STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Trace Nursing and Rehabilitation Center	250 Lovers Lane Washington, NC 27889

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and resident interviews, the facility failed to treat a resident with dignity and respect when a staff member did not knock or announce their presence before entering a resident's room (Resident #49) and failed to maintain residents' dignity when a resident had an uncovered urinary catheter drainage bag, leaving the urine visible to the public (Resident #7). The reasonable person concept was applied for Resident #7 as individuals have the expectation of being treated with dignity and would not want urine visible to visitors, staff and other residents. This was for 2 of 7 residents reviewed for dignity (Resident #49, Resident #7).Findings included: 1. Review of Resident #49’s Minimum Data Set assessment dated [DATE] revealed she was assessed as cognitively intact. During observation on 8/19/25 at 8:08 AM Housekeeper #1 was observed to enter Resident #49’s room without knocking or announcing her presence. Resident #49 was in the bed closest the door and the door was fully open during this observation. During an interview on 8/19/25 at 8:10 AM Housekeeper #1 stated if the residents were already awake, she did not need to knock or announce her presence before entering their room but if they were asleep, she knocks. During an interview on 8/19/25 at 8:12 AM Resident #49 stated she would prefer staff knock or announce their presence before entering her room because she liked to know who was in her room and what they were doing. During an interview on 8/19/25 at 2:54 PM the Housekeeping Supervisor stated staff were to always announce their presence before entering a resident's room including if the resident was awake. During an interview on 8/19/25 at 3:03 PM the Administrator stated staff were always to knock or announce their presence prior to entering resident rooms. 2. Resident #7 was admitted to the facility on [DATE] with diagnoses that included obstructive uropathy and non-Alzheimer’s dementia. Resident #7’s comprehensive care plan initiated 7/24/25 revealed he required an indwelling urinary catheter. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5-day Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 revealed he was moderately cognitively impaired and had an indwelling urinary catheter. An observation conducted on 8/18/25 at 11:45 AM revealed Resident #7 walked around the day room and a urinary catheter bag which contained urine, hung on the right side of his walker. The urine in the bag was visible. There were several residents, a visitor and staff in the day room. An observation was conducted on 8/18/25 at 12:40 PM. Resident #7 was in the day room and a urinary catheter bag hung on the right side of his walker. The urinary catheter bag was one-quarter full of urine and visible to staff, residents and visitors. In an interview with Nurse #1 on 8/18/25 at 12:40 PM she revealed she was not aware a urinary catheter bag should be covered for dignity. Nurse #1 stated she didn’t think the facility had privacy bags available for catheter bags. On 8/18/25 at 12:52 PM an interview was conducted with Nurse Aide (NA) #1. NA #1 stated she was assigned to Resident #7 that day. She further stated she had never seen a urinary catheter bag privacy bag on the unit and if he had one it would be in his room, but she didn’t see one that morning. A follow-up observation was conducted on 8/18/25 at 4:00 PM. Resident #7 was seated in the day room. His urinary catheter bag hung on the right side of his walker and urine was visible through the bag. In an interview with the Director of Nursing (DON) on 8/19/25 at 1:09 PM she stated all urinary catheter bags should have a privacy cover and that the facility supplied them. The DON indicated the covers were to preserve the dignity of residents with indwelling urinary catheters by keeping the urine hidden from the view of visitors, residents and staff. In an interview with the Administrator on 8/19/25 at 2:11 PM, she stated the facility provided privacy bags to cover urinary catheter bags. She further stated all urinary catheter bags should be covered with a privacy bag. The Administrator indicated the cover was for the resident’s privacy and dignity.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and resident interviews, the facility failed to assess a resident's ability to self-administer medications for 1 of 6 residents reviewed for self-administering medications (Residents #101).Resident #101 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, anxiety, depression and insomnia.Review of Resident #101's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #101 was cognitively intact with no delusions, behaviors, or rejection of care.Review of Resident #101's medical record revealed no documentation that Resident #101 had been assessed to self-administer medications.Further review of Resident #101's medical record revealed no care plan for self-administration of medications.An observation of Resident #101 on 8/19/25 at 1:00 PM revealed her to be in her room, sitting on the side of the bed eating her lunch. On Resident #101's overbed tray was a medicine cup that contained 8 pills.An interview with Resident #101 on 8/19/25 at 1:01 PM revealed Medication Aide #1 came in and put the medicine cup with the pills on her tray. Resident #101 went on to say she did not know what the medications were or why she took the medications. An interview with Medication Aide #1 on 8/19/25 at 1:10 PM revealed she always left Resident #101's medication on the overbed tray for the resident to take when she wanted to take them. She also stated she did not know if the resident had been assessed to self-medicate, nor did she know where to locate that information. She went on to say she was aware that it was not good practice, and she should never leave medications unattended in a resident's rooms. She identified the medications left in the room as acyclovir (an antiviral medication used to treat infections) 400 milligrams (mg), aspirin 81mg, magnesium oxide 400 tablet, Revlimid (used to treat several types of cancer) 5mg, sertraline (depression) 50 mg, potassium chloride 10MEQ, vitamin D3 50 mcg, and Tylenol 500mg.An interview was held on 8/19/25 at 2:00 pm with the Director of Nursing. She stated her expectation would be that medications were never left at the bedside. She went on to say the medication aide should have stayed in the room until all medications were consumed. If the resident did not consume the medications, they should have been discarded.An interview with the Administrator was conducted on 8/21/25 at 11:00 AM, she revealed she would expect the person passing medications to stay in the resident's room and watch the resident consume all medications.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, staff and Responsible Party (RP) interviews, the facility failed to ensure a copy of the Medical Power of Attorney advanced directive document was obtained and in the resident's medical record. This was for 1 of 3 residents reviewed for advanced directives (Resident #99).Findings included:Resident #99 was admitted to the facility on [DATE] with a diagnosis of dementia.A physician's progress note for Resident #99 dated 8/1/24 revealed in part her family member was listed as her medical power of attorney.Resident #99's care conference record dated 8/2/24 listed her family member as her medical power of attorney.Resident #99's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact.Resident #99's facility face sheet listed her family member as her medical power of attorney and RP.There was no evidence in Resident #99's facility medical record of a copy of her medical power of attorney document.On 8/19/25 at 2:47 PM a telephone interview with Resident #99's RP indicated Resident #99 had executed an advanced directive medical power of attorney (POA) document. He stated he served as Resident #99's RP and medical POA. He reported although he could not say when or to whom he had given it, he had brought a copy of the document to the facility to ensure they had record of it. He reported that if there was an issue, he would be glad to provide another copy.On 8/21/25 at 4:20 PM an interview with Resident #99 indicated her family member was her medical power of attorney. She reported the facility should have a copy of the medical power of attorney document.On 8/19/25 at 3:17 PM an interview with the Medical Records Director indicated he had been responsible for medical records at the facility since December of 2023. He reported that normally, an advanced directive document such as a medical power of attorney would first go to the Social Worker (SW) or Admissions Director who would then provide the document for him to upload in the resident's medical record. He stated he did not have a medical power of attorney document for Resident #99, and there was not one in her medical record.On 8/19/25 at 3:27 PM an interview with SW #1 indicated she would not be the person to obtain or receive a copy of a resident's medical power of attorney document. She stated this would normally go to the Admissions Director or the Medical Records Director.On 8/19/25 at 3:30 PM an interview with SW #2 indicated he would not be the person to obtain or receive a copy of a resident's medical power of attorney document.On 8/21/25 at 4:13 PM an interview with the Admissions Director indicated if a resident or family member brought him a copy of a medical power of attorney or other advanced directive document, he would provide this to the Medical Records Director to upload into the resident's record. He stated he did not recall ever receiving a copy of Resident #99's medical power of attorney document. He reported he did not see a copy of the document in Resident #99's record.On 8/22/25 at 11:26 AM an interview with the Director of Nursing indicated she was not really sure what the facility's process was for ensuring a copy of any advanced directive including a medical power of attorney a resident had executed was present in the resident's medical record. She reported if she needed to know whether or not a resident had a medical power of attorney and who that was, she would be looking in the medical record to see the document itself.On 8/22/25 at 11:38 AM an interview with the Administrator indicated if a resident had executed an advanced directive such as a medical power of attorney, a copy of the document should be obtained by the facility and scanned into the resident's medical record. She reported the facility did not currently have a plan of correction in place for this issue.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, Medical Director, and Pharmacist interviews, the facility failed to protect the resident's right to be free from the misappropriation of their narcotic medications (oxycodone and hydrocodone) prescribed to treat pain for 4 of 8 residents reviewed for misappropriation of property (Residents #38, #24, #50, and #107).Findings included:1a. Resident #38 was admitted to the facility on [DATE] with a diagnosis of chronic pain.A physician's order for Resident #38 dated 10/17/24 revealed oxycodone 10 milligrams (mg) take 1 tablet orally every 8 hours for chronic pain. A review of a Packing Slip proof of delivery from the facility's Pharmacy revealed 90 tablets of Oxycodone 10 mg were delivered to the facility on [DATE] for Resident #38's prescription number. The packing slip was signed by Nurse #2 and Nurse #3 acknowledging this medication was received. Nurse #2's Interviewee Statement dated 12/23/24 indicated Nurse #2 verified she received 3 cards of 30 Oxycodone 10 mg tablets for Resident #38 on 11/18/24 from the pharmacy. Multiple attempts for a telephone interview with Nurse #2 were unsuccessful. On 8/20/25 at 10:58 AM an interview with Nurse #3 indicated her signature on the Packing Slip from the Pharmacy dated 11/18/24 verified that 90 tablets of Oxycodone 10 mg for Resident #38 were received. She stated there would have been 3 cards of 30 tablets each. Resident #38's Medication Administration Record for November 2024 revealed documentation indicating Oxycodone 10 mg was administered to Resident #38 every 8 hours as ordered by the physician from 11/1/24 through 11/30/24. Resident #38's Medication Administration Record for December 2024 revealed documentation indicating Oxycodone 10 mg was administered to Resident #38 every 8 hours as ordered by the physician from 12/1/24 through 12/08/24. The Controlled Substance Count Record labeled 1 of 3 accounting for 30 tablets of Resident #38's Oxycodone 10 mg was missing. The Controlled Substance Count Records labeled 2 of 3 and 3 of 3 for Resident #38's Oxycodone 10 mg revealed the record labeled 3 of 3 was utilized prior to the record labeled 2 of 3. The Controlled Substance Count Record labeled 3 of 3 for Resident #38's Oxycodone 10 mg revealed documentation indicating the first dose of 30 tablets accounted for on the sheet was administered on 11/19/24 at 1:54 PM and the last dose completing the card was administered on 11/29/24 at 1:30 PM. The Controlled Substance Count Record labeled 2 of 3 for Resident #38's Oxycodone 10 mg revealed documentation indicating the first dose of 30 tablets accounted for on the sheet was administered on 11/29/24 at 9:00 PM and the last dose completing the card was administered on 12/07/24 at 10:00 PM. Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. On 8/20/25 at 12:09 PM an interview with Resident #38 indicated he had no concerns with receiving his narcotic pain medication. On 8/20/25 at 12:18 PM an interview with Corporate Nurse Consultant #1 indicated on 12/8/24, she became aware that Resident #38 required an early refill of his Oxycodone 10 mg medication. She stated an investigation determined Controlled Substance Count Record labeled 1 of 3 for Resident #38's Oxycodone 10 mg and the corresponding 30 doses of Oxycodone 10 mg medication could not be accounted for. Corporate Nurse Consultant #1 confirmed the medication had not been returned to the pharmacy. She reported the unaccounted for medication was replaced by the pharmacy at the facility's expense. She indicated Resident #38 did not miss any doses of the medication. b. Resident #24 was admitted to the facility on [DATE] with a diagnosis of chronic pain. A physician's order for Resident #24 dated 4/29/24 revealed Oxycodone 5 milligrams (mg) take 1 tablet by mouth every 12 hours for pain. A review of a Packing Slip proof of delivery from the facility's Pharmacy revealed 60 tablets of Oxycodone 5 mg were delivered to the facility on [DATE]. The packing slip was signed by Nurse #5 acknowledging this medication was received. Nurse #5's undated Interviewee Statement indicated she confirmed that on 10/14/24 she signed the packing slip for receiving Resident #24's medication. She could not recall any specifics. Attempts to interview Nurse #5 during the investigation were unsuccessful. Resident #24's October 2024 and November 2024 Medication Administration Records revealed documentation Oxycodone 5 mg was administered to Resident #24 every 12 hours as ordered by the physician. The Controlled Substance Count Record labeled 1 of 2 accounting for 30 tablets of Resident #24's Oxycodone 5 mg was missing. The Controlled Substance Count Record labeled 2 of 2 accounting for 30 tablets of Resident #24's Oxycodone 5 mg revealed documentation indicting the first of 30 tablets accounted for on the sheet was administered on 10/23/24 at 8:00 PM and the last dose completing the card was administered on 11/4/24 at 8:00 PM. Resident #24's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to develop an individualized, person-centered comprehensive care plan to include the use of anticoagulant medication (Resident #54) and diabetes mellitus type II (Resident #97) for 2 of 5 residents reviewed for comprehensive care plans (Resident #54 and Resident #97).The findings included: 1. Resident #54 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation and coronary artery disease. Resident #54's 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired and was prescribed an anticoagulant (blood thinning) medication. The comprehensive care plan initiated on 8/4/25 did not reveal a care plan indicating Resident #54 took anticoagulant medication. An interview was conducted with the MDS Nurse on 8/20/25 at 11:43 AM. She indicated the admitting nurse was responsible for adding high risk medications such as anticoagulants to the care plan upon admission. In an interview with the admitting Nurse (Nurse #1) on 8/20/25 at 12:12 PM she stated she did not add medications to care plans when completing an admission. Nurse #1 indicated she was not aware adding medications to the care plan was part of the admission paperwork process. In an interview with the Assistant Director of Nursing (ADON) on 8/20/25 at 12:51 PM, she indicated that staff nurses were supposed to add high risk medication with interventions to the care plan upon admission. She was unaware Resident #54 did not have a care plan for anticoagulant medication. In an interview with the Director of Nursing (DON) on 8/20/25 at 12:54 PM she stated she would expect all residents on anticoagulant medication to have a care plan upon admission given that it was a high-risk drug class. She was unaware Resident #54 did not have a care plan for the medication. An interview was conducted with the Administrator on 8/20/25 at 1:08 PM. She indicated that Resident #54 should have had a care plan for anticoagulant medication upon admission. 2. Resident #97 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus type II. Resident #97's quarterly MDS assessment dated [DATE] indicated he was severely cognitively impaired and was taking a hypoglycemic medication (used to lower blood sugar levels). Review of Resident #97's physician orders revealed he received sliding scale insulin, blood glucose level checks twice daily, received an oral hypoglycemic medication twice daily and was on a consistent carbohydrate diet used to help control blood glucose levels with diet. Review of Resident #97's comprehensive care plan initiated 4/25/25 revealed there was not a care plan for diabetes mellitus type II. In an interview with the MDS nurse on 8/20/25 at 11:43 AM she stated the admitting Nurse (Nurse #1) would have been responsible for initiating the diabetes mellitus type II care plan upon admission. In an interview with the admitting Nurse (Nurse #1) on 8/20/25 at 12:12 PM she stated she did not add diagnoses to care plans when completing an admission. Nurse #1 indicated she was not aware adding diagnoses to the care plan was part of the admission paperwork process. In an interview with the Assistant Director of Nursing (ADON) on 8/20/25 at 12:51 PM, she indicated that staff nurses were supposed to add high risk diagnoses such as diabetes mellitus type II with interventions to the care plan upon admission. She was unaware Resident #97 did not have a care plan for diabetes mellitus type II. In an interview with the Director of Nursing (DON) on 8/20/25 at 12:54 PM she stated she would expect all residents who have diabetes mellitus type II to have a care plan upon admission as it was a high-risk diagnosis. She was unaware Resident #97 did not have a care plan for diabetes mellitus type II. An interview was conducted with the Administrator on 8/20/25 at 1:08 PM. She indicated that Resident #97 should have had a care plan for diabetes mellitus type II upon admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to revise the comprehensive care plan to accurately reflect the code status for 1 of 3 residents reviewed for advanced directives (Resident #108).Findings included:Resident #108 was admitted to the facility on [DATE] with a diagnosis of dementia.Resident #108's active comprehensive care plan revealed a focus area for advanced directives. The goal was for Resident #108's advanced directives to be honored per the established documentation through the next review. An intervention was Cardio-Pulmonary Resuscitation (CPR is a lifesaving procedure performed when someone's heartbeat or breathing has stopped) Full Code.A physician's order for Resident #108 dated [DATE] entered into Resident #108's electronic medical record by the Assistant Director of Nursing (ADON) was Do Not Resuscitate (DNR is the refusal of CPR).On [DATE] at 4:03 PM an interview with the ADON indicated she entered the DNR order into Resident #108's electronic medical record on [DATE]. She stated she would have been responsible for updating Resident #108's comprehensive care plan to accurately reflect Resident #108's code status of DNR at that time. She reported she did not know why she had not.On [DATE] at 11:38 AM an interview with the Administrator indicated the ADON should have updated Resident #108's comprehensive care plan when she entered the physician's order changing Resident #108's code status to DNR.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observations, record review, and staff and Medical Director interviews, the facility failed to ensure staff were trained and competent in following manufacturer's guidelines for cleaning and disinfecting a shared glucometer for 1 of 1 observed (Resident #34). On 8/20/25 Nurse #1 was observed obtaining Resident #34's blood glucose (sugar) level followed by the nurse cleaning the glucometer with an alcohol wipe that was not an Environmental Protection Agency (EPA)-registered disinfectant. Nurse #1 revealed she worked at the facility since March of 2025, had always used an alcohol wipe to clean the glucometer, had not been trained on how to disinfect the glucometer, and was unaware an EPA-registered disinfectant needed to be used. The Infection Preventionist revealed she was unsure what the manufacturer's guidelines were for cleaning and disinfecting a shared glucometer. Resident #34 resided on the locked unit and this shared glucometer was utilized for 2 other residents (Residents #92 and #97) who resided on that unit. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to ensure staff are trained and competent to disinfect a shared glucometer in accordance with the manufacturer's instructions has the high likelihood to expose residents to bloodborne pathogens. There were no residents with a blood-borne pathogen in the facility at the time of the investigation. The deficient practice was identified for 1 of 3 nursing staff members (Nurse #1) reviewed for glucometer disinfection competency. Immediate Jeopardy began on 8/20/25 when Nurse #1 failed to demonstrate competency to disinfect a shared glucometer per manufacturer's instructions. Immediate jeopardy was removed on 8/22/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education is completed and monitoring systems put into place are effective. Findings included:A continuous observation of Nurse #1 was conducted on 8/20/25 from 12:36 PM through 12:51 PM revealed the following: On 8/20/25 at 12:36 PM, Nurse #1 was standing by the medication cart in the day room of the locked unit with Resident #34 standing next to her. Nurse #1 took the glucometer out of the top left drawer of the cart where it had been stored. Nurse #1 put the glucometer on top of the cart, gathered supplies and obtained Resident #34's blood glucose. The Nurse was observed to clean the glucometer with a small alcohol wipe for less than one minute and place the glucometer back into the top left drawer of the medication cart. In an interview with Nurse #1 during the observation that began on 8/20/25 at 12:36 PM she stated the glucometer was used on all residents in the locked unit that had orders for blood glucose testing. Nurse #1 further stated she had worked in the facility since March of 2025 and had always used an alcohol wipe to clean the glucometer. Nurse #1 indicated she had not been trained on how to disinfect the glucometer with an EPA-registered germicidal wipe. A follow-up interview was conducted with Nurse #1 on 8/20/25 at 1:37 PM. She revealed there was only one resident (Resident #34) who required blood glucose monitoring at lunchtime. Nurse #1 indicated she had completed three blood glucose checks before breakfast on 8/20/25 and used an alcohol wipe to clean the glucometer between each resident (Resident #34, Resident #92 and Resident #97). An interview on 8/20/25 at 12:54 PM with the Infection Preventionist (IP), who was also the Director of Nursing (DON) revealed each medication cart in the facility had one glucometer to be used for all residents on that hall that require blood glucose testing. The IP/DON indicated nurses should be cleaning and disinfecting the glucometers per manufacturer's instruction and facility policy. She stated that she had only been at the facility for three weeks and was unsure when the last in-service/training on glucose monitor disinfection was conducted. The IP further stated she was unsure what the facility policy or manufacturer's instructions for glucometer cleaning and disinfecting instructed. She indicated she was aware that improper disinfection of a shared glucometer could lead to blood-borne pathogens being transferred from one resident to another. A follow-up interview was conducted on 8/20/25 at 2:03 PM with the IP/DON. She stated there were no residents with known blood-borne pathogens in the facility. In an interview with the Administrator on 8/20/25 at 1:08 PM she indicated Nurses should be disinfecting glucometers per manufacturer's instructions between each resident and before use if it is stored with other items such as in the medication cart drawer. The Administrator was unsure when the last in-service training was conducted on the cleaning and disinfecting of glucose monitors. A telephone interview was conducted on 8/21/25 at 8:50 AM with the Medical Director who stated all nursing staff should be educated regarding the cleaning and disinfecting of glucose monitoring before their first shift at the facility. The facility was unable to provide

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River Trace Nursing and Rehabilitation Center	250 Lovers Lane Washington, NC 27889

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, Medical Director, and Pharmacist interviews, the facility failed to have effective safeguards and systems in place to prevent drug diversion of discontinued controlled narcotic and antianxiety medications (hydromorphone, oxycodone, morphine and lorazepam). This was for 3 of 8 residents reviewed for misappropriation (Residents #8, #115, and #141).Findings included: 1a. Resident #8 was admitted to the facility on [DATE] with a diagnosis of arthritis. A physician's order for Resident #8 dated 11/13/24 revealed hydromorphone (narcotic medication) 2 milligram (mg) tablet take 1 tablet every 4 hours as needed for mild hand amputation pain and 2 tablets as needed every 4 hours for moderate to severe pain. A Packing Slip proof of delivery from the facility's Pharmacy revealed 60 tablets of hydromorphone 2 mg were delivered to the facility on [DATE] for Resident #8. The packing slip was signed by Nurse #6 acknowledging this medication was received. Nurse #6's Interviewee Statement dated 12/26/24 revealed she confirmed she received 2 cards of 30 tablets each of Resident #8's hydromorphone 2 mg from the pharmacy on 11/13/24. It further revealed Nurse #6 indicated the medication would have been placed on the medication cart. Attempts to interview Nurse #6 during the investigation were unsuccessful. On 12/6/24 Resident #8's order for hydromorphone from 11/13/24 was discontinued when he was discharged to the hospital. The Occurrence Investigation Report for Resident #8 dated 12/20/24 revealed in part documentation of administration on his November and December 2024 Medication Administration Records accounted for 12 tablets from the supply of 60 hydromorphone tablets delivered on 11/13/24. This would have been the only supply of hydromorphone available to administer to Resident #8. There was no Controlled Substance Count Record for the hydromorphone. Resident #8's annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. On 8/20/25 at 2:47 PM an interview with Resident #8 indicated he had no concerns with receiving his pain medication when he needed it until he was discharged to the hospital. On 8/20/25 at 1:10 PM an interview with Corporate Nurse Consultant #1 indicated as a result of an audit into the facility's narcotic process that began on 12/8/24 it was discovered that a number of Resident #8's hydromorphone 2 mg tablets received by Nurse #6 on 11/13/24 were unaccounted for. She reported after a review of Resident #8's Medication Administration Record (MAR), it was determined 12 tablets from this prescription could be accounted for through documentation on the MAR of administration. She went on to say there were no Controlled Substance Count Records, no shift change sheet to confirm the medication was ever added to a medication cart, and no accounting for the remaining 48 tablets of the 60 tablet prescription. She stated the pharmacy had verified that the remaining medication had not been returned to the pharmacy after it was discontinued on 12/6/24 when Resident #8 was discharged to the hospital. Corporate Nurse Consultant #1 reported the facility's process for controlled narcotic medication at that time was for 1 nurse to sign the packing slip with the courier verifying that the medication was received and only one nurse to sign the declining Controlled Substance Count Records sheet verifying the receipt and only one nurse to sign the shift change sheet when adding medication to a cart. She reported that this process had changed since the incident. b. Resident #115 was admitted to the facility on [DATE] with a diagnosis of arthritis. A physician's order for Resident #115 dated 11/5/24 revealed to take 1 tablet of Oxycodone (a narcotic medication) 5 mg every 4 hours as needed for pelvic fracture pain. A Packing Slip proof of delivery from the facility's Pharmacy revealed 30 tablets of Oxycodone 5 mg was delivered to the facility on [DATE] for Resident #115. The packing slip was signed by Nurse #2 and Nurse #11 acknowledging this medication was received. Attempts to interview Nurse #2 were unsuccessful. On 8/21/25 at 9:39 AM a telephone interview with Nurse #11 indicated when narcotic medication was delivered from the pharmacy, 2 nurses would sign the packing slip verifying that the medication was received, and then 2 nurses would sign and verify when the medication was added to the medication cart. She stated she really didn't recall specifically signing for Resident #115's medication on 11/5/24. Resident #115's Medication Administration Records (MARs) for November and December 2024 revealed documentation that 1 tablet of Oxycodone 5 mg was administered to her on 11/10/25 and 11/12/24. There was no Controlled Substance Count Record for the oxycodone. On 12/1/24 Resident #115's order for Oxycodone from 11/5/24 was discontinued. Resident #115's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. On 8/20/2025 at 5:06 PM an interview with Medication Aide (MA) #6 indicated she was familiar with Resident #115 and cared for her in November 2024. She reported she had no

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Medical Director interviews, the facility failed to notify the physician or Nurse Practitioner (NP) of abnormal laboratory test results. This deficient practice affected 1 of 6 sampled residents (Resident #130).Resident #130 was admitted to the facility on [DATE] with diagnoses that included obstructive sleep apnea, chronic kidney disease, chronic atrial fibrillation (a condition where the heart beats irregularly and often too fast), and congestive heart failure. Resident #130 had a telephone order called in from the NP from the Cardiology office on 10/11/24 for a BMP (basic metabolic panel, which was a common blood test that measures glucose, calcium, sodium, potassium, chloride, carbon dioxide, blood urea nitrogen and creatinine), draw to be done at the facility. The order was signed off by a nurse on 10/14/2024. Several unsuccessful attempts were made to reach the NP that ordered the lab.Review of the lab results report showed the blood specimen was collected on 10/16/2024, reported to the facility on [DATE] and reviewed by the Medical Director on 10/21/2024. The lab results showed out of range for glucose which was 113 with a reference range of 70-99, creatinine which was 1.53 with a reference range of .57-1.00, carbon dioxide which was 19 with a reference range of 20-29, red blood count 3.60 with a reference range of 3.77-5.28, hemoglobin which was 11.0 with a reference range of 11.1-15.9, hematocrit which was 33.6 with a reference range of 34.0-46.6, and iron which was 23 with a reference range of 27-139. An interview was held with the patient access representative at the cardiology office on 8/20/2025 at 12:30 PM. She stated the office never received the results of Resident #130's BMP. She went on to say the NP ordered additional blood work on 10/30/2024 to be completed at an offsite provider and the results were reported to the NP the same day. An interview with the Assistant Director of Nursing was held on 8/20/2025 at 11:00 AM at which time she revealed the facility completes the blood drawings and the results should have been reported to the provider that ordered the blood test.A telephone interview with the facility Medical Director was held on 8/20/2025 at 2:00 PM, and he referred this surveyor back to the Assistant Director of Nursing to see who should have reported the lab results to the ordering provider. He went on to say he did not feel the lack of reporting adversely affected this resident.And interview was conducted with the Director of Nursing on 8/20/2025 at 3:15 PM, she revealed she was not sure of the policy as she was new to the facility. She went on to say typically lab results would be a provider-to-provider conversation.A follow up interview with the Assistant Director of Nursing was conducted on 8/20/2025 at 3:30 PM, she stated the nurse assigned to the hall where the resident lived should have called in the results to the provider that ordered the lab work.An interview with the Administrator was held on 8/20/2025 at 3:40 PM, she revealed she was new to the facility and not sure who should have reported the blood draw results to the provider that ordered the labs.An interview was conducted with the Regional Nurse Consultant on 8/20/2025 at 3:50 PM. She revealed anyone could communicate the results of blood work but typically the unit manager would notify the prescribing provider of the results.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to ensure facial hair was covered during food preparation for 1 of 1 cook observation in the kitchen. This practice had the potential to affect food served to residents. Findings include:An observation was conducted on 8/18/2025 at 10:30am revealed the [NAME] was wearing a facial covering however his mustache and sides of his beard were exposed while preparing/cutting food.An interview was conducted on 8/18/2025 at 1:04pm with Dietary Manager Consultant revealed all staff should have a beard restraint that covered all facial hair.An interview was conducted on 8/21/2025 at 8:56pm with Administrator revealed that she was unaware that proper beard restraint was not practiced in the kitchen. She stated it was expected that all staff wear hair restraints and covered all facial hair while in the kitchen and when preparing foods.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, staff and Medical Director interviews, the facility failed to implement their infection control policies and procedures when Nurse #1 did not follow the manufacturer's instructions for cleaning and disinfecting a shared blood glucose meter (glucometer) before and after resident usage for 1 of 1 resident observed whose blood glucose (sugar) level was checked (Resident #34). On 8/20/25 Nurse #1 was observed obtaining Resident #34's blood glucose level followed by the nurse cleaning the glucometer with an alcohol wipe that was not an Environmental Protection Agency (EPA)-registered disinfectant. Nurse #1 then stated that she worked at the facility since March of 2025 and had always used an alcohol wipe to clean the glucometer indicating that she was unaware an EPA-registered disinfectant needed to be used. Resident #34 resided on the locked unit and this shared glucometer was utilized for 2 other residents (Residents #92 and #97) who resided on that unit. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an EPA-registered disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood-borne pathogens. There were no residents with a blood-borne pathogen in the facility at the time of the investigation. The facility staff also failed to change gloves between cleansing a wound and applying a new dressing and failed to perform hand hygiene between the removal of soiled gloves and the application of clean gloves (Wound Care Nurse). Finally, the facility failed to handle soiled linen in a manner that prevented the potential transmission of pathogenic (disease causing) microorganisms (germs) when Nurse Aide (NA) #2 placed soiled linen directly onto the floor. These deficient practices were identified for 3 of 10 staff members (Nurse #1, Wound Care Nurse, and NA #2) reviewed for infection prevention and control. Immediate Jeopardy began on 8/20/25 when Nurse #1 was observed performing a blood glucose check on Resident #34 using a shared glucometer without disinfecting per manufacturer's instructions. Immediate jeopardy was removed on 8/21/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for findings #2 and #3 and to ensure education is completed and monitoring systems put into place are effective. Findings included:1. The blood glucose meter manufacturer's instructions for cleaning and disinfecting dated 09/2024 indicated the meter should be cleaned and disinfected after use on each patient with EPA-registered product. A list of EPA-registered products was listed in the instructions. Additional instructions were to read the manufacturer's instructions for the use of the EPA-registered cleaning and disinfecting product. Alcohol wipes were not listed as an EPA-registered product. Review of the facility policy “Glucometer Disinfection”, undated, indicated that the objective was to prevent infection due to potential blood-borne pathogen exposure. The equipment and supplies were listed as gloves and germicidal disposable cloth/wipes. The procedure for disinfecting glucometers included: Step 1. Apply gloves Step 2. When visible blood or body fluids are present, clean by wiping the external surfaces to remove any visible organic material. A cloth dampened with soap and water, or a germicidal wipe may be used according to the manufacturer’s instructions and then discard. Step 3. After any visible blood or body fluids have been removed, or if no visible blood or bodily fluids are present: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a.) Use EPA-registered germicidal disposable cloth/wipe horizontally and vertically to thoroughly wet the entire external surface of the glucometer according to the manufacturer’s instructions. b.) Allow treated surface to remain wet for the germicidal wipe manufacturer’s recommended exposure time. If needed, utilize a new germicidal wipe to keep the glucometer surface wet. Step 4. After allowing the full amount of exposure time according to manufacturer’s product direction, discard the used cloth/wipe and allow the glucometer to thoroughly air- dry. Step 5. Remove and discard gloves. Perform hand hygiene. Step 6. When glucometer is completely dry, it may be used for the next resident or if not proceeding to another resident, store glucometer in med cart or specified storage area. A continuous observation of Nurse #1 was conducted on 8/20/25 from 12:36 PM through 12:51 PM revealed the following: On 8/20/25 at 12:36 PM, Nurse #1 was standing by the 500-hall medication cart in the day room of the locked unit with Resident #34 standing next to her. Nurse #1 took the glucometer out of the top left drawer of the cart where it had been stored. Nurse #1 put the glucometer on top of the cart, gathered supplies and obtained Resident #34’s blood glucose. The Nurse was observed to clean the glucometer with a small alcohol wipe for less than one minute and place the glucometer back into the top left drawer of the medication cart. An EPA-registered container of wipes that was located on top of the medication cart indicated to disinfect nonfood contact surfaces; thoroughly wet surface, allow treated surface to remain wet for two minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for blood-borne pathogen use. In an interview conducted with Nurse #1 during the observation that began on 8/20/25 at 12:36 PM she stated the glucometer was used on all residents in the locked unit that had orders for blood glucose testing. Nurse #1 further stated she had worked in the facility since March of 2025 and had always used an alcohol wipe to clean the glucometer. Nurse #1 indicated she had not been trained on how to disinfect the glucometer with an EPA-registered germicidal wipe. A follow-up interview was conducted with Nurse #1 on 8/20/25 at 1:37 PM. She revealed there was only one resident (Resident #34) who required blood glucose monitoring at lunchtime. Nurse #1 indicated she had completed three blood glucose checks before breakfast on 8/20/25 and used an alcohol wipe to clean the glucometer between each resident (Resident #34, Resident #92 and Resident #97). An interview on 8/20/25 at 12:54 PM with the Infection Preventionist (IP), who was also the Director of Nursing (DON), revealed each medication cart in the facility had one glucometer to be used for all residents on that hall that require blood glucose testing. The IP/DON indicated nurses should be cleaning and disinfecting the glucometers per manufacturer’s instruction and facility policy. The IP/DON stated she was unsure what the facility policy on glucometer disinfection said. She indicated she was aware that improper disinfection of a shared glucometer could lead to blood-borne pathogens being transferred from one resident to another. A follow-up interview was conducted on 8/20/25 at 2:03 PM with the IP/DON. She stated there were no residents with known blood-borne pathogens in the facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Administrator on 8/20/25 at 1:08 PM she indicated nurses should be disinfecting glucometers per manufacturer’s instructions between each resident and before use if it is stored with other items such as in the medication cart drawer. A telephone interview was conducted on 8/21/25 at 8:50 AM with the Medical Director who stated the danger of not cleaning the shared glucometer per manufacturer’s instructions was that blood-borne pathogens could be transmitted between residents. He indicated that all shared glucometers should be cleaned per manufacturers’ instructions between residents and before use when the glucometer is stored with other items in a medication cart drawer. The Administrator was notified of immediate jeopardy on 8/21/25 at 9:30 AM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: On 8/20/25, Nurse #1 removed a glucometer from the 500-hall (locked unit) medication cart drawer. Nurse #1 performed the blood glucose check on Resident #34 then wiped the glucometer with an alcohol wipe and placed the glucometer back into the medication cart drawer. Nurse #1 stated she was not aware she was to use an Environmental Protection Agency (EPA) germicidal approved wipe. On 8/20/25, the Facility Consultant completed a medical record audit of all residents, including Resident #34, Resident #92, and Resident #97, who received blood glucose checks. This audit was to identify any diagnosed blood-borne pathogen infections to ensure there were no infections related to improper cleaning and disinfecting of glucometers. No residents were identified with a blood-borne pathogen. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 8/20/25, the unit managers and the treatment nurse completed the cleaning and disinfecting of all resident glucometers including Resident #34, Resident #92, and Resident # 97, in accordance with the manufacturer’s instructions for cleaning and disinfecting glucometers. The instructions include utilizing an EPA-registered germicidal wipe, allowing full exposure time according to the manufacturer’s product directions, then discarding the used wipe and allowing the glucometer to thoroughly air-dry before using it for the next resident. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/20/25, the Director of Nursing, Assistant Director of Nursing, Treatment Nurse and Unit Managers initiated, in person, education with all nurses to include Nurse #1 and medication aides regarding the importance of following facility and manufacturer’s instructions for cleaning and disinfecting a shared glucometer including (1) using a EPA-registered germicidal disposable cloth/wipes (2) exposure times (3) dry time (4) the policy for cleaning and disinfecting glucometers (5) germicidal instructions for cleaning and disinfecting a glucometer are located on the container of the germicidal wipes (6) the risk factors of not properly cleaning shared glucometers. The in-service will be completed by 8/20/25. The Director of Nursing will monitor the completion of staff in-services. After 8/20/25, any nurse or medication aide who has not worked or received the in-service will receive the education prior to the next scheduled work shift. All newly hired nurses or medication aides including agency, will be in-serviced by the Director of Nursing, Assistant Director of Nursing or Unit Managers during orientation regarding the importance of following facility and manufacturer’s instructions for cleaning and disinfecting a shared glucometer. On 8/20/25, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers initiated in-person return demonstrations of properly cleaning and disinfecting glucometers with all nurses to include Nurse #1 and all medication aides including agency. The purpose of the return demonstrations is to ensure that staff demonstrate knowledge and understanding of the glucometer cleaning and disinfecting procedures, including adhering to the manufacturer’s instructions. Staff will be immediately retrained for any identified areas of concern. The return demonstrations will be completed by 8/20/25. Any nurse or medication aide who does not successfully pass the return demonstration will be immediately re-educated and will be required to repeat the return demonstration until successful demonstration is achieved. The return demonstrations were completed by 8/20/25 for all nurses and medication aides who worked. The Director of Nursing will monitor the completion of the glucometer cleaning return demonstrations. After 8/20/25, staff who have not completed the return demonstrations will complete it prior to their next scheduled work shift. On 8/20/25, the Director of Nursing, Assistant Director of Nursing and Unit Managers initiated in person quizzes with all nurses to include Nurse #1 and medications aides, including agency to validate knowledge and understanding of the importance of following facility and manufacturer’s instructions for cleaning and disinfecting a shared glucometer. The quizzes included (1) how often do you need to clean a glucometer (2) what should you use to clean and disinfect a glucometer? (3) why is it important to follow the manufacturer’s instructions to clean and disinfect a shared glucometer? (4) how do you know the exposure time for the disinfectant you are utilizing? Any nurse or medication aide that does not successfully pass the quiz will be immediately re-educated and will be required to retake the quiz at the time of administration until a successful passing score is achieved. The quizzes were completed by 8/20/25 for all nurses and medication aides who worked. The Director of Nursing will monitor the completion of staff quizzes. After 8/20/25, any nurse or medication aide who has not completed the quiz will complete it prior to their next scheduled work shift. Alleged immediate jeopardy removal date: 8/21/25 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A validation of immediate jeopardy removal plan was conducted on 8/22/25. The facility had compiled a list of nursing staff that were responsible for blood glucose monitoring. All staff were educated on the glucometer disinfection process before being allowed to work. The facility provided an immediate in-service for Nurse #1 with a return demonstration provided. All staff members responsible for blood glucose monitoring also completed a skills validation with return demonstration to the Director of Nursing, Assistant Director of Nursing or Unit Manager. An observation was conducted of glucose disinfection while onsite. The staff member cleaned the glucometer according to manufacturer instructions. Nursing staff interviews revealed they had received education on the disinfection of glucometers. The immediate jeopardy removal date of 8/21/25 was validated. 2. A review of the facility policy titled “Handwashing Policy” revised 4/2023 provided by the facility revealed in part: “Personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice. Personnel should wash their hands: … When indicated between tasks and procedures to prevent cross contamination of different body sites.” During observation on 8/20/25 at 11:29 AM the Wound Care Nurse was observed providing wound care to Resident #4. The wound care nurse was observed to perform hand hygiene and don personal protective equipment including gloves. The Wound Care Nurse was observed to cleanse the sacral wound with wound cleanser. After cleaning the wound, with the same gloves she cleansed the wound with, she then cut the xeroform (a non-adhering protective dressing) gauze to the size of the wound and placed the dressing over the wound bed. She then changed gloves, did not perform hand hygiene, and covered the xeroform gauze with a dry dressing. During an interview on 8/20/25 at 11:35 AM the Wound Care Nurse stated after cleansing the wound she should have performed hand hygiene and changed gloves prior to applying the xeroform gauze and dry dressing to prevent cross contamination and did not because she was nervous. During an interview on 8/20/25 at 11:38 AM the Director of Nursing stated hand hygiene, and a glove change should be performed between cleaning a wound and applying a new dressing to not cross contaminate the area being treated. 3. A review of the facility’s policy dated 3/10/2020 titled “Linen Handling Policy” revealed in part “All soiled linen should be considered contaminated. The risk of actual disease transmission from soiled linen with pathogenic (disease causing) microorganisms (germs) is insignificant if it is handled, transported, and laundered in a way that avoids the transfer of microorganisms. Soiled linen should be bagged or placed in containers at the location where it is used.” On 8/18/25 at 2:55 PM soiled linen including towels and a gown were observed directly on the floor of Resident #1’s room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Trace Nursing and Rehabilitation Center	250 Lovers Lane Washington, NC 27889

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/18/25 at 2:58 PM an interview with Nurse Aide (NA) #2 outside the room indicated the soiled towels and gown where from the bathing she provided to Resident #1 at approximately 2:45 PM that day. She stated she should have placed these soiled items into a bag and not left them directly on the floor, but she did not. She indicated she had bags available and did not know why she had not done this. She reported she had been educated not to place soiled linen directly onto the floor in resident’s room so that any germs on them did not get tracked around. On 8/22/25 at 11:25 AM an interview with the Director of Nursing (DON) indicated she also served as the facility’s Infection Preventionist. She stated she was glad that NA #2 acknowledged that placing soiled linen directly on the floor in a resident’s room was inappropriate, because this should never occur. She reported all soiled linen should be placed in bags. The DON stated this was for infection control purposes to prevent the spread of germs. On 8/22/25 at 11:38 AM an interview with the Administrator indicated soiled linen should be bagged at the time of removal and never placed directly on the floor.