was trying to raise essure up to 80 mm Hg by . She had not noticed the is >120 mm Hg when she e she was focused on her	F 760				

Facility ID: 953293

If continuation sheet Page 68 of 88

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345234	B. WING			_		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HARBOR	VIEW LUMBERTON				1555 WILLIS AVENUE LUMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	outside of the parameters significance. She report recommended to the that the medication has error when the systoli but only listed a small enough to show a treat the medication was gi 2025. She stated she errors continued to or she had been told that educated (when she for regarding the Februar March 10, 2025) and re-education would "ta An interview was commendations. She seen the February 20 Recommendation to for medication errors. She aware that any medication errors. She aware that any medication not been aware of any An interview was common 04/02/25 at 1:23 P provided any education errors. She aware that any medication errors are on 04/02/25 at 1:23 P provided any education errors. An interview was common 04/02/25 at 1:23 P provided any education errors. An interview was common to be aware of any An interview was common 04/02/25 at 1:23 P provided any education errors. An interview was common to be aware of any An interview was common to be aware of a	h his blood pressure was beters was of clinical orted that she had nursing staff on 02/14/25 ad been administered in c blood pressure was >120 sample of dates, just nd, but not all the dates that iven in error in February did not alert the facility that occur in March 2025 because at the nurses had been followed up with the facility ry recommendation on she thought the ake a while." ducted with the Unit at 12:23 PM. She he received the pharmacy nd acted on the he stated she had never 25 Pharmacy Nursing Staff that listed the e explained she was not ation errors had occurred. ducted with the SDC Nurse M. She stated she had not on to the nursing staff parameters, and she had	F	760				

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 05/13/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345234	B. WING		_		C 10/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	•	
HARBOR	IEW LUMBERTON			555 WILLIS AVENUE UMBERTON, NC 28358	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760 F 761 SS=E	errors that had occurr January 2025 and Ma she signed off on all m and/or reprimands that known. She stated that she learned today of t errors that had occurr A telephone interview Medical Director on 00 stated that she expect administer medication parameters. She repor notified of the medicat Resident #95 had not to the medication error of errors was significat Label/Store Drugs and CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the facil biologicals in locked of temperature controls, personnel to have accor	vare of any medications ed in the facility between rch 2025. She explained nedication error reports it occurred and would have at she was surprised when he number of medication ed. was conducted with the 4/03/25 at 4:36 PM. She ted the nursing staff to is according to the ordered rted that she had not been tion errors. She noted significant outcome related rs even though the number nt. d Biologicals 1)(2) of Drugs and Biologicals used in the facility must be with currently accepted is, and include the v and cautionary expiration date when f Drugs and Biologicals rdance with State and ity must store all drugs and iompartments under proper and permit only authorized	F 760				4/25/25

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OLIVIER		MEDICAID SERVICES					O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
345234		B. WING			C 04/10/2025		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HARBOR							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETIO DATE
F 761	Continued From page	e 70	E F	761			
		affixed compartments for					
		drugs listed in Schedule II of					
		Drug Abuse Prevention and					
		Control Act of 1976 and other drugs subject to					
	abuse, except when the facility uses single unit						
	package drug distribution systems in which the quantity stored is minimal and a missing dose can						
	-	be readily detected.					
	-	is not met as evidenced					
	by:						
	Based on observatio	Based on observations and staff interviews the			The facility failed to discard expired		
	facility failed to discar			medications, record an opened date o	na		
	record an opened da			multi-dose oral inhaler that had a			
		ortened expiration date, and			shortened expiration date, and refriger		
	to the manufacturer's	ophthalmic drops according			unopened ophthalmic drops according the manufacturer's guidelines on 2 of		
) hall, 800 hall) and in 2 of 2			medication carts and in 2 of 2 medicat		
		poms (300 hall, 400 hall) that			storage rooms that were reviewed for		
	were reviewed for me				medication storage. All medications		
					discovered to be out of compliance we		
	Findings included.	Findings included.			discarded and replaced as necessary.		
	1) An abaam stian of				residents suffered any ill effects relate	d to	
		the 400-hall medication cart AM revealed the following			this practice.		
	medications:	Air revealed the following			All residents have the potential to be		
					affected by this deficient practice.		
	One bottle of Latanop	prost .005% ophthalmic					
	drops that was unope	ened and not refrigerated.			All licensed nurses were educated by	the	
	Deview of the second	- Aurona muidalin 6			Administrator, Director of Nursing,		
		acturers guidelines for nic solution instructed to			Assistant Director of Nursing, and Sta Development Nurse on 4/17/25 on	11	
		es under refrigeration at 2° to			medication storage and labeling.		
		nce a bottle was opened for					
		at room temperature up to			All newly hired licensed nurses will be		
	25°C (77°F) for 6 wee				educated during orientation on medica storage and labeling.		
	Fluticasone propiona						
		ns (mcg)/50mcg that was in			The facility has identified a medication		
	use with no opened o	late labeled on the inhaler.			cart champion who has organized eac	h	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345234 B. WING 04/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1555 WILLIS AVENUE** HARBORVIEW LUMBERTON LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 761 Continued From page 71 F 761 cart to promote consistency and Fluticasone propionate salmeterol inhaler (Advair compliance with medication storage and diskus)100 micrograms (mcg)/50mcg with an labeling. Beginning the week of 4/28/25, opened date of 1/09/25. the medication cart champion will audit all medication carts one to two times weekly Review of the manufacturers guidelines for and provide immediate feedback to the Fluticasone propionate salmeterol inhaler assigned nurse responsible for the instructed to discard one month after opening the medication cart at the time of the audit. A foil pouch. reference document of medications with shortened expiration dates will be One box of Hemorrhoidal suppositories that were laminated and placed on each cart for house stock with an expiration date of 11/2023. quick reference. Additionally, each medication cart will be taken to the Clobetasol 0.5% topical ointment with an Director of Nursing's office once weekly at expiration date of 9/2024. a scheduled time to be audited by the Director of Nursing. Any identified areas Invexxy vaginal suppositories 10mcg with an of concern will be addressed immediately expiration date of 10/2024. with re-education given as necessary. The Assistant Director of Nursing will be During an interview on 04/02/25 at 11:30 AM responsible for auditing all medication Nurse #2 stated all nurses were responsible for storage rooms weekly. The audits will be checking the medication carts for expired conducted x 12 weeks. medications. She indicated she had not checked the cart so far today due to being busy with the The Director of Nursing will present the morning medication pass. She stated the findings of the audits to the QAPI medications should have been discarded and an committee monthly for a minimum of 3 opened date labeled on the inhaler. She indicated months to determine if additional she was not aware that the Latanoprost audits/training are required. The Director ophthalmic drops had to be refrigerated if not of Nursing will be responsible for ensuring compliance as of 4/25/25. opened. 2.) An observation of the 800-hall medication cart on 04/02/25 at 11:45 AM revealed the following medications: One bottle of Latanoprost .005% ophthalmic drops that was opened and in use with no opened date recorded.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 05/13/2025

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345234	B. WING				C 10/2025
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HARBOR	VIEW LUMBERTON				1555 WILLIS AVENUE LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	One bottle of Lansopr milliliter suspension w Review of the manufa Lansoprazole suspen after 30 days and stor During an interview o Nurse #4 stated all nu checking the medicat medications and to er expiration dates were date. She stated this 3.) An observation of storage room on 04/0 the following: Two bottles of wound expiration date of 4/30 During an interview o Manager #1 stated sh the storage room for stated it was an overs 4.) An observation of storage room on 04/0 the following: Lansoprazole suspen expiration date of 03/0 During an interview o Nurse #2 stated that of Assistant Director of I all responsible for che	razole 3 milligrams per vith a use by date of 3/31/25. Acturer's instructions for ision instructed to discard re in the refrigerator. In 04/02/25 at 11:45 AM urses were responsible for ion carts for expired hsure medications with short e labeled with an opened was an oversight. The 300-hall medication 2/25 at 12:30 PM revealed cleanser (antiseptic) with an 0/24 and 9/2023. In 04/02/25 at 12:30 PM Unit he thought she had checked expired medications. She sight. The 400-hall medication 12/25 at 11:55 AM revealed sion 3 mgs with an 01/25. In 04/02/25 at 11:55 AM central supply staff, the Nursing and the nurses were ecking the medication pired medications. She	F	761			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/13/2025 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345234	B. WING		_		C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				1555 WILLIS AVENUE			
HARBOR	IEW LUMBERTON			LUMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	273	F 76	1			
F 812 SS=E	Central Supply staff m routinely checked the for expired medication responsible for over-th prescription medication PM with the Director of the Administrator. The assigned nurse was m medication carts for e ensure all medications opened date. She sta member was respons medication storage ro medication storage ro medication storage ro medication storage was staff. Food Procurement, St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or considered state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe	medication storage rooms hs. She stated she was he-counter medications not ons. ducted on 04/03/25 at 3:01 of Nursing (DON) along with e Administrator stated the esponsible for checking xpired medications and to s were labeled with an ted the central supply staff ible for checking the ooms for expired ed education regarding ould be provided to nursing ore/Prepare/Serve-Sanitary 2) y requirements. e food from sources ed satisfactory by federal, es. ood items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable	F 81	2			4/23/25

Event ID: WCHO11

Facility ID: 953293

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		MEDICAID SERVICES					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	1 Y /	TE SURVEY MPLETED
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			
		345234	B. WING			C	
	ROVIDER OR SUPPLIER	010201			TREET ADDRESS, CITY, STATE, ZIP CODE	(4/10/2025
					555 WILLIS AVENUE		
HARBOR	IEW LUMBERTON				UMBERTON, NC 28358		
(X4) ID	SUMMARY ST	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETIO DATE
F 812	Continued From page	e 74	F٤	312			
	\$492 60/i)/2) Store	proporo distributo and					
		prepare, distribute and ance with professional					
	standards for food se	•					
		is not met as evidenced					
	by:						
		ns and staff interviews, the			Based on observations and staff		
	-	and date an opened food			interviews, the facility failed to label an		
		refrigerator and failed to ainers of milk from 2 of 3			date an opened food item in 1 of 1 wa refrigerator and failed to remove expir		
	-	Secured Unit and East			containers of milk from 2 of 3 nourishr		
		es had the potential to affect			rooms (Secured Unit and East Wing).		
	food service for the re	-			These practices had the potential to a food service for the residents.	ffect	
	The findings included	:			a. The initial tour of the kitchen with th Dietary Manager on 3/31/2025 at 10:5		
		ne kitchen with the Dietary			AM revealed an open package of slice		
		25 at 10:50 AM revealed an			turkey in the walk-in refrigerator that w		
		ed turkey in the walk-in			not labeled and dated. An interview w		
	reingerator that was i	not labeled and dated.			the Dietary Manager was conducted of 3/31/2025 at 11:00 AM. The Dietary	n	
	An interview with the	Dietary Manager was			Manager stated that all open food in the	he	
		025 at 11:00 AM. The Dietary			kitchen was supposed to be labeled w		
	Manager stated that a	all open food in the kitchen			an opened date and an expiration dat		
		abeled with an opened date			She further stated she was going to		
		e. She further stated she			discard the package of turkey becaus	e it	
		the package of turkey			was not labeled and dated.		
	because it was not la	beled and dated.			b. A tour of the East Wing nourishmer room with the Dietary Manager on	IT	
	b. A tour of the Fast \	Ning nourishment room with			3/31/2025 at 11:05 AM revealed a		
		on 3/31/2025 at 11:05 AM			container of 2% milk with the expiration	n	
	revealed a container				date of 3/29/2025. c. A tour of the		
	expiration date of 3/2	9/2025.			Secured Unit nourishment room with t	he	
					Dietary Manager on 3/31/2025 at 11:0		
		ed Unit nourishment room			revealed 2 containers of 2% milk with	the	
	-	ager on 3/31/2025 at 11:08			expiration date of 3/29/2025.		
	revealed 2 containers				No residents were effected. The wede	tod	
	expiration date of 3/2	9/2023.			No residents were affected. The unda	ieu	

Facility ID: 953293

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ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA	ATE SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B) cc	MPLETED
						С
		345234	B. WING			04/10/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	IEW LUMBERTON		1555 WILLIS AVENUE			
				LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 812	Continued From page	e 75	F 81	2		
		Dietary Manager was	101	discarded.		
		025 at 11:10 AM. The Dietary				
	Manager stated that	•		All residents had the pote	ntial to be	
		ing the nourishment rooms		affected.		
		d items. She indicated the				
	expired milk containe			100% of dietary staff were		
	removed from the no	urishment rooms.		reeducated. Dairy produc		
	An interview with the	Administrator was		relocated to the kitchen fr to floor staff 24/7.	idge accessible	
	An interview with the completed on 4/3/202					
		she expected opened food		Starting 4/28/25, the dieta	arv manager or	
		nd dated correctly. She		designee will check the w		
	further stated that the	-		pantry rooms 5 times a w	-	
	weekend and no one	was assigned to check the		weeks to ensure food is s	tored and	
	nourishment rooms o	on the weekend.		labeled properly.		
				Any deficiencies found wi		
				be corrected immediately		
				re-education done as nec dietary manager.	essary by the	
				dietary manager.		
				The findings of the audits	will be taken to	
				QAPI meeting monthly x		
				Dietary Manager to deter	mine if changes	
				need to be made.		
F 825 SS=D	Provide/Obtain Speci CFR(s): 483.65(a)(1)	ialized Rehab Services (2)	F 82	25		4/23/25
	\$483.65 Specialized	rehabilitative services.				
	§483.65(a) Provision					
		tative services such as but				
	-	l therapy, speech-language				
		nal therapy, respiratory				
		ative services for mental				
		al disability or services of a				
		t forth at §483.120(c), are				
	care, the facility must	ent's comprehensive plan of t-				
	sare, the facility must					

Event ID: WCHO11

Facility ID: 953293

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· /	TE SURVEY MPLETED
		345234	B. WING			C 04/10/2025	
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 •	
HARBOR	/IEW LUMBERTON		1555 WILLIS AVENUE LUMBERTON, NC 28358				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 825	Continued From page	e 76	F	825			
	§483.65(a)(1) Provide	e the required services; or					
	obtain the required se resource that is a pro rehabilitative services participating in any fe programs pursuant to the Act. This REQUIREMENT by: Based on record revi Nurse Practitioner int	and is not excluded from deral or state health care section 1128 and 1156 of is not met as evidenced iew, resident, staff and erviews, the facility failed to services per the resident's is for 1 of 2 residents			The facility failed to provide ordered physical and occupational therapy services to a resident admitted from th hospital with therapy orders. Therapy services were delayed due to a pendir order for a PRAFO (pressure-relieving ankle-foot orthosis).	ng	
	Findings included Review of Resident # summary dated 3/17/ was hospitalized from The discharge summ remained functionally skilled nursing facility from the hospital due daily living (bathing, c limitations. Physical a was recommended to nursing facility with po long-term care. The indicated it was import continued with range			Physical therapy and Occupational Therapy have been initiated for Resid #93 since identification of the deficien Resident #93 was reassessed to determine any missed therapy needs compensatory sessions were provided appropriate. The resident was notified the delay in services and updated regarding the correction plan. PRAFO been ordered – fitting appointment is scheduled the week of 4/28/25. All residents have the potential to be affected by this practice.	cy. and d as of has		
		mitted to the facility on es of sacral pressure ulcer			A review was conducted of all residen admitted within the past 30 days with orders for PT/OT from the hospital. An identified residents with a delay in the initiation of therapy services were		

Facility ID: 953293

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345234 B. WING 04/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1555 WILLIS AVENUE** HARBORVIEW LUMBERTON LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 825 Continued From page 77 F 825 Resident #93's physician orders revealed orders immediately addressed, with services dated 3/17/25 for speech, occupational and initiated or resumed. A new physical therapy to evaluate and treat as interdisciplinary therapy initiation protocol indicated. has been implemented: Upon admission, therapy referrals will be reviewed within 24 A therapy screening form dated 3/18/25 hours by the rehab department. Therapy completed by the Rehabilitation Director revealed services will be initiated regardless of the reason for the screen was admission to the pending equipment, if clinically indicated. facility. The form was not completed and the Therapy personnel have been justification for "no evaluation" indicated Resident re-educated by the Regional Director of #93 was total care, required a mechanical lift for Rehab on the expectation that OT and PT transfers and needed a PRAFO boot before must be initiated as ordered, even if therapy. The form indicated the facility was in the equipment is delayed. Rehab director or process of obtaining the PRAFO boot. designee will conduct daily reviews of all new admissions to ensure timely therapy Resident #93's physician orders revealed no initiation. order for a PRAFO boot (Pressure Reduction Ankle Foot Orthosis used to manage ankle/foot Beginning the week of 4/28/25, a weekly audit of new admissions with PT/OT anomalies by keeping the ankle and foot aligned and relieves pressure off the heel) to be applied orders will be completed by the Director of to resident's left lower extremity. Rehab or designee for 4 weeks. If no further concerns are identified after 4 A Nurse Practitioner note dated 3/18/25 indicated weeks, audits will be reduced to monthly physical and occupational therapy was consulted for an additional 2 months. in the hospital and recommendation was written in the discharge summary for skilled nursing due Findings will be reported to the Quality to activity of daily living limitations and sacral Assurance Performance Improvement wound. Physical and occupation therapy was (QAPI) Committee by the Rehab Director recommended with possible transition to monthly x 3 months to determine if long-term care, however the resident reported additional audits/training are required. she would like to return home to family. On assessment Resident #93 was in the room with family members who confirmed the resident would be returning home. The assessment and plan indicated that Resident #93 was to receive physical and occupational therapy to address mobility and activities of daily living with the goal of returning home with family.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 05/13/2025

		D HUMAN SERVICES MEDICAID SERVICES					FORM	05/13/2025 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345234	B. WING _					C 10/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE	•	
HARBOR	/IEW LUMBERTON				555 WILLIS AVENUE UMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE
F 825	Resident #93's care p the resident required daily living related to s weakness, impaired n ankle fracture. Interva assistance with activit therapy as ordered. Resident #93's admis (MDS) dated 3/23/25 cognitively intact with Resident #93 required assistance with activit #93 did not receive of speech therapy servic A physician progress PM indicated Resider ankle fracture and una approximately 2 years indicated Resident #9 weight on the left ank decreased strength al extremity. The physic Resident #93 had dec movement in the right extremities. An interview was cond 3/31/25 at 2:41 PM. F was still waiting to get she did not know why therapy. Resident #9 was supposed to rece she wanted to work w mobility.	lan dated 3/18/25 indicated assistance with activities of stroke with right sided nobility, and history of an entions included to provide ies of daily living tasks and sion Minimum Data Set indicated the resident was no rejection of care. d extensive to total ties of daily living. Resident ccupational, physical or ces since admission. note dated 3/24/25 at 12:37 at #93 had a history of a left derwent surgery a ago. The physician note 13 needed to start putting le since now she had nd movement in her lower cian's assessment indicated creased strength and	F	325				

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	OF DEFICIENCIES	MEDICAID SERVICES				IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		E SURVEY IPLETED
			A. BUILDIN			С
		345234	B. WING		04/10/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		+/10/2023
				1555 WILLIS AVENUE		
HARBOR	VIEW LUMBERTON			LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 005		70				
F 825			F 8	25		
		day shift from 7:00 AM to				
	-	bugh Friday. Nurse #4 Its were usually evaluated by				
		ere admitted to the facility.				
	Nurse #4 stated she					
	Resident #93 had bee	en evaluated by therapy or if				
	she was receiving the	erapy or not.				
		ducted with the Themeny				
		ducted with the Therapy 1:05 PM. The Therapy				
		ent #93 was screened by				
		ermined to require total				
		tivities of daily living and				
	-	riority to receive therapy				
	-	by Director stated they were				
		RAFO boot for the resident				
		history of an ankle fracture. stated Resident #93 was				
		int of the cost of the PRAFO				
		irector stated he spoke with				
		g her portion of the cost of				
		Resident #93 stated she				
		le to do so. The Therapy				
		ent #93 was not able to				
		ces until she was able to pay Therapy Director stated that				
		coding the information to				
	-	ce copy for the PRAFO boot				
		can take a while. The				
		unable to explain why				
		ot receive occupational				
		concentrated on upper body				
	body was obtained.	RAFO boot for the lower				
	A follow up interview	with the Therapy Director on				
	-	vealed he was aware that				
		occupational therapy were				
	recommended by the		1	1		1

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	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY IPLETED
		345234	B. WING		0	C 4/10/2025
NAME OF P	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARBOR	VIEW LUMBERTON			555 WILLIS AVENUE UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 825	Continued From page	e 80	F 825			
	providers however the resident was not able to receive therapy services until she had the PRAFO boot.					
	at 3:00 PM revealed a admitted with orders and speech therapy. indicated that the exp evaluated residents v services. The Nurse	Nurse Practitioner on 4/3/25 that Resident #93 was for physical, occupational The Nurse Practitioner bectation was that the facility with orders for therapy Practitioner stated there the PRAFO boot and it was sipation in therapy.				
F 842	new admissions all at for short-term rehabil stated she understoo the facility, that Resid long-term care and th started upon admission short-term patient. T the facility did not req the PRAFO boot but or her insurance paid than the facility. The was not aware that the for the PRAFO boot a Therapy Director indiversible for it. Resident Records - Id	25 at 8:15 AM. The the facility had an influx of t once that were truly here itation. The Administrator d, from a prior admission to lent #93 was admitted for herapy services were not on due to not being a he Administrator indicated ure the resident to pay for the facility preferred that she for the equipment, rather Administrator stated she he resident was asked to pay and did not know why the cated that the resident was dentifiable Information	F 842			4/24/25
SS=D	§483.20(f)(5) Resider	nt-identifiable information. elease information that is				

Facility ID: 953293

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUP COMPLET 345234 B. WING 04/10/1	URVEY
	0/2025
04/10/	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HARBORVIEW LUMBERTON 1555 WILLIS AVENUE LUMBERTON, NC 28358	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)IDPREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)C	(X5) COMPLETION DATE
F 842 Continued From page 81 F 842 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (i) Complete; (i) Accurately documented; (ii) Readily accessible; and (ii) To the individual, or their resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident's records, regardless of the form or storage method of the records, except when release is- (ii) To the individual, or their resident representative where permitted by applicable law; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 146.505; (iv) For public health administrative proceedings, law enforcement purposes, roseard purposes, or loa conners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>	G		MPLETED
						С
		345234	B. WING		04/10/2025	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				1555 WILLIS AVENUE		
HARBORV	VIEW LUMBERTON			LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 842	Continued From page	e 82	F 84	42		
	unauthorized use.					
	§483.70(h)(4) Medical records must be retained for-					
	(i) The period of time required by State law; or (ii) Five years from the date of discharge when					
	there is no requireme					
	(iii) For a minor, 3 yea legal age under State	ars after a resident reaches e law.				
		edical record must contain- ion to identify the resident;				
	(ii) A record of the res	sident's assessments;				
	provided;	ive plan of care and services				
		y preadmission screening				
	and resident review e					
	determinations condu	-				
		e's, and other licensed				
	professional's progre	logy and other diagnostic				
		equired under §483.50.				
	-	Γ is not met as evidenced				
	by:					
		iew, and staff and Physician		The facility failed to docur		
	interviews, the facility			rate in the medical record		
		cord by 1.) not documenting		administration of the media		
		rior to the administration of resident with an order for		resident with an order for h	•	
		ation to treat high blood		medication to treat high blow with a parameter to hold the		
	•	meter to hold the medication		for a heart rate less than 6		
		han 60 beats per minute		minute (resident #24) and		
		naintain an accurate medical		maintain an accurate med		
	record for weight mor	nitoring (Resident #17). This		weight monitoring for resid	lent #17. The	
		f 6 residents whose medical		order for hydralazine for re		
	record was reviewed.			updated to include docume heart rate on the MAR. Nu		
	Findings included:			verbally counseled on not weights that she documen	-	

Event ID: WCHO11

Facility ID: 953293

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				PLE CONSTRUCTION	OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	G	(X3) DATE SURVEY COMPLETED
					С
		345234	B. WING		04/10/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E
HARBOR\	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLET
F 842	Continued From page	e 83	F 84	42	
	_	admitted to the facility on		MAR.	
		es which included stroke and			
	hypertension.			All residents have the potentia	
				affected by this same deficient	practice.
		cian orders revealed an			
		Director of Nursing (DON) alazine 25 milligrams (mg)		An audit was conducted of cur	rent
	every 8 hours for hyp			residents MARs who have ord	
		ic blood pressure (the top		blood pressure medications wi	th hold
	-	pressure) less than 100 or		parameters to ensure the MAF	
		ure (the bottom number) less		space to document the necess	-
	than 50 or heart rate	less than 60.		parameters. Any MARs that di include a space to document t	
	Resident #24's electr	onic Medication		necessary parameters were up	
	Administration Recor	d (eMAR) revealed that the		allow for accurate documentat	
		e 25 mg three times per day			
		and 10:00 PM with the		All licensed nurses were educa	
		systolic blood pressure less blood pressure less		4/17/25 by the Administrator, I Nursing, Assistant Director of I	
		n 60 were electronically		and Staff Development Nurse	
	signed as given. The			maintaining accurate medical	
	recorded for each do	se administered. The		medication administration and	
		e was no pulse or heart rate		documentation.	
	recorded.			Education to include maintaini	na acquirata
	Review of Resident #	#24's electronic health record		Education to include maintaini medical records, medication	
		no pulse or heart rate results		administration and documenta	tion will be
	recorded at 6:00 AM,	2:00 PM or 10:00 PM in the		included in orientation of all ne	
	vital sign record for M	larch 2024.		licensed nurses.	
		nducted with Nurse #5 on		Beginning the week of 4/28/25	
		Nurse #5 reviewed the order he parameters to hold the		Director of Nursing or Assistan Nursing will audit the MARs of	
	-	-			
		ure to be recorded but a		medications with parameters to	
	pulse was not require	ed when documenting the		the MAR has space to allow for	r
		medication hydralazine.		documentation of necessary p	
	medication. Nurse # required blood press pulse was not require administration of the Nurse #5 stated that	5 stated that the computer ure to be recorded but a ed when documenting the		with new orders for blood pres medications with parameters to the MAR has space to allow for	sure o ensure or arameters, ily weights.

Facility ID: 953293

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ATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	<u>0. 0938-039</u> E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
						С
		345234	B. WING			/10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HARBOR	VIEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 842	Continued From page	> 84	F 842			
1 042	require the pulse to b stated that she used a cuff to obtain a blood administering Reside the cuff also displaye she checked the bloo to administering the n there wasn't a place of pulse. An interview was con 4/2/25 at 4:30 PM. N assigned to Resident PM Monday through the order for hydralaz hold the medication. order did not require to recorded but she obta administering the met- was an error that the	e documented. Nurse #5 an automatic blood pressure pressure prior to nt #24's hydralazine and that d a pulse. Nurse #5 stated d pressure and pulse prior nedication per order but on the eMAR to record the ducted with Nurse #9 on furse #9 stated she was #24 from 3:00 PM to 11:00 Friday. Nurse #9 reviewed tine and the parameters to Nurse #9 stated that the the pulse (heart rate) to be ained a pulse prior to dication. Nurse #9 stated it order did not require the	Г 042	 weekly x 12 weeks. Any discreption be corrected immediately with re-education being done by the Nursing to the party responsible. The audit findings will be report Director of Nursing to the QAP monthly for a minimum of three. 	e Director of le. ted by the I committee	
	4/3/25 at 10:35 AM. assigned to Resident PM and 11:00 PM to she checked Residen prior to administering not record it. The eM pulse be recorded bu administering the me she was aware there the medication based Nurse #8 stated that recorded but she did	ducted with Nurse #8 on Nurse #8 stated she was #24 from 3:00 PM to 11:00 7:00 AM. Nurse #8 stated at #24's pulse (heart rate) the hydralazine but she did IAR did not require that a t she obtained it prior to dication. Nurse #8 stated was a parameter for holding I on the pulse reading. the pulse should have been not correct the a anyone about correcting it.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345234	B. WING		-	C 04/10/2025		
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
HARBORVIEW LUMBERTON					LUMBERTON, NC 28358	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 842	was a nurse that work from 7:00 AM to 7:00 she recalled administe hydralazine as orderer were parameters for h based on the blood pr Nurse #7 stated she of administering Resider checking to ensure th parameter. Nurse #7 require the pulse to be asked anyone about of Attempts were made interview Nurse #3 wi return call received. If Resident #24 on Satu 7:00 AM to 3:00 PM. An interview with the Administrator on 4/3/2 they expected that me transcribed correctly a appropriately. The Do when she transcribed that she did not enter the pulse or heart rate administered. An interview with the at 3:00 PM revealed t parameters to hold a pressure or pulse rear prior to administering recorded. The Nurse	Aced Saturdays and Sundays PM. Nurse #7 indicated ering Resident #24's ed and was aware there holding the medication ressure and pulse prior to int #24's hydralazine after at it was within the stated the eMAR did not e recorded and she had not correcting it. on 4/2/25 and 4/3/25 to th messages left and no Nurse #3 was assigned to ardays and Sundays from Director of Nursing and 25 at 2:50 PM revealed that edication orders would be and would be documented ON stated it was an error the order for hydralazine the requirement to record e when the medication was Nurse Practitioner on 4/3/25 hat when an order had medication for a blood ding, the readings obtained the medication should be Practitioner stated that the ded prior to administering	F	842				

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		ID HUMAN SERVICES				FORM	05/13/2025 APPROVED
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
345234			B. WING	_	C 04/10/2025		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
HARBOR	/IEW LUMBERTON			1555 WILLIS AVENUE LUMBERTON, NC 2835	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	 2.) Resident #17 was 1/3/25 with diagnosis failure and chronic kind A physician's order day was to obtain daily we heart failure. Review of the Medica (MAR) dated March 2 revealed the following 3/01/25 weight 318.6 by Nurse #7 3/02/25 weight 292 lb 3/09/25 weight 292 lb 3/15/25 weight 292 lb 3/16/25 weight 292 lb 3/22/25 weight 292 lb 3/23/25 we	admitted to the facility on including congestive heart dney disease. Ated 3/1/25 for Resident #17 eights due to congestive tion Administration Record 2025 for Resident #17 g weights recorded: pounds (lbs.) documented lbs. documented by Nurse s. documented by Nurse #7 s. documen	F 842				

Facility ID: 953293

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/13/2025 APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
345234			B. WING			-	C 04/10/2025		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE			
HARBORVIEW LUMBERTON					555 WILLIS AVENUE UMBERTON, NC 28358	i -			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page 87 weights.		F	842					
	PM with the Director of the Administrator. The both stated that Nurse	ducted on 04/03/25 at 3:33 of Nursing (DON) along with e DON and Administrator e #7 should have obtained recorded accurate weights dical record.							

Facility ID: 953293

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