STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Health and Rehabilitation Center	1403 Conner Drive Windsor, NC 27983

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interviews, the facility failed to position a urinary drainage bag from touching the floor to reduce the risk of infection for 1 of 2 residents reviewed with urinary catheters (Resident #49).The findings included:Resident #49 was admitted to the facility on [DATE] with diagnoses which included suprapubic catheter due to neuromuscular dysfunction of the bladder.Resident #49's care plan revised on 9/10/2025 identified the suprapubic catheter with interventions including: keeping the catheter bag covered to maintain dignity and positioning the catheter bag and catheter tubing below the level of the bladder and away from the entrance door.Resident #49's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was severely cognitively impaired. Resident #49 was coded for an indwelling / (suprapubic) catheter.An initial observation was conducted on 1/28/2026 at 11:30 AM of Resident #49 as he was lying in his bed. The bed was noted to be in the lowest position with the catheter bag lying on the floor wedged between the floor and the bed frame. There was no tension noted on the catheter tubing.Additional observation on 1/28/2026 at 1:45 PM revealed Resident #49 was still lying in his bed. The bed had been raised approximately 3 inches off the floor and the catheter bag remained on the floor with no barrier between the floor and the catheter bag.An interview was conducted with Nurse Aide (NA) #2 on 1/29/2026 at 9:18 AM. She confirmed she had been assigned to Resident #49 on 1/28/2026. NA #2 stated Resident #49's catheter bag was secured on the right side of the bedframe and below the bladder. NA #2 stated the catheter bag may have fallen on the floor when they lowered the bed to feed him. NA #2 stated the catheter bag was not supposed to touch the floor and she would position the bag back onto the bedframe, so it did not touch the floor. She explained she had checked on Resident #49 before lunch and again around 2:30 to 3:00 pm and stated Resident #49's catheter bag was not touching the floor during those times. NA #2 also stated education was provided during orientation on caring catheters.On 1/29/2026 at 11:18 AM an interview was conducted with Nurse #1. She stated when she came in yesterday (1/28/2026 at 7:00 am) Resident #49's catheter bag was on the floor. Nurse #1 stated she picked up the catheter bag and placed it on the bed frame. Nurse #1 stated she did not assess if the catheter bag was on the floor at any other time on 1/28/26. She stated catheter bags were to be off the floor to prevent possible infection. Nurse #1 revealed she received annual education on catheter bag placement which included keeping the catheter bag from touching the floor.An interview was conducted with the Director of Nursing (DON) / Infection Preventionist on 01/29/2026 at 11:27 AM. The DON stated the staff most likely did not understand that lowering the bed would cause the catheter bag to be on the floor. The DON explained the staff should raise the bed so the catheter bag would be at least 2 to 3 inches off the floor to prevent possible infections and to check behind themselves prior to leaving the room regarding the position of catheter bag. The DON stated the facility provided education regarding catheter care and placement during (continued on next page)

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.

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
	345404	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Health and Rehabilitation Center	1403 Conner Drive Windsor, NC 27983

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orientation to new staff and annually.On 01/29/2026 at 12:29 PM an interview was conducted with the Administrator. The Administrator stated everyone should know the catheter bag should not be touching the floor. She did not know why the NA did not identify the catheter bag on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Health and Rehabilitation Center	1403 Conner Drive Windsor, NC 27983

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, consulting Pharmacist and staff interviews, the facility failed to date an opened multi-dose pen injector of insulin medication in 1 of 2 medication administration carts reviewed for medication storage (200 hall medication cart).The findings include:Per manufacturer's recommendations insulin isophane human/insulin regular human 70/30 insulin pen can be stored at room temperature (59 to 86 degrees Fahrenheit) for 31 days.On 1/28/2026 at 2:58 PM, an observation of the 200-hall medication administration cart with Nurse #1 revealed one opened and undated multi-dose insulin isophane human/insulin regular human 70/30 insulin pen. The insulin pen was assigned to Resident #55. An interview conducted on 1/28/2026 at 3:00 PM with Nurse #1, who was working from the 200-hall medication cart, revealed insulin pens should be dated when opened and she was not aware the insulin isophane human/insulin regular human 70/30 insulin pen was not dated. Nurse #1 stated nurses were supposed to check their medication administration carts daily, but she did not check it that day (1/28/2026). Nurse #1 did not offer an explanation as to why she had not checked the medication administration cart.On 1/29/2026 at 3:16 PM an interview was conducted with the consulting Pharmacist. The consulting Pharmacist revealed she reviewed at a minimum two medication administration carts every two months that included reviewing the medications inside the cart for labels and open dates on insulin bottles and pens. She stated there should be a label with an open date on any open insulin and the facility should inspect their medication administration carts monthly.On 1/29/2026 at 3:31 PM an interview was completed with the Director of Nursing (DON). The DON indicated nurses were responsible for checking the medication administration carts they were assigned to daily and the Nurse Managers were responsible for inspecting medication carts monthly. During these inspections the nurse's and Nurse Managers were observing for the date of opened medications and expired medications. The DON was not certain why Nurse #1 had not checked her cart.On 1/29/2026 at 4:18 PM during an interview, the Administrator stated the nurses completed the labeling and dating of insulin pens. She stated an insulin pen should be removed from the refrigerator and labeled when opened. The Administrator stated the responsibility of checking medication administration carts included the Pharmacy Consultant who completed random checks monthly, the Nursing Administration Manager completed random checks monthly, and the nurses should check prior to administering medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Health and Rehabilitation Center	1403 Conner Drive Windsor, NC 27983

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 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 clean 1 of 1 deep fryer, 1 of 1 steamer, 1 of 1 tray line cooler, 1 of 4 kitchen walls, the floor of 1 of 1 walk-in refrigerator and 2 of 5 meal carts. These practices had the potential to affect food served to residents. The findings included: A continuous observation of the kitchen and interview with the Dietary Manager and Dietary Aide #1 was conducted on 1/28/26 from 10:25 AM through 10:48 AM. A white residue was observed on the tops and on the bottom inner surfaces of two meal carts. The Dietary Manager stated that the meal carts were cleaned weekly. Cloudy (white) oil was observed inside the deep fryer along with food crumbs along all areas surrounding the oil. The Dietary Manager stated that the deep fryer was last cleaned on 1/23/26 by removing all food crumbs and changing the oil. However, shrimp was fried for dinner on 1/27/26 and the deep fryer should have been cleaned after use. [NAME] drip marks were observed covering the wall behind the fryer, steamer and convection oven. The Dietary Manager stated that the wall could not be cleaned because the kitchen equipment was attached to gas and none of the items could be moved. A black substance surrounding the edges of a large plastic bin holding up steamer pans on the clean rack was observed. Also, two full size steamer pans with holes were observed with a black substance on the inner surface. The Dietary Manager stated that the plastic bin and steamer pans with holes were no longer used in the kitchen. However, they should not be dirty. A brown substance was observed on the inner bottom surface of the tray line cooler. Also, a white substance was observed covering the bottom doors of the tray line cooler. The Dietary Manager stated those areas needed to be cleaned. A buildup of a yellow and white flakey substance was observed covering the top of the dishwasher. The Dietary Manager stated that it should be cleaned weekly. A white liquid substance was observed on the floor under the boxes holding up milk cartons inside the walk-in refrigerator. The Dietary Manager stated she did not know how long the white spillage was present because she was late this morning and had not gone in the walk-in refrigerator yet. Dietary Aide #1 stated that he saw the white spillage in the walk-in refrigerator earlier in the morning but did not clean it up. He stated any spillage should be cleaned up but could not provide a reason why he did not clean the white substance on the floor of the walk-in refrigerator. Review of the Kitchen Cleaning Checklist Log for the months of December 2025 through January 2026 (the dates of 1/11/26 - 1/19/26 only) revealed that the log showed a Monday - Sunday table for each task (all items to be cleaned weekly). Some spaces were left blank, some staff members put the date near their name, and some staff wrote the date and signed their name inside the table. According to the Kitchen Cleaning Checklist Logs, the deep fryer had not been cleaned since 12/22/25, the steamer had not been cleaned since December 2025 (no date specified), and the dishwasher had not been cleaned since 1/15/26. An interview was conducted with [NAME] #1 (daytime cook) on 1/29/26 at 11:37 AM. She revealed that all unclean areas observed on 1/28/26 were able to be cleaned. [NAME] #1 stated that she tried to clean as she worked but some days, she was too busy. She stated that the night shift did not complete their cleaning on 1/27/26. As far as the cleaning schedule goes, [NAME] #1 indicated that when she was working and assigned a task, she was expected to complete it. Dietary Aide #2, who worked the evening shift on 1/27/26, was interviewed on 1/29/26 at 11:40 AM. She revealed that she worked with a new employee (hired 1 month ago) during the evening shift of 1/27/26. All tasks fell on her during the shift, and she did not have any time to clean after the shift. During a follow-up interview with the Dietary Manager on 1/29/26 at 11:55 AM, she revealed that all the issues observed in the kitchen on 1/28/26 were cleaned later that day. The Dietary Manager stated all the issues identified in the kitchen were not addressed on 1/28/26 because she did not go behind (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Health and Rehabilitation Center	1403 Conner Drive Windsor, NC 27983

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them (kitchen staff) frequently. When she assigned a cleaning task, she expected staff to make sure it was completed. However, sometimes she was the cook during a shift and could not see everything. The Dietary Manager indicated that training was performed monthly during huddle; however, she did not document these training courses prior to 1/22/26. She planned to document the huddles going forward to ensure all staff were informed of things such as the cleaning checklist log. An interview was conducted with [NAME] #2 (evening cook) on 1/29/26 at 11:59 AM. He revealed that he was asked to come in early on 1/29/26 to help clean the kitchen. Normally, he did not come in early to help clean. Cooks were expected to clean up after themselves and any equipment they used during their shift. [NAME] #2 stated that the cleaning checklist log was only for deep cleaning. [NAME] #2 indicated if he was assigned a task, he would mark it on the log. Some staff members put the date of completion, and some did not. [NAME] #2 indicated that he could not always complete his cleaning during the first shift because there were two meals to prepare. Therefore, the evening shift would have to pick up the slack if cleaning was missed during the day shift. During a follow-up interview with the Dietary Manager on 1/29/26 at 2:05 PM, she revealed that each task on the Kitchen Cleaning Checklist Log should be completed weekly, and she expected staff to date and sign when completed. The Dietary Manager indicated the cleaning log was supposed to be posted weekly in December 2025 but did not happen due to many holiday events. The cleaning log for 1/1/26 through 1/11/26 could not be found. The Dietary Manager stated that cleaning tasks were rotated each week, but some staff did not do what they were supposed to do. The interview further revealed the deep fryer was broken from 1/4/26 until 1/20/26 or 1/21/26 (unsure of exact date) because it was not reaching the proper temperature and was last cleaned on 1/16/26. The first time it was used was on 1/23/26 and then again on 1/27/26. The Dietary Manager stated that the last training was completed on 1/22/26 for all kitchen staff related to hand hygiene, food contamination, and single use gloves. The Administrator was interviewed on 1/30/26 at 8:34 AM and stated the kitchen cleaning schedules should be followed.