PRINTED: 07/11/2023 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED	
		345072	B. WING _				C / 15/2023
	ROVIDER OR SUPPLIER A RIVERS NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	investigation survey through 05/11/23. Tompliance with the	ecertification and complaint was conducted on 05/08/23 The facility was found in requirement CFR 483.73, edness. Event ID # MCVN11.	F	000			
	to conduct a recertif investigation survey Additional information Therefore, the exit of Event ID# MCVN11 investigated: NC002	ntered the facility on 05/08/23 fication survey and complaint and exited on 05/11/23. On was obtained on 05/15/23. Hate was changed to 05/15/23. 1. The following intakes were 201767, NC00201835, 0195623, NC00194305 and					
F 578 SS=E	deficiency.	int allegations did not result in cntnue Trmnt;FormIte Adv Dir (i)(8)(g)(12)(i)-(v)	F 5	578			6/10/23
	discontinue treatme to participate in exp formulate an advance §483.10(c)(8) Nothic construed as the rig the provision of medical stream of the stream of th	ight to request, refuse, and/or nt, to participate in or refuse erimental research, and to be directive. Ing in this paragraph should be ht of the resident to receive dical treatment or medical edically unnecessary or					
	inappropriate. §483.10(g)(12) The requirements specif subpart I (Advance (i) These requireme	facility must comply with the ied in 42 CFR part 489,			TITI E		(X6) DATE

Electronically Signed 06/10/2023

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
	345072		B. WING			C 05/15/2023		
	ROVIDER OR SUPPLIER A RIVERS NURSING AN	ID REHABILITATION CENTER		1839 (ET ADDRESS, CITY, STATE, ZIP CODE DNSLOW DRIVE EXTENSION (SONVILLE, NC 28540	, ,	J. 10.2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE	
F 578		ne 1 vritten information to all adult g the right to accept or refuse	F!	578				
	medical or surgical tresident's option, for (ii) This includes a wfacility's policies to ir and applicable State (iii) Facilities are perentities to furnish this legally responsible for requirements of this (iv) If an adult individume of admission ar	reatment and, at the mulate an advance directive. rritten description of the mplement advance directives law. mitted to contract with other information but are still or ensuring that the section are met. Jual is incapacitated at the ind is unable to receive						
	has executed an advance di individual's resident with State law. (v) The facility is not provide this informat or she is able to receive Follow-up procedure the information to the appropriate time.	ate whether or not he or she vance directive, the facility irective information to the representative in accordance relieved of its obligation to ion to the individual once he eive such information. s must be in place to provide individual directly at the						
	Based on records re the facility failed to h in the residents' reco residents. (Resident #21, Resident #47, F Resident #6). Findings included:	eviews and staff interviews, ave Advance Directives (AD) ords for 7 of 7 sampled #49, Resident #95, Resident Resident #58, Resident #84,		Ci Ri Si th th cc ap	578 Request/Refuse/Discontinue reatment; Formulate Advance Dire arolina Rivers Nursing and ehabilitation acknowledges receipt tatement of Deficiencies and proposis Plan of Correction to the extent e summary of findings is factually prect and to maintain compliance oplicable rules and provisions of quite care of residents. The Plan of	of the oses that with		
	01/13/2022.	. I I I I I I I I I I I I I I I I I I I		C	orrection is submitted as a written legation of compliance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			C	
		345072	5072 B. WING		0,	5/15/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0/10/2023	
				1839 ONSLOW DRIVE EXTENSION			
CAROLIN	A RIVERS NURSING	AND REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETION DATE	
F 578	Continued From p	page 2	F 5	78			
	Minimum Data So	et (MDS) dated 04/14/2023					
		nt#49's cognition was severely		Carolina Rivers Nursing an	ıd		
	impaired.			Rehabilitation response to			
				of Deficiencies does not de	note		
		nputerized clinical record for		agreement with the Statem	ent of		
		ealed no advanced directive		Deficiencies nor does it cor			
	noted in the reside	ent's medical record.		admission that any deficien	•		
				Further, Carolina Rivers Nu			
		ent#49's admission's "Receipt		Rehabilitation reserves the	•		
		nowledgments" dated led no note that the resident		any of the deficiencies in the Deficiencies through Inform			
		ite an advance directive or		Resolution, formal appeal p	•		
	refused.	ar advance directive of		and/or any other administra			
	Tordood.			proceeding.	ativo or logar		
	During phone inte	rview with Social Worker (SW)		' "			
		:42 AM, she acknowledged		On 5/9/23, the Admissions	Director		
	there was no note	indicating Resident#49's		informed the resident repre	sentative (RR)		
	representative wa	nted to formulate an advance		for Resident #49 of the righ			
	directive or refuse	ed to formulate one.		an advance directive and p			
				information on advance dire	ectives as		
	_	w with Admission Coordinator		requested.			
		at 1:42 PM, she indicated that		Didt #05 dib			
		e indicating Resident#49's		Resident #95 was discharg	ed from the		
	1 -	inted to formulate an advance ed to formulate one. She		facility on 5/31/23.			
		SW was responsible for		On 5/9/23, the Admissions	Director		
		advance directives were		informed Resident #21 of the			
	_	umented in the resident's		formulate an advance direc	•		
		sed to formulate one.		provided information on ad			
	,			directives as requested.			
	During the intervie	ew with Director of Nursing		·			
		023 at 01:04 PM, she stated		On 5/11/23, the Admissions			
		n's Coordinator (AC)or SW was		informed Resident #47 of the	•		
		viewing the advance directive		formulate an advance direc			
		idents or responsible party		#47 did not wish to formula			
		ion to the facility. She added		directive or receive informa	ition regarding		
		on was that the advanced		advance directives.			
		ave been completed and		Decident #50 h. J.	alina atio		
	i scanned in Reside	ent #49's computerized clinical	1	Resident #58 had advance	unective	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345072 B. WING			C 05/15/2023			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	15/2025
	10115211 011 001 1 2.2.1				839 ONSLOW DRIVE EXTENSION		
CAROLINA	A RIVERS NURSING ANI	D REHABILITATION CENTER			ACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG				(X5) COMPLETION DATE			
F 578	Continued From page	e 3	F t	578			
	record or a note indic to formulate an advar	ating the resident's refusal nce directive.			information reviewed and updated in the medical record.	ne	
	05/09/2023 at 1:30 P directives should hav	vith the Administrator on M, He stated the advanced e been completed and #49's clinical record or a II.			Resident #84 was discharged from the facility on 5/16/23. On 5/9/23, the admissions director informed Resident #6 of the right to formulate an advance directive and		
	2- Resident #95 was 04/12/2023.	admitted to the facility on			provided information on advance directives as requested.		
		MDS) dated 04/12/2023 5's cognition was intact.			On 5/9/23, the Admissions Director and the Assistant Director of Nursing (ADC initiated an audit of all residents' medic records to ensure documentation was	N)	
		terized clinical record for d no advanced directive s medical record.			present regarding the discussion of a resident's right to formulate, or decline establish, an advance directive. The au will be completed by 6/10/23. Any		
	of information Acknow 04/12/2023 revealed	#95's admission's "Receipt vledgments" dated no note that the resident an advance directive or			concerns identified during the audit will immediately addressed by the Admissi Director, ADON, and/or the Administra to include providing advance directive information with documentation in the medical record as applicable.	ons	
	on 05/09/23 at 10:42 there was no note inc representative wante directive or refused to	w with Social Worker (SW) AM, she acknowledged licating Resident#95's d to formulate an advance o formulate one. with Admission Coordinator			On 5/22/23, the facility nurse consultar in-serviced the Administrator, Director Nursing (DON), Assistant Director of Nursing (ADON), Social Worker (SW), nurse managers, Medical Record Director, and Admissions Director on		
	(AC) on 05/09/23 at 1 there was no note inc	:42 PM, she indicated that licating Resident#95's d to formulate an advance o formulate one. She ' was responsible for			Advance Directives with emphasis on resident's rights to formulate, or decline establish, an advance directive and to provide documentation in the medical record of discussion with the resident and/or resident representative; All	e to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, , ,	(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 05/15/2023	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP	•	371372023	
				1839 ONSLOW DRIVE EXTENSION			
CAROLINA	A RIVERS NURSING AN	D REHABILITATION CENTER		JACKSONVILLE, NC 28540			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 578	Continued From page	e 4	F 5	78			
	reviewed and documerecord if they refused	ented in the resident's to formulate one.		residents with established directives must have a cop medical record. All newly administrators, DONs, AD	py in the hired		
	(DON) on 05/09/2023 that the Admission's or responsible for review forms with the reside during the admission	with Director of Nursing B at 01:04 PM, she stated Coordinator (AC)or SW was ving the advance directive nts or responsible party to the facility. She added		Nurse Managers, Medical Directors, and Admissions receive the in-service on A Directives during orientatic Development Coordinator consultant.	Records Directors will Advance on by the Staff		
	that the expectation was that the advanced directive should have been completed and scanned in Resident #95's computerized clinical record or a note indicating the resident's refusal to formulate an advance directive. During the interview with the Administrator on 05/09/2023 at 1:30 PM, He stated the advanced directives should have been completed and scanned in Resident #95's clinical record or a note indicating refusal.			On 5/30/23, the administrate letters to all resident repre (RRs) regarding advance information and contact in additional resources.	esentatives directive		
				On 6/2/23, the Admissions the ADON initiated an aud with an advance directive ensure a copy of the adva present in the medical rec will be completed by 6/10/concerns identified during	lit of all residents established to ince directive is ord. The audit '23. Any		
	08/18/2015.	admitted to the facility on		immediately addressed by Director, ADON, and/or th	the Admissions e Administrator		
	directive/advance car 11/10/2020 revealed wanted to formulate a	#21's admission's advanced re planning summary dated no note that the resident an advance directive or		to include entering advance documentation in the med applicable.	ical record as		
		ectives. It was left blank.		The Medical Records Dire	and/or the		
		MDS) dated 08/18/2023 21's cognition was intact.		Admissions Director will re admissions during Interdis Meeting (IDT) 5 times a w	ciplinary Team		
		terized clinical record for ed no advanced directives smedical record.		then monthly x 1 month, u Advance Directive Monitor audit is to ensure that the reviewed advance directiv	tilizing the ring Tool. This Social Worker		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343072	1 2:		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	15/2023
NAME OF FI	NOVIDER OR SUFFLIER						
CAROLINA	A RIVERS NURSING AN	D REHABILITATION CENTER			839 ONSLOW DRIVE EXTENSION IACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page	e 5	F 5	578			
	During an interview we condinate that there we reviewed and documer record if they refused. During telephone interview and of or mulate an advancefusal. During the interview of the Administrator on they stated that the Administrator on the Administrator	with Resident #21 on ed she did not remember directives on admissions or facility. With the Admission /2023 at 10:56 AM, she was no note indicating to formulate an advance of formulate one. She call Worker was responsible advance directives were ented in the resident's to formulate one. Enview with the Social Worker 29 AM, she acknowledged dicating Resident #21 wanted fince directive or a note of with Director of Nursing and 05/09/2023 at 11:39 AM, dmission's Coordinator were responsible for e directive forms with the ble party during the ity. They also added should have been completed dent #21's computerized of the indicating the resident's			regarding the right to formulate, or decto establish, an advance directive with resident and/or resident representative and documentation was provided in the medical record. The Medical Records Director, Admissions Director, and/or on the number of the Advance Directive Monitoring Tool 5 times a weak weeks, then monthly x 1 month, to ensure all concerns are addressed. The DON will forward the results of the Advance Directive Monitoring Tool to the Executive Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QI Committee will meet mor x 2 months and review the Advance Directive Monitoring Tool to determine trends and / or issues that may need further interventions put into place and determine the need for further and / or frequency of monitoring.	the e QI ce ek x e ne	
	10/19/2022.	admitted to the facility on IDS) dated 03/10/2023					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345072	B. WING		05/15/2023	
	ROVIDER OR SUPPLIER A RIVERS NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 578	Continued From pag	ge 6	F 578	3		
	indicated Resident a cognitively impaired					
	medical record reve	esident #47's electronic aled there was no esident #47's advanced				
	Responsible Party (interview with Resident #47 RP) on 05/09/2023 at 08:40 to answer any questions #47.				
	indicated that there Resident #47 or the formulate an advance formulate one. She Worker was response advance directives of	9/2023 at 10:56 AM, she was no note indicating Responsible Party wanted to ce directive or refused to indicated that the Social sible for ensuring that the were reviewed and resident's record if they				
	on 05/09/2023 at 11 she had not written #47 or the Respons	terview with the Social Worker :09 AM, she acknowledged any notes indicating Resident ible Party wanted to formulate e or refused to formulate one.				
	the Administrator or they stated that the and/or Social Worke reviewing the advar residents or respons admission to the fact advanced directives	with Director of Nursing and 105/09/2023 at 11:39 AM, Admission's Coordinator er were responsible for ace directive forms with the sible party during the cility. They also added should have been completed aident #47's computerized				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345072	B. WING _		0	C 5/15/2023	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578		ge 7 note indicating the resident's an advance directive.	F 5	78			
	5- Resident #58 wa 10/08/2021.	s admitted to the facility on					
		(MDS) dated 02/17/2023 #58's cognition was severely					
	revealed no docum	esident #58's electronic file entation that the resident e an advance directive or					
	on 05/09/2023 at 10 there was no note in Responsible Party of advance directive of She indicated that the tresponsible for ensidirectives were review.	with Admission Coordinator 0:56 AM, she indicated that ndicating Resident #58 or the wanted to formulate an or refused to formulate one. The Social Worker was uring that the advance sewed and documented in the they refused to formulate one.					
	on 05/09/2023 at 1°she had not written #58 or the Respons an advance directive During the interview the Administrator of they stated that the and/or Social Work reviewing the advantage of the state of	interview with Social Worker 1:09 AM, she acknowledged any notes indicating Resident sible Party wanted to formulate re or refused to formulate one. with Director of Nursing and n 05/09/2023 at 11:39 AM, Admission's Coordinator er were responsible for nce directive forms with the sible party during the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345072	B. WING		05/15/2023	
	ROVIDER OR SUPPLIER A RIVERS NURSING A	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 00.10.2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 578	advanced directives and scanned in Re- clinical record or a	age 8 cility. They also added s should have been completed sident #58's computerized note indicating the resident's an advance directive.	F 5	78		
	3/21/2023. Minimum Data Set indicated Resident Review of the compression of the resident #84 reveal noted in the resident 05/09/2023 at 8:20 did not remember of on admission to the During an interview on 05/09/2023 at 10 there was no note in to formulate an advisormulate one. She Worker was responsadvance directives documented in the refused to formulate During telephone in 05/09/2023 at 11:05/09/2023 at 11:05	with Resident #84 on AM, Resident #84 stated he discussing advanced directives e facility. with Admission Coordinator 0:56 AM, she indicated that indicating Resident #84 wanted wance directive or refused to indicated that the Social insible for ensuring that the were reviewed and resident's record if they				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345072	B. WING		C 05/15/2023
	ROVIDER OR SUPPLIER A RIVERS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	1 00/10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 578	the Administrator on they stated that the A and/or Social Worker reviewing the advance residents or responsi admission to the facil advanced directives and scanned in Residential record or a not refusal to formulate a 7 - Resident #6 was a 5-15-12 with diagnos respiratory failure. He Set (MDS) indicated a Record review did not directives for Resident about advanced directives for Resident admission Coordinate admission packet. She form used to communicare. During an interview of Administrator revealed discussed with the adsaid they had an advifacility would ask their admission coordinated	with Director of Nursing and 05/09/2023 at 11:39 AM, dmission's Coordinator were responsible for se directive forms with the ble party during the ity. They also added should have been completed dent #84's computerized of indicating the resident's in advance directive admitted to the facility on ses that included chronic er quarterly Minimum Data she was cognitively intact. It indicate advanced in #6. In 5/9/23 at 11:00 AM, the or revealed information ctives was discussed in the se did not have an additional nicate preferences regarding In 5/11/23 at 1:00 PM, the sed advanced directive were dmission packet. If a resident anced directive in place, the more to bring it in. The or discussed advanced have written documentation	F 57	78	
F 609 SS=D	Reporting of Alleged CFR(s): 483.12(b)(5)		F 60	09	6/10/23
	3 .00.12(0) III 100poil	to the same game to or ababe,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345072	B. WING_		C 05/15/2023
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	03/13/2023
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 609	must: §483.12(c)(1) Ensure involving abuse, neg mistreatment, includi source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause abuse and do not rest the administrator of tofficials (including to adult protective servi for jurisdiction in long accordance with Stat procedures. §483.12(c)(4) Report investigations to the designated representaccordance with Stat Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on staff intervalue involved the state of t	e that all alleged violations lect, exploitation or ng injuries of unknown priation of resident property, ately, but not later than 2 lation is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ces where state law provides perform care facilities) in the law through established. The results of all administrator or his or her tative and to other officials in the law, including to the State of the leged violation is verified the action must be taken. It is not met as evidenced views, and record reviews, ubmit an initial allegation	F 6	F 609 Reporting of Alleged Violation	ns
		gation report to the state of 3 sampled residents ewed for abuse.		Carolina Rivers Nursing and Rehabilitation acknowledges receipt Statement of Deficiencies and proporthis Plan of Correction to the extent the summary of findings is factually correct and to maintain compliance	oses that
		policy revised on 10/15/22 t, or Misappropriation of		applicable rules and provisions of que of care of residents. The Plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING			С		
	20,4252.02.01221.52	345072	D. WING _		TDEET ADDRESS SITU STATE TIP SODE	05/	15/2023	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLIN	A RIVERS NURSING AN	D REHABILITATION CENTER			839 ONSLOW DRIVE EXTENSION			
				J	ACKSONVILLE, NC 28540			
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F 609	Continued From page	e 11	F 6	509				
	Resident Property Po	olicy," revealed under			Correction is submitted as a written			
	subheading "Reportir				allegation of compliance.			
		sure all allegation that						
		sults in serious bodily injury,			Carolina Rivers Nursing and			
	state agency, adult p	rotective services are			Rehabilitation response to this Stateme	ent		
	notified immediately l	out no later than 2 hours			of Deficiencies does not denote			
	after the allegation is	received, and determination			agreement with the Statement of			
	of alleged abuse is m	ade. For all allegations that			Deficiencies nor does it constitute an			
		or result in serious bodily			admission that any deficiency is accura	ate.		
	1	tor will ensure that the state			Further, Carolina Rivers Nursing and			
	agencies are notified	no later than 24 hours.			Rehabilitation reserves the right to refu			
					any of the deficiencies in this Statemer	it of		
		dmitted to the facility on			Deficiencies through Informal Dispute			
	06/22/2022 with diag				Resolution, formal appeal procedure			
	1	ne, and a history of falling.			and/or any other administrative or lega	1		
	The resident was disc 08/19/2022.	charged nome on			proceeding.			
					Resident #148 no longer resides in the			
	I .	num Data Set (MDS) dated			facility.			
	06/29/2022 revealed							
		S did not indicate the			The Initial Allegation report for Resider	it		
	resident had any beh	aviorai symptoms			#148 was submitted to the state			
	Pavious of Pagidant#	148's investigation dated			regulatory agency on 5/10/23 at 9:47 a	m.		
	06/23/2022 revealed				The Investigation Report for Resident			
		breast during admission			#148 was submitted to the state			
	exam and called police	-			regulatory agency on 5/12/23 at 10:20	am		
		indicated to the police that			regulatory agency on 0/12/20 at 10:20	aiii.		
	I .	and the nurse was doing her			On 5/19/223, the facility consultant			
	I .	admission assessment.			completed an audit of all events that m	eet		
	After Resident #148 v				criteria for reporting to the state regula			
		a second report for sexual			agency, Health Care Personnel Regist			
	I .	t that happened 06/23/2022			(HCPR), for the past 30 days to include	•		
		summary of investigation			but not limited to, injury of unknown ori			
		ectronic health records,			misappropriation, and abuse. The facili	-		
		lesident #148 medical			consultant also completed an audit of a			
		#1's admission to police that			investigation visits to the facility by the	ĺ		
	1	cur, the facility and police did			police department and/or Adult Protect	ive		
	I .	abuse. Further review of the			Services (APS) for the past 30 days. T			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
							С
		345072	B. WING _			05/	15/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				18	839 ONSLOW DRIVE EXTENSION		
CAROLINA RIVERS NURSING AND REHABILITATION CENTER			J	ACKSONVILLE, NC 28540			
(X4) ID PREFIX			ID PREFI)	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 609	Continued From pag		F 6	609			
	investigation reveale	d that the facility did not			audit is to ensure all reportable events		
	submit the initial repo	ort and the investigation			were reported within the two-hour time	:	
	report to the State Ag	gency.			frame when indicated and that the faci	lity	
					submitted an accurate investigation re	port	
					within 5 days per the HCPR requirement		
					Upon completion of this audit, one eve	nt	
	Resident # 148 was			was identified as meeting the reporting			
	facility and did not answer the phone call.				requirements for Resident #63, regard	ing	
	•	·			misappropriation on 4/16/23. The Initia	-	
	During the interview			Report was submitted to the HCPR on			
	(DON) on 05/10/23 at 11:15 AM, she explained a				5/19/23 and the Investigational Report		
	police officer came to the facility sometime in				with unsubstantiated outcome was		
	June 2022 and said he was investigating a				submitted on 5/24/23 by the administra	ator.	
	complaint from Resid						
	fondling the resident'			On 5/10/23, the facility consultant			
	admission's assessm			completed an in-service with the			
	after resident was dis	scharged on 08/19/2022, she			administrator and the Director of Nursi	ng	
	filed on 10/24/2022 a	second report for sexual			(DON) regarding Health Care Personr	el	
	battery referring to th	e incident that happened in			Registry reportable requirements with		
	June 2022. DON sta	ted the police officer's			emphasis on reporting allegations to		
	investigation conclud	led on June 06/23/2022 the			include but not limited to injury of		
	nurse was doing her	job and the abuse did not			unknown, misappropriation, abuse, po	lice	
	occur. DON indicated	d the police were unable to			visits, and APS investigation visits to t	ne	
	substantiate the alleg	gation. DON reported the			facility within 2 hours when indicated a	ınd	
	facility did not submit the investigation report to				completion of an accurate investigation	า	
	the State Agency after	er the investigation in June			report within 5 days per HCPR		
	2022 and August 202			requirements. All newly hired			
	allegation was resolv	ed. The DON explained that			administrators and/or DONs will be		
	the initial report and	the investigation report			in-serviced during orientation regardin	g	
	should have been se	nt to the State Agency within			Health Care Personnel Registry		
	2-5 days after the co	nclusion of the investigation			reportable requirements.		
	per facility policy.						
					The admissions director and/or the fac	ility	
	During the interview			consultant will review all investigative			
	05/10/23 at 10:35 AM			folders weekly x 4 weeks, then monthl	•		
		as not present at the facility			1 month, utilizing the HCPR Investigat		
	•	lleged allegation of abuse			Monitoring tool. This audit is to ensure		
		22. He explained when an			HCPR reportable events to include inj	ury	
allegation of abuse was made by Resident#148,		as made by Resident#148,			of unknown origin, misappropriation,		

· ,		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING				C 45/2022	
	ROVIDER OR SUPPLIER A RIVERS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540			15/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 609		e 13 ve followed the protocol of and the investigation report	F	609	police visits, APS investigation visits, and/or abuse are reported timely, and a accurate investigative report completed within 5 days per HCPR requirements. The admissions director and/or the faci consultant will address all areas of concern identified during the audit to include reporting initial and investigative reports when indicated and re-training staff. The facility consultant or corporate leadership will review the HCPR Investigation Monitoring tool weekly x 4 weeks then monthly x 1 month to ensurall concerns were addressed. The Administrator will present the finding of the HCPR Investigation Monitoring to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the HCPR Investigation Monitoring tool to determine trends and/or issues that maneed further interventions put into place and to determine the need for further frequency of monitoring.	d llity e e tre ngs pool		
F 759 SS=D	Free of Medication E CFR(s): 483.45(f)(1) §483.45(f) Medication	rror Rts 5 Prcnt or More	F	759			6/12/23	
	The facility must ensu §483.45(f)(1) Medica percent or greater; This REQUIREMENT by:				F 759 Free of Medication Error Rate	s 5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345072	B. WING		0.5	C
NAME OF D	ROVIDER OR SUPPLIER	040072		STREET ADDRESS, CITY, STATE, ZIP CO		5/15/2023
NAIVIE OF F	NOVIDER OR SUFFLIER				DE	
CAROLIN	A RIVERS NURSING	AND REHABILITATION CENTER		1839 ONSLOW DRIVE EXTENSION		
				JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 759	Continued From p	page 14	F 7	F 759		
		cility failed to have a medication han 5% as evidenced by 2		Percent or Greater		
	medication errors gave the facility a This affected 2 of	out of 28 opportunities which medication error rate of 7.14%. 4 residents observed during istration (Resident #31 and		Statement of Deficiencies an this Plan of Correction to the the summary of findings is fa	Carolina Rivers Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually	
	The findings inclu	ded:		correct and to maintain comp applicable rules and provisio of care of residents. The Pla	ns of quality	
	were reviewed, a	May 2023 Physician Orders nd she was prescribed Oyster tamin D 500-200 1 tablet twice		Correction is submitted as a allegation of compliance.	written	
	a day.			Carolina Rivers Nursing and Rehabilitation response to the	is Statement	
	05/10/23 at 9:05 a MT #1 was obser	uinistration was observed on a.m. with Med Tech (MT) #1. wed dispensing Calcium 500mg eation cup and then Resident #31.		of Deficiencies does not den agreement with the Stateme Deficiencies nor does it cons admission that any deficienc Further, Carolina Rivers Nur.	nt of stitute an y is accurate.	
	(eMAR) was revie and Oyster Shell tablet was docum	edication Administration Record ewed on 05/20/23 at 10:10 a.m. Calcium / Vitamin D 500-200 1 ented as having been 95/10/23 by MT #1.		Rehabilitation reserves the ri any of the deficiencies in this Deficiencies through Informa Resolution, formal appeal pri and/or any other administrati proceeding.	ight to refute s Statement of al Dispute ocedure	
	MT #1 stated she medication she al	ewed on 05/10/23 at 10:50 a.m. gave Resident #31 the ways gave her and thought she correct medication.		On 5/10/23, Resident #31 was by the assigned hall nurse at reactions were noted from a the incorrect medication.	nd no adverse	
	were reviewed, a	s May 2023 Physician Orders nd he was prescribed Sodium 8.6-50 2 tablets twice a		On 5/10/23, the assigned nu the physician in the facility of assessment findings for Res new orders were received.	f the	
		ninistration was observed on a.m. with Nurse #1. Nurse #1		On 5/10/23, Resident #35 was		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING _			1	C 15/2023	
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2023		
				1	839 ONSLOW DRIVE EXTENSION			
CAROLINA	A RIVERS NURSING ANI	D REHABILITATION CENTER		J	IACKSONVILLE, NC 28540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 759	F 759 Continued From page 15		F7	F 759				
	was observed dispen medication cup and the Resident #35.	sing Senna 8.6 2 tabs into a nen administered it to			reactions were noted from administering the incorrect medication.	ıg		
	The eMar was review a.m. and Senna-Docutablets was documen administered on 05/1. Nurse #1 was interview a.m. Nurse #1 explairerror as the reason for incorrect medication of the medication of the medication of the medication. He expressed for the medication of the	ewed on 05/10/23 at 10:42 ned it had been human or her administering the to Resident #35. with the Administrator on the Administrator stated it hat nurses and med techs						
					the physician's orders specified on the MAR. No concerns were identified duri the audit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345072	B. WING				C 15/2023
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2023
CAROLIN	A DIVEDO MUDOINO ANI	DELIABILITATION CENTER		183	39 ONSLOW DRIVE EXTENSION		
CAROLINA	A RIVERS NURSING ANI	D REHABILITATION CENTER		JA	CKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	Continued From page	÷ 16	F	759	On 5/19/23, a medication pass audit fo licensed nurses and medication aides vinitiated by the ADON, Quality Improvement (QI) Nurse, and Unit Manager to ensure all medications wer administered according to the physician orders as specified on the MAR. The awill be completed by 6/12/23. Any area concern identified during the audits will immediately addressed by the QI Nurse the ADON, and/or the unit manager to include additional staff training and increased monitoring of medication passes. On 5/19/23, an in-service was initiated the ADON and the facility consultant fo licensed nurses and medication aides the ensure medications were administered correctly utilizing the "5 Rights of Medication Administration," including administering medications according to the physician's orders as specified on the MAR. The in-service will be completed 6/12/23. All newly hired licensed nurses and medication aides will be provided withis in-service by the Staff Development Coordinator (SDC) during orientation. 10% of licensed nurses and medication aides, to include Nurse #1 and Medicat Aide #1, will be audited by the QI Nurse the ADON, and/or the unit manager weekly x 4 weeks, then monthly for 1 month, utilizing a Medication Pass Aud form, to ensure medications are administered according to the physician orders as specified on the MAR. Any areas of concern identified during the	was e n's udit s of be e, by r all co he l by s with ut n tion e, it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345072	B. WING			C 05/15/2023	
NAME OF PROVIDER OR SUPPLIER CAROLINA RIVERS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540	E	03/13/2023	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 759	Continued From page	ge 17	F 7	audit will be immediately addit QI Nurse, the ADON, and/or the manager to include prompt as the involved resident, notifical physician, if applicable, and/or additional staff training. The I Nursing (DON) will review the Pass Audit forms weekly for a monthly for 1 month, to acknow completion of the audit. The administrator and/or the present the findings of the Me Pass Audit forms to the Exect Assurance and Performance Improvement (QAPI) committed for 2 months. Any issues, co and/or trends identified will be by implementing changes as to include continued frequency monitoring. The administrator and the DO responsible for the implement corrective actions to include a audits, in-services, and monitor to the plan of correction.	the unit assessment tion of the providing Director of the Medication will edication utive Qualities addresses accessary, by of DN will be tation of all 100%	of nen	