STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345465	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Nursing & Rehabilitation Center	3003 Kensington Park Drive New Bern, NC 28560

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 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 observations, record review and staff interviews the facility failed to revise the comprehensive care plan to accurately reflect code status and the use of bedrails. This was for 1 of 3 residents (Resident #45) reviewed dementia care, and 2 of 2 residents (Resident #11 and Resident #40) reviewed for the use of bed rails. Findings included: 1. Resident #45 was admitted to the facility on [DATE] with a diagnosis of dementia. A physician's order for Resident #45 dated [DATE] was Do Not Resuscitate. (DNR is the refusal of Cardio-Pulmonary Resuscitation, a lifesaving procedure performed when someone's heartbeat or breathing has stopped). Resident #45's current active comprehensive care plan revealed a focus area desiring Cardio-Pulmonary Resuscitation (CPR). The goal dated last revised on [DATE] was for Resident #45 and her family's wishes for Full Code status (Full Code status involves CPR when someone's heartbeat or breathing has stopped) to be honored through the next review. An intervention was to ensure proper documentation supporting full code status was present in Resident #45's chart. On [DATE] at 8:15 AM an interview with the Minimum Data Set (MDS) Nurse indicated she would have been responsible for ensuring the code status on Resident #45's comprehensive care plan was accurate. She reported a care plan meeting had been arranged with Resident #45 and her family because Resident #45 had been declining. She went on to say there had been paperwork that needed to be signed for a DNR code status. The MDS Nurse stated Resident #45, and her family member had wanted to think about this, so she informed Resident #45's family member to give the paperwork to the Social Worker (SW) when he was finished. She reported she had been aware that all the steps for the completion of the paperwork for a DNR code status had been completed. The MDS Nurse reported this could have been in [DATE], although she could not recall exactly. She stated she should have updated Resident #45's comprehensive care plan immediately when the process including the obtaining of the physician's order for DNR code status was complete, but she missed it. On [DATE] at 9:15 M an interview with the Director of Nursing indicated the MDS Nurse would have been responsible for updating Resident #45's comprehensive care plan to accurately reflect Resident #45's DNR code status. She reported the MDS Nurse should have done this immediately. On [DATE] at 1:09 PM an interview with the Administrator indicated Resident #45's care plan should have been revised to accurately reflect her code status of DNR. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #11 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure. Review of Resident #11's electronic medical record revealed an assessment titled bed rail assessment dated [DATE] and completed by the Director of Nursing (DON). The assessment revealed Resident #11 used bilateral side rail/assist bars on her bed. A care plan with the latest review date of [DATE] revealed no reference to use of side rails (u-shaped grab bars) for Resident #11. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact. The MDS indicated Resident #11 was dependent on staff for bed mobility and was non-ambulatory. The MDS further revealed Resident #11 had impairment to her lower extremities and no impairment to her upper extremities. The MDS indicated Resident #11's u-shaped grab bars were not used as a restraint. An observation on [DATE] at 11:10 AM revealed Resident #11 lying in bed with bilateral u-shaped grab bars in the raised position. A follow-up observation and interview with Resident #11 was conducted on [DATE] at 1:55 PM. Resident #11 was observed lying in bed with bilateral u-shaped grab bars in the raised position. Resident #11 stated she had the u-shaped grab bars since she was admitted and used them to assist with mobility and positioning in bed. In an interview with the MDS Nurse on [DATE] at 8:32 AM she stated she was responsible for creating and updating care plans. The MDS Nurse was unaware u-shaped grab bars were supposed to be included on a residents comprehensive care plan. In an interview with the Administrator on [DATE] at 8:35 AM she stated she was unaware a residents comprehensive care plan should have included u-shaped grab bars. In an interview with the DON on [DATE] at 8:43 AM she stated she was unaware u-shaped grab bars were to be included on a resident's comprehensive care plan. 3. Resident #40 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure. Review of Resident #40's electronic medical record revealed an assessment titled bed rail assessment dated [DATE] and completed by the Director of Nursing (DON). The assessment revealed Resident #40 used bilateral side rail/assist bars (u-shaped grab bars) on her bed. A care plan with the latest review date of [DATE] revealed no reference to use of u-shaped grab bars for Resident #40. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively intact. The MDS indicated Resident #40 was independent with bed mobility and transfers and was ambulatory with a walker. The MDS further revealed Resident #40 had impairment to both lower extremities and one side of upper extremities. The MDS indicated Resident #40's u-shaped grab bars were not used as a restraint. An observation on [DATE] at 1:10 PM revealed Resident #40 sitting on the side of the bed with bilateral u-shaped grab bars in the raised position. A follow-up observation and interview with Resident #40 was conducted on [DATE] at 2:22 PM. Resident #40 was observed lying in bed with bilateral u-shaped grab bars in the raised position. Resident #40 stated she had the u-shaped grab bars since she was admitted and used them to assist with positioning in bed and to help her stand when getting out of bed. In an interview with the MDS Nurse on [DATE] at 8:32 AM she stated she was responsible for creating and updating care plans. The MDS Nurse was unaware u-shaped grab bars were supposed to be included on a residents comprehensive care plan. In an interview with the Administrator on [DATE] at 8:35 AM she stated she was unaware a residents comprehensive care plan should have included u-shaped grab bars. In an interview with the DON on [DATE] at 8:43 AM she stated she was unaware that u-shaped grab bars were to be included on a resident's comprehensive care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and resident interviews the facility failed to assess entrapment risk and failed to attempt alternatives prior to siderail use for 2 of 2 residents (Resident #11, Resident #40) reviewed for side rails. Findings included: 1. Resident #11 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure. Review of Resident #11's electronic medical record revealed an assessment titled bed rail assessment dated [DATE] and completed by the Director of Nursing (DON). The assessment revealed Resident #11 used bilateral side rail/assist bars (u-shaped grab bars) on her bed. The bed rail assessment noted that Resident #11 used the u-shaped grab bars as an enabler to promote independence and that she expressed desire to have the u-shaped grab bar. The bed rail assessment did not include an entrapment risk evaluation or if any alternatives were attempted before installation of the u-shaped grab bars. A care plan with the latest review date of 8/22/25 revealed no reference to use of u-shaped grab bars for Resident #11. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact. The MDS indicated Resident #11 was dependent on staff for bed mobility and was non-ambulatory. The MDS further revealed Resident #11 had impairment to her lower extremities. The MDS indicated Resident #11's u-shaped grab bars were not used as a restraint. An observation on 11/17/25 at 11:10 AM revealed Resident #11 lying in bed with u-shaped grab bars in the raised position. The bars were white, metal and about 8 inches wide x 16 inches tall. They were attached to the frame of the bed. A follow-up observation and interview with Resident #11 was conducted on 11/18/25 at 1:55 PM. Resident #11 was observed lying in bed with bilateral u-shaped grab bars in the raised position. Resident #11 stated she had the u-shaped grab bars since she was admitted and used them to assist with positioning in bed. In an interview with the DON on 11/18/25 at 2:30 PM she stated she was the staff member who conducted Resident #11's side rail assessment on 5/30/25 and that the facility referred to them as u-shaped grab bars. The DON revealed that staff did not conduct an entrapment risk assessment or attempt alternative interventions before using side rails. The DON further stated she was unaware that alternatives needed to be tried and documented and that an entrapment risk evaluation needed to be conducted before using u-shaped grab bars. The DON indicated that the MDS Nurse often conducted the quarterly side rail assessments. In an interview with the MDS Nurse on 11/18/25 at 2:40 PM she stated she often conducted quarterly side rail assessments for the use of the u-shaped grab bars. The MDS Nurse further stated she was unaware an entrapment risk evaluation needed to be conducted and alternatives to u-shaped grab bars needed to be tried and documented. In an interview with the Administrator on 11/18/25 at 3:46 PM she stated that the therapy department assessed residents for entrapment risk when using the u-shaped grab bars when they did their bed mobility evaluation. An interview was conducted with the Rehabilitation Manager on 11/18/25 at 3:54 PM. She stated therapy did not conduct entrapment risk evaluations. The Rehabilitation Manager further stated that when therapy conducted an evaluation regarding bed mobility and they felt the resident could use side rails to help, they would verbally inform that residents charge Nurse and Maintenance to have the side rails put on the bed if they don't already have them. In a follow-up interview with the Administrator on 11/18/25 at 4:02 PM, she indicated nursing staff used the side rail assessment tool that the corporate clinical team provided to the facility. The Administrator stated she was unaware that an entrapment risk evaluation needed to be done and that alternatives needed to be tried and documented before the use of u-shaped grab bars. 2. Resident #40 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease, chronic kidney disease and heart failure. Review of Resident #40's electronic medical record revealed an assessment title bed rail assessment dated [DATE] and completed by the Director of Nursing (DON). The assessment revealed Resident #40 used bilateral side rail/assist bars (u-shaped grab bars) on her bed. The bed rail assessment noted that Resident #11 used the u-shaped grab bars as an enabler to promote independence and that she expressed desire to have the u-shaped grab bar. The bed rail assessment did not include an entrapment risk evaluation or if any alternatives were attempted before installation of the u-shaped grab bars. A care plan with the latest review date of 10/17/25 revealed no reference to use of u-shaped grab bars for Resident #40. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively intact. The MDS indicated Resident #40 was independent with bed mobility and transfers and was ambulatory with a walker. The MDS further revealed Resident #40 had impairment to both lower extremities and one side of upper extremities