STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Lumberton	1555 Willis Avenue Lumberton, NC 28358

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, and Physician interviews, the facility failed to ensure that a resident received wound care and treatment to a new surgical site following admission for a left below knee amputation. This occurred for 1 of 1 resident reviewed for non-pressure related wound care (Resident #112).Findings included: Resident #112 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare following left below knee amputation. Review of Resident #112's hospital Discharge summary dated [DATE] revealed to apply xeroform (a petroleum gauze used for wound healing, that keeps the wound moist and halts bacteria growth), 4 x 4 gauze, ABD pad (an absorbent dressing that pulls exudate (wound fluid) away from the wound bed) and wrap with Kerlix (type of gauze that absorbs fluid and provides cushion) and apply ace wrap (provides compression) daily. The discharge summary was signed as reviewed by Unit Manager #1. The baseline care plan dated 5/13/26 signed by Nurse #1 revealed Resident #112 had no impaired skin integrity on admission. The baseline care plan was corrected by the Minimum Data Set (MDS) nurse on 5/21/26 to reflect altered skin integrity related to left below knee amputation. Review of the admission skin assessment dated [DATE] at 10:51 PM signed by Nurse #1 revealed left below knee amputation aftercare with no additional wound information. Review of Resident #112's electronic medical record including the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) from 5/13/26 through 5/18/26 revealed no documented wound care treatments provided to the surgical site. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #112 had moderately impaired cognition, and no rejection of care. Resident #112 had a surgical wound, with no wound care. A physician's order dated 5/19/26 for Resident #112 entered by the Wound Nurse revealed to apply xeroform to the surgical site on the left lower extremity and wrap with Kerlix every other day. Review of the weekly skin assessment dated [DATE] and signed by the Wound Nurse revealed Resident #112 admitted with a left below knee amputation. The surgical wound had 28 visible staples. The wound is to be treated with xeroform and wrapped with Kerlix every other day. Review of Resident #112's Treatment Administration Record (TAR) dated May 2026 revealed wound treatments were provided to Resident #112 on 5/19/26, and 5/21/26 as evidenced by the wound nurses initials. During an interview on 6/3/26 at 1:15 PM the Wound Nurse stated the admission process included the assigned nurse would complete the admission skin assessment and would notify her if there were any skin issues. She stated there were no skin issues reported to her following Resident #112's admission and she was not aware of the surgical site until the Assistant Director of Nursing (ADON) notified her on 5/19/26 that Resident #112 had a left below knee amputation that needed to be looked at. The Wound Nurse stated she assessed Resident #112 that day (5/19/26) and saw that there were no wound care orders in place and she notified the Physician and obtained wound treatment orders. The Wound Nurse stated she performed the initial wound treatment on 5/19/26 and the new order was for every other day wound treatment. During an interview on 6/4/26 at 11:50 AM the Assistant Director of Nursing (ADON) stated Resident #112 was a dialysis resident. A dialysis nurse called for general information on 5/19/26 and when she reviewed Resident #112's medical record she saw that she had a below knee amputation, so she informed the wound nurse to go (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluate her. During an interview on 6/3/26 at 4:00 PM the Director of Nursing (DON) stated typically the Unit Managers reviewed and entered admission orders. If the Unit Managers were not available the assigned nurse would be responsible for reviewing, clarifying and entering admission orders.During an interview on 6/3/26 at 4:15 PM Nurse #1 indicated she was the assigned nurse on 3:00 PM to 11:00 PM shift when Resident #112 was admitted . She stated she saw that Resident #112 had a below knee amputation and usually she would notify the wound nurse or leave her a note if there were any wounds on admission. Nurse #1 stated she could not recall why she did not notify the wound nurse of Resident #112's new surgical wound. Nurse #1 stated she did not review Resident #112's hospital discharge summary on admission to see if there were any wound treatment orders but indicated she thought the Unit Manager entered the admission orders that day. During a phone interview on 6/4/26 at 6:00 PM Unit Manager #1 stated the Unit Managers, or the assigned nurse were responsible for entering new admission orders. She stated if she signed off on Resident #112's hospital discharge orders and did not enter the wound treatment orders into Resident #112's electronic medical record that it was due to human error. During a phone interview on 06/04/2026 at 12:10 PM the Physician stated that wound care should have been initiated for Resident #112 upon admission and performed according to the hospital discharge orders. The Physician indicated there was no outcome reported to her and Resident #112 discharged to the hospital (on 5/22/26) unrelated to the surgical wound and did not return to the facility. The Physician indicated failure to provide timely wound care had the potential to delay healing and increase the risk of infection or other complications.An interview was conducted on 6/4/26 at 3:00 PM with the Administrator along with the Director of Nursing (DON). The Administrator stated she reviewed Resident #112's hospital discharge orders today and stated wound treatment orders were on the discharge summary. The Administrator stated they would review the admission process to determine what they could implement to prevent these type of errors. The Administrator stated the wound treatments should have been provided daily to Resident #112 following admission on [DATE] and that did not occur.