STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345072	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carolina Rivers Nursing and Rehabilitation Center	1839 Onslow Drive Extension Jacksonville, NC 28540

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43798 Based on record review and staff interviews, the facility failed to prevent a resident from rolling off the bed during care which resulted in an abrasion of the posterior scalp and left ankle soft tissue swelling from a fall for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE]. Her diagnoses included hemiplegia following cerebral infarction (stroke) affecting left side. Resident #1 ' s care plan, initiated 1/3/24 had a care focus area of activities of daily living/ personal care with one of the interventions noted as totally dependent on two-person assistance for bed mobility initiated 5/27/24. Resident #1 ' s quarterly Minimum Data Set Assessment (MDS) dated [DATE] coded the resident as moderately cognitively impaired and dependent with toileting and rolling left and right in bed. Resident #1 ' s medication administration record (MAR) dated August 2024 revealed Resident #1 received acetaminophen oral suspension (325 milligram/10.15 milliliter) 20 milliliters on 8/25/24 at 4:45 PM for 4/10 pain, 8/26/24 at 10:41 AM for 2/10 pain, 8/28/24 at 9:28 PM for 5/10 pain, and on 8/30/24 at 10:14 PM for 3/10 pain level. Prior to the fall Resident #1 received acetaminophen on 8/7/24 at 12:22 AM for 3/10 pain and on 8/15/24 at 10:25 PM for 5/10 pain level. The MAR also revealed Resident #1 was on Eliquis (blood thinner) 2.5 milligram twice a day. An incident report dated 8/25/24 stated NA #1 called to Nurse #1 stating that Resident #1 had fallen out of bed while being changed. When Nurse #1 entered the room, Resident #1 was on her back on the floor between Resident #1 ' s bed and roommate's bed. Resident #1 ' s bed was at a height of 2 feet. Resident was alert and able to answer questions. Resident #1 was assessed by Nurse #1 for pain/injury. Resident reported no pain. Upon assessment Resident #1 showed no facial grimacing or verbal cue for pain. Resident #1 vital signs were obtained, and nursing staff assisted Resident #1 back to bed. Upon transfer back to the bed scant blood was observed on Resident #1 ' s bed pillow. Nurse #1 observed dime size opening to Resident ' s right posterior head and minimal bleeding noted. On call provider was notified and advised Resident #1 to be sent to the emergency department (ED) for further evaluation. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated Interview statement written by Nursing Assistant #1 (NA #1) indicated alleged occurrence date: 8/25/24 and alleged occurrence time: 3:40 AM. The statement indicated NA #1 was doing her rounds and at around 3:40 AM she entered Resident #1 ' s room and Resident #1 told her she was soiled. NA #1 began performing incontinence care. Resident #1 was laying on her side facing away from NA #1 who was holding the Resident with her left hand and cleaning her with her right hand. Resident #1 tensed up which caused her to grab the side of the bed and her body to move forward and away from NA #1 and she rolled off the bed. NA #1 tried to stop the fall, but she was unable to. She immediately alerted Nurse #1 who came to assess Resident #1. Hospital discharge summary dated 8/25/24 indicated Resident #1 was seen at the emergency department (ED) on 8/25/24 for a fall after being rolled out of bed in a nursing home. The note indicated Resident #1 was complaining of right shoulder and left ankle pain. X-ray of the chest and right shoulder, computed tomography (CT) scan of the head and cervical spine completed at the ED showed no acute significant findings. X- ray of left ankle showed soft tissue swelling. Clinical impression on the discharge plan indicated acute pain of right shoulder, acute left ankle pain and fall. Resident #1 ' s ED discharge instructions dated 8/25/24 indicated Resident was seen at the ED on 8/25/24 for acute pain of right shoulder, acute left ankle pain, fall, and abrasion of scalp. The discharge instructions indicated give Tylenol/ ibuprofen every 6-8 hours for ankle pain, clean right posterior scalp abrasion with soap and water and follow up with primary care provider the next day. Facility Nurse Practitioner (NP) progress note dated 8/26/24 indicated Resident #1 was seen by the NP for assessment following return from ED consult for right shoulder/left ankle pain following fall. The note indicated Resident #1 was alert, at baseline medication (no new added medications) without signs of distress and denied pain at the time of the assessment. The note further indicated fall precautions reviewed, ED consult notes reviewed and fall precautions reiterated with Resident #1 and nursing staff. During an interview on 10/1/24 at 12:36 PM with Nurse #1, she revealed she was the primary nurse for Resident #1 when the resident fell off the bed on 8/25/24. She indicated she became aware of the fall after Nursing Assistant (NA #1) called for assistance from Resident #1's doorway. When she walked into the room, Resident #1 was on the floor between her bed and her roommate ' s bed. Resident #1 stated she was cold, her back hurt and asked to get off the floor. After they transferred Resident #1 back to bed, Nurse #1 noticed a trace amount of blood on the pillow and realized the Resident had hit her head. Nurse #1 notified the on-call physician who gave orders for Resident to be transferred to the ED for further evaluation. She called emergency services who came to transport Resident #1 to the hospital. During an observation on 10/1/24 at 2:00 PM, Resident #1 was observed in bed on a low wing mattress and her bed was noted to be in the lowest position. Resident #1 did not appear to be in any pain or distress. She denied pain when asked if she was in any pain and attempts to carry on conversation were unsuccessful. Attempts to interview NA # 1 were unsuccessful. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 12:54 PM with the Assistant Director of Nursing (ADON), he indicated Resident #1 fell while being provided incontinent care by NA #1. The ADON stated Resident #1 was care planned for two-person assistance and NA #1 should have ensured there were two people in the room to provide incontinence care. The ADON indicated Resident #1 had not had a change in activity level after the fall. An interview was conducted with the Director of Nursing (DON) and the facility Administrator on 10/1/24 at 2:20 PM. The DON stated NA #1 should have had assistance in the room to provide incontinence care for Resident #1. She also stated NA #1 should have looked at the care plan because Resident #1 was care planned for two-person assist.