DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APP							
	RS FOR MEDICARE	& MEDICAID SERVICES	1	(MB NO.	0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
34G017		34G017	B. WING		C 03/11/2025		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
RIVERBE	IND			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 X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMEN	rs	W 0	00			
	3/11/25 for intakes #NC00227381. Th						
W 189			W 1	89			
	initial and continuin employee to perfor efficiently, and com This STANDARD i Based on observat interview the facility sufficiently trained t	s not met as evidenced by: tion, record review and / failed to ensure staff were to meet with needs of 1 of 2 relation to wheelchair					
	utilized a motorized throughout the facil observed sitting on	10/25 revealed client #1 I wheelchair for ambulation lity. Client #1 was also top of a blue sling placed in used for lift transfers.					
	Program Plan (IPP #1 continues to be environment using	of client #1's Individualized) dated 7/2/24 revealed client able to navigate his his motorized wheelchair. Iff assistance for all grooming, ng activities.					
	were times he will u	5 with client #1 revealed there urinate on himself while sitting					
LABORATORY	UIRECTOR'S OR PROVIL	DER/SUPPLIER REPRESENTATIVE'S SIG	NALUKE	TITLE		(X6) DATE	

DRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 03/13/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 34G017 B. WING 03/11/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 140 PIRATES ROAD NEW BERN, NC 28562 140 PIRATES ROAD NEW BERN, NC 28562			AND HUMAN SERVICES				FORM	03/13/2025 APPROVED 0938-0391		
346017 B. WING 03/11/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RIVERBEND STREET ADDRESS, CITY, STATE, ZIP CODE (%1) ID PREFIX COMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLUTION OR LSD DENTIFYING INFORMATION) PROVIDER STATE CONSTRUCTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLUTION OR LSD DENTIFYING INFORMATION) PREFIX PREFIX PROVIDER STAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLUTION OR LSD DENTIFYING INFORMATION) PREFIX PREFIX PROVIDER STAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLUTION OR LSD DENTIFYING INFORMATION) PREFIX PREFIX PROVIDER STAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLUTION OR LSD DENTIFYING INFORMATION) PREFIX PREFIX PROVIDER STAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLUTION OR LSD DENTIFYING INFORMATION) W 189 W 189 Continued From page 1 in his wheelchair and it would take staff quite a while to change him. Client #11 state up if staff ever cleaned his wheelchair a lot of concerns regarding client #11 s us so . W 189 W 189 Image: client wheelchair a lot of concerns regarding client #11 s us so . Image: client wheelchair a lot of concerns regarding client #11 s us so . Image: client wheelchair a lot of	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
Interview on 3/10/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure how often the client #1's care. She visited client #1 sheelchair and the suing that client #1 sits on. W 189 W 189 Interview on 3/10/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure how often the client #1's care. She visited client #1 sheelchair swere cleaned. The facility had a form that staff were to use to document due was not sure as to wheelchair calaning form howevers the beleved the supervisors to ensure the forms are completed. W 189	34G017			B. WING						
RVERBEND NEW BERN, NC 28562 (M) D PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECT WAS THE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENS PLAN OF CORRECTION TAG PROVIDENS PLAN OF CORRECTION (EACH CORRECT VALCTORY PROCESS TO THE APPROPRIATE DEFICIENCY) OME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OME DEFICIENCY) W 189 Continued From page 1 in his wheelchair and it would take staff quite a while to change him. Client #1 stated he was not sure if staff ever cleaned his wheelchair. He further stated staff would leave his wheelchair. against the wall in his bedroom each night. W 189 W 189 Interview on 3/10/25 with the local Department of Social Services representative revealed she has a lot of concerns regarding client #1's care. She visited client #1 recently and there was a very strong urine odor that she believed to be coming from his wheelchair and the sling that client #1 sits on. Interview on 3/10/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure how often the clients wheelchairs have been cleaned. However, it is the responsibility of the supervisors to ensure the forms are completed. Interview on 3/10/25 with the Administrator revealed she was not sure how often staff cleaned the clients wheelchair. Usually the Habilitation Assistant would check client #1's chair each morning but she was not sure as to when his chair or sling was last cleaned. They previously documented this information on a wheelchair cleaning form however she believed they stopped using the form a while ago. W 249	NAME OF F	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION INFORMATION W 189 Continued From page 1 in his wheelchair and it would take staff quite a while to change him. Client #1 stated he was not sure if staff ever cleaned his wheelchair against the wall in his bedroom each night. W 189 Interview on 3/10/25 with the local Department of Social Services representative revealed she has a lot of concerns regarding client #1's care. She visited client #1 recently and there was a very strong urine door that she believed to be coming from his wheelchair and the sling that client #1 sits on. Interview on 3/10/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure how often the clients wheelchairs wave cleaned. The facility had a form that staff were locaned. However, it is the responsibility of the supervisors to ensure the forms are completed. Interview on 3/10/25 with the Administrator revealed she was not sure how often staff cleaned the clients wheelchair, Shave been cleaned. However, it is information on a wheelchair cleaning form however she believed they stopped using the form a while ago. W 249	RIVERBE	IND								
in his wheelchair and it would take staff quite a while to change him. Client #1 stated he was not sure if staff ever cleaned his wheelchair. He further stated staff would leave his wheelchair against the wall in his bedroom each night. Interview on 3/10/25 with the local Department of Social Services representative revealed she has a lot of concerns regarding client #1's care. She visited client #1 recently and there was a very strong urine odor that she believed to be coming from his wheelchair and the sling that client #1 sits on. Interview on 3/10/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure how often the clients wheelchairs were cleaned. The facility had a form that staff were to use to document once the wheelchairs have been cleaned. However, it is the responsibility of the supervisors to ensure the forms are completed. Interview on 3/10/25 with the Administrator revealed she was not sure how often staff cleaned the clients wheelchair. Usually the Habilitation Assistant would check client #1's chair each morning but she was not sure as to when his chair or sling was last cleaned. They previously documented this information on a wheelchair cleaning form however she believed they stopped using the form a while ago. W 249 PROGRAM IMPLEMENTATION	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION		
As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed		in his wheelchair ar while to change him sure if staff ever cle further stated staff y against the wall in h Interview on 3/10/2 Social Services rep a lot of concerns re visited client #1 rec strong urine odor th from his wheelchair sits on. Interview on 3/10/2 Disabilities Profess not sure how often cleaned. The facilit use to document or cleaned. However, supervisors to ensu Interview on 3/10/2 revealed she was n cleaned the clients Habilitation Assistan chair each morning when his chair or sl previously document wheelchair cleaning they stopped using PROGRAM IMPLE CFR(s): 483.440(d)	and it would take staff quite a an. Client #1 stated he was not eaned his wheelchair. He would leave his wheelchair his bedroom each night. 5 with the local Department of oresentative revealed she has garding client #1's care. She eently and there was a very hat she believed to be coming r and the sling that client #1 5 with the Qualified Intellectual ional (QIDP) revealed she was the clients wheelchairs were ty had a form that staff were to have the wheelchairs have been it is the responsibility of the ure the forms are completed. 5 with the Administrator hot sure how often staff wheelchair. Usually the nt would check client #1's but she was not sure as to ling was last cleaned. They nted this information on a g form however she believed the form a while ago. MENTATION 0(1) rdisciplinary team has s individual program plan, ceive a continuous active							

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

Facility ID: 942020

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES				FORM	03/13/2025 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G017			B. WING			C 03/11/2025	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERBE	END				40 PIRATES ROAD IEW BERN, NC 28562		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	interventions and se and frequency to su objectives identified plan.	ervices in sufficient number upport the achievement of the I in the individual program	W 2	249			
	Based on record re facility failed to ensu- received continuous of interventions and	s not met as evidenced by: eview and staff interviews, the ure 1 of 2 audit clients (#1) s active treatment consisting d services as identified in their plan (IPP) in the area of e finding is:					
	an IPP dated 7/2/24 assistance for all gr activities. He shoul assist with groomin hand. Client #1 rec	of client #1's record revealed 4 revealed client #1 needs staff rooming, dressing and bathing d be encouraged to actively g and dressing using his left ceives a pan bath in the bath in the evening.					
	receives pan baths while laying in his b to receive a tub bat been over a month tub bath. He also do often. Staff washed while giving him a p further stated that s	5 with client #1 revealed he in the morning and at night, ed. However, he is supposed h at night. Client #1 stated it's since he's had a shower or besn't get his hair washed d his hair every now and again ban bath in bed. Client #1 cometimes he will urinate on i n his wheelchair and it would hile to change him.					
	Social Services rep a lot of concerns re	5 with the local Department of resentative revealed she has garding client #1's care. She ently and there was a very					

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

Facility ID: 942020

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES			FORM	: 03/13/2025 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DAT COM	(X3) DATE SURVEY COMPLETED		
		34G017	B. WING			C 03/11/2025	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
RIVERBE	END			140 PIRATES ROAD NEW BERN, NC 28562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
W 249		•	W 24	9			
	strong urine odor that she believed to be coming from his wheelchair and the sling that client #1 sits on. She also stated she was informed that client #1 only receives pan bath while in bed but never tub baths or showers.						
	Interview on 3/10/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she received an email from client #1's guardian stating the high school notified her of concerns regarding client #1's personal hygiene. Prior to this email, she had no knowledge that the school had concerns. The school contacted her in January 2025 to inform her that client #1 needed a change of clothes brought to the school and since then the facility has sent extra clothes with him to school each day. She stated that she was not aware that client #1 wasn't receiving a shower or tub bath at night. She further confirm staff should be following client #1's IPP as written.						
	revealed she was n providing a shower just informed as of provide pan baths t	5 with the facility Administrator not aware that staff were not or tub bath at night. She was 3/10/25, that staff were only o client #1. She confirmed owing client #1's IPP as written.					

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

Facility ID: 942020

If continuation sheet Page 4 of 4