STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**140 PIRATES ROAD NEW BERN, NC 28562**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 06/21/23 for intake #NC00202671. The complaint was substantiated, with a deficiency cited related to the allegation.	W 000		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to notify 1 of 2 audit clients (#2) guardian of a significant change in a timely manner. The finding is: Review on 6/21/23 of client #2's Hospital Summary on Saturday, 4/8/23 revealed a week ago, his gastrostomy (g) tube had to be changed. Client #2 was sent back to the hospital because the g-tube site was turning red and continued to leak, with chronic drainage. Client #2 was also diagnosed with a urinary tract infection and cellulitis on the abdominal wall and would need a new tube. Review on 6/21/23 of the Nurse's Note for client #2 on Saturday, 4/8/23 on 4:00PM to 5:00PM, Nurse #2 revealed client #2 had moderate amount of gastric juice and blood leaking from gastrostomy site. Skin around the site was broken down and open from gastric juices leakage. Client #2 gestured that he was in pain. The Physician Assistant (PA) was notified and verbally	W 148		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**140 PIRATES ROAD NEW BERN, NC 28562**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 148	Continued From page 1 ordered to send client out to the hospital for further evaluation. A voicemail was left for the Qualified Intellectual Disabilities Professional (QIDP) and attempted to reach Department of Social Services (DSS) but unable to as it was outside of office hours. Nurse #2 revealed she was unable to leave a voice mail on the DSS worker's voicemail. A report was given to the charge nurse. Interview on 6/21/23 with the DSS guardian revealed the facility has been given their contact phone number for after hour emergencies that will require their consent for medical treatment. The guardian revealed her voicemail lists the Craven County sheriff's phone number who must be contacted for after-hours emergencies. The guardian revealed she was never contacted by any staff at the facility regarding client #2's hospitalization. The guardian revealed on 4/12/23 she received a phone call from the hospital, asking her permission to surgically change client #2's g-tube. The guardian also indicated the facility also failed to notify her that client #2 was sent to hospital on 4/2/23. The guardian revealed she had met with the QIDP at the facility recently and insisted her agency be notified. The guardian revealed she gave the QIDP the after-hours emergency contact information to put in client #2's chart. Interview on 6/21/23 with the QIDP. The QIDP revealed someone in nursing left a voicemail for her, the evening of 4/9/23 about client #2 being hospitalized. The QIDP revealed she did not have access to her contact information for DSS at home and could not call the guardian. The QIDP acknowledged she tried to contact the guardian unsuccessfully on Monday, 4/10/23 but did not	W 148		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**140 PIRATES ROAD NEW BERN, NC 28562**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 148	Continued From page 2 know how to make an outgoing call. Interview on 6/21/23 with Nurse #1 revealed she's been instructed to leave a message for DSS outside of business hours and ask them to call the facility back. In addition, Nurse #1 acknowledged DSS normally did not return the call until the next business day. Interview on 6/21/23 with Nurse #2 revealed she was the charge nurse on the Solarium on 4/8/23 and was notified by the med tech that client #2's g-tube was leaking and had blood and stomach contents. Nurse #2 revealed she got orders from the PA to send client #2 to the hospital approximately 8:00AM. In addition, Nurse #2 stated she "believed I talked to someone at DSS" about sending client #2 to the hospital on 4/8/23. Interview on 6/21/23 with the Administrator revealed the nurse should call the guardian when sending a client to the hospital. In addition, the Administrator revealed, if the nurse reached the guardian/DSS's voicemail, after hours, a message should be left to return their call. The Administrator revealed the QIDP should follow up with DSS after the nurse leaves a message on voicemail. The Administrator also revealed the facility was not successful calling the sheriff department for after-hours emergency for clients in DSS custody, because "most of the times, the sheriff thinks we are crazy if we call."	W 148		