Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078111	A. BUILDING: _____ B. WING _____	R-C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE OF LUMBERTON	550 BAILEY ROAD LUMBERTON, NC 28359

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D 000	Initial Comments The Adult Care Licensure section conducted an annual and follow-up survey, and complaint investigation on 08/06/24, 08/13/24-08/15/24.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure was free of hazards in the Special Care Unit (SCU) by residents having access to aerosolized air freshener, personal care items, mouth wash, perfume, wrinkle reducer spray and numerous other items and in Assisted Living (AL) Unit by not properly storing oxygen canisters in a storage closet. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 104 residents with an Assisted Living (AL) capacity of 65 and a Special Care Unit (SCU) capacity of 39 residents. Review of the facility's resident roster on 08/13/24 revealed the facility's census was 87 with AL census was 50 and the SCU census was 37. Review of the facility's special care unit's	D 079	8/16/24 Administrator ensured the SCU was free of all hazards. The administrator/designee will perform weekly/as needed checks to ensure that all hazard materials on the special care unit are in lockable spaces and only accessible by staff. See attachment 1a 8/16/2024 CAN/PCA will perform room checks for hazardous materials while they are performing 15-minute resident checks. All hazardous materials found will be placed in a lockable space only accessible by staff. See attachment 1b 8/16/2024 Inservice staff to educate the importance of keeping all hazards materials locked in special care unit and not accessible to the resident.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 9/13/24

Reviewed and acknowledged 09/13/2024

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D 079	Continued From page 1 disclosure (not dated) revealed: -For safety of the residents, each resident was provided with lockable space within his/her room to store personal care and hygiene items, or facility will provide a safe lockable space of storage. -The safe and lockable space for storage was to prevent ingestion of any chemicals that may be hazardous to the resident. -The key for the lockable space will be maintained by the staff. Observation of the Special Care Unit (SCU) on 08/14/24 at 10:10am revealed: -Room 12 contained a bottle of body wash, bottle of hand sanitizer, a bottle of lotion and a can of shaving cream with a warning the contents were under pressure, don not puncture or incinerate, do not hear for any purpose, keep out of reach of children and avoid prolonged exposure to water, sitting on top of the resident's chest of drawers which was easily accessible by the residents. -Room 19 contained a can of aerosolized air freshener, a container of stick deodorant with a warning to keep out of reach of children, and if swallowed to get medical Poison Control Center right away, a bottle of body wash, several bottles of shampoo, and a bottle of mouthwash with a warning to keep out of reach of children and if more than used for rinsing was accidentally swallowed get medical help or contact a Poison Control Center right away, sitting on top of the resident's chest of drawers which was easily accessible by the residents. -Room 8 contained a large bottle of cocoa butter body lotion with a caution for external use only and to keep out of reach of children an if kin irritation occurred stop using the product, and a smaller bottle of body lotion sitting on top of the resident's chest of drawers which was easily	D 079		

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D 079	Continued From page 2 accessible by the residents. -Room 21 contained a bottle of body lotion, a tube of body lotion, a tube of toothpaste, a bottle of face cream, and a container of stick deodorant with a warning to keep out of reach of children, and if swallowed to get medical Poison Control Center right away sitting on top of the resident's chest of drawers which was easily accessible by the residents. -Room 13 contained a glass bottle of perfume, a bottle of shampoo, 4 containers of stick deodorant with a warning to keep out of reach of children, and if swallowed to get medical Poison Control Center right away, a bottle of mouth wash, and 2 spray bottles of perfumed body spray with a warning label CAUTION: FLAMMABLE Keep away from flame or high heat, not for underarm use sitting on top of the resident's chest of drawers which was easily accessible by the residents. Interview with a personal care aide (PCA) on 08/14/24 at 10:20am revealed: -Most personal care products were usually kept in the residents' closets in their rooms. -The closets in the residents' rooms were locked and the residents did not have keys. -Only facility staff members had keys to the residents' closets and could access the personal care products. -There were a few residents with personal care products in their rooms, but those residents were not as confused as some of the other residents. -She was not aware of any residents who had attempted to ingest any personal care products. -There were several residents who wandered in and out of other residents' rooms and required redirection. Interview with the Memory Care Coordinator	D 079		

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D 079	Continued From page 3 (MCC) on 08/14/24 at 10:23am revealed: -Personal care products should be stored in the residents' closet and locked. -Some of the residents had personal care products in their rooms, but those residents usually kept their room doors locked. -The residents in the special care unit (SCU) were not supposed to have any type of air fresheners in their rooms. -She was not aware of any residents who had attempted to ingest any personal care products. -There were a few residents who wandered in and out of other residents' rooms. -The PCAs were responsible for checking the residents' rooms daily to ensure personal care products were stored securely. -She was responsible for making sure the PCAs checked rooms daily, but she had been unable to check behind them the last few days. -Personal care products left in the residents' reach were a safety concern because a resident could ingest a product and be harmed. Interview with the Administrator on 08/15/24 at 9:20am revealed: -The residents in SCU were not supposed to have access to any personal hygiene products. -Their families would bring items in for them but were supposed to let the staff know so the items could be secured. -The staff were supposed to lock the items up in their closets and keep the key to unlock the closets as needed. -She would have to remind the families not to give the items directly to the resident but give them to the staff to be secured. 2. Review of the facility's undated medication storage policy revealed oxygen cylinders were to be properly stored in a designated locked area.	D 079		

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D 079	Continued From page 4 Observation of resident room D7 on 08/06/24 at 9:19am revealed there was an oxygen cylinder unsecured and not in a storage rack on the floor beside the closet. Observation of resident room D7 on 08/13/24 at 9:25am revealed there were two oxygen cylinders unsecured and not in a storage rack on the floor beside the closet. Interview with a resident in room D7 on 08/13/24 at 9:25am: -He used oxygen continuously. -He used his oxygen concentrator while he was in his room, and he used the portable oxygen cylinders when he left his room. -The facility staff assisted him with his portable oxygen cylinders. -The two oxygen cylinders by his closet were empty, and he was unsure how long the cylinders had been there. -He did not have a rack to store oxygen cylinders in his room. -He was unsure where his full oxygen cylinders were stored. Observation of a resident's room on 08/06/24 at 8:27am revealed: -There was one unsecured oxygen (O2) tank sitting upright on the floor next to the wall. -There was no holder or crate to stabilize O2 tank. Interview with a resident on 08/06/24 at 8:27am revealed the O2 tanks belonged to her roommate who was moved to another room on Sunday (08/04/24). Interview with a medication aide (MA) on	D 079	8/16/2024 Administrator checked all rooms of facility and ensured all oxygen tanks were properly stored. The Administrator/Designee will complete weekly checks of all rooms to ensure all tanks are secure and properly stored. See attachment 2a CNA/PCA will conduct 2 hr checks of rooms to ensure all tanks are properly stored and free of potential hazards. The administrator/ Designee will complete weekly/as needed checks of all rooms to ensure all tanks are secure and properly stored. See attachment 2b 8/16/2024 Inservice staff on placement and proper storage of used and new oxygen tanks.	

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D 079	Continued From page 5 08/06/24 at 8:30am revealed: -The O2 tanks belonged to a resident who was moved to another room, and staff had not cleaned her room since she was moved. -The resident was moved on Sunday 08/04/24). -The O2 tanks should be stored in an O2 holder. -She was not sure why the O2 tanks had not been removed from the resident's room. Interview with a medication aide (MA) on 08/13/24 at 11:55am revealed: -The residents' portable oxygen cylinders were stored in the oxygen storage room. -MAs had keys to the storage room and were responsible for getting full oxygen cylinders for residents. -MAs were responsible for taking the empty cylinders to the storage room and placing them in the designated rack. -All oxygen cylinders should be stored in a rack. -There was a rack for empty oxygen cylinders in the oxygen storage room. Observation of the facility's oxygen storage room on 08/13/24 at 11:57am revealed: -There was a red sign posted outside of the room with "no smoking, oxygen in use". -The door was locked, and the medication aide (MA) opened the storage room with a key. -There was a rack containing several empty oxygen cylinders. -There were several racks containing full oxygen cylinders. Interview with the Resident Care Coordinator (RCC) on 08/13/24 at 12:04pm revealed: -The residents' portable oxygen cylinders were stored in the oxygen storage room. -The oxygen storage room was locked and accessible only to facility staff.	D 079		

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D 079	Continued From page 6 -There were specific racks for full and empty oxygen cylinders. -All oxygen cylinders should be stored in a rack. -Medication aides (MA) were responsible for ensuring empty oxygen cylinders were taken to the oxygen storage room and stored in a rack. -She was working as a MA on the hall where room D7 was located today, 08/13/24, but had not noticed the oxygen cylinders on the floor in room D7. -She was unsure why the two oxygen cylinders were on the floor in room D7. -Oxygen cylinders should not be stored on the floor because it was a safety concern. -The two oxygen cylinders should have been removed from the resident's room and placed in the rack for empty cylinders in the oxygen storage room. Interview with the Administrator on 08/15/24 at 9:20am revealed: -Empty and full oxygen cylinders should be stored in the oxygen storage room. -There were designated racks for empty and full oxygen cylinders in the storage room. -Oxygen cylinders should be always stored in a rack whether the cylinders were full or empty. -Medication aides (MA) were responsible for ensuring empty cylinders were brought to the oxygen storage room and placed in a rack. -She was unsure why the oxygen cylinders were left in room D7, but the oxygen cylinders should not have been stored on the floor. -The empty oxygen cylinders should have been removed from the room and placed in the rack designated for empty cylinders in the oxygen storage room. -Oxygen cylinders that were not stored in a rack were a concern for residents' safety.	D 079		

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D 282	Continued From page 7	D 282		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were protected from contamination during the breakfast meal as evidenced by several staff who did not remove gloves nor wash their hands before plating and serving residents' food. Review of the Food Service Orientation Manual North Carolina Department of Health and Human Services Division of Health Service Regulation-Adult Care Licensure Section (not dated) revealed: -Clean refers to being free from visible dirt. -Sanitize means disinfected, not just removable of visible dirt, but bacteria (germs) were killed. -The elderly are particularly susceptible to harmful bacteria. -These bacteria may find their way into food from poor food-handling. -Another way bacteria find their way into food is through your hands. -Your hands carry illness-causing bacteria.	D 282	The Administrator/Designee will perform one random meal check daily for one month and then weekly/as needed checks will be performed to ensure residents are protected from contamination during meals. See attachment 3a 8/16/2024 Inservice of staff on the importance of hand washing and the proper techniques when handling utensils, plates, and cups at mealtimes. River's Edge has implemented the following changes to mealtimes: Dietary staff will ensure all dirty dishes are removed from tables, tables will then be cleaned, and staff will perform proper hand hygiene and glove changes before setting the table to prevent cross contamination. Infection control was completed by all staff on 08/16/2024 and hand hygiene competency validation was completed on 09/09/2024 to ensure all staff are using the proper techniques for hand washing. See attachment 3b	

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D 282	Continued From page 8 -This is why you should wash your hands prior to preparing food or beverage. -This is especially important prior to preparing or serving ready-to-eat foods such as tossed salads, beverages and fresh fruit. -Ready-to eat foods such as these are not cooked, so any bacteria that might have contaminated them will not be killed by cooking. -Bacteria from your hands can contaminate foods and utensils and cause illness in a resident. -Elderly residents are particularly susceptible to food-borne illness, so being sanitary is very important. -Your hands should be washed thoroughly with soap and water to prevent spreading the bacteria to other foods or objects. -Also, you can pick up harmful bacteria from other things such as garbage cans, the floor, dirty rags, or even your own body. -Hand hygiene is very important in preventing the spread of bacteria. -Just blowing your nose, using the toilet or scratching your head or body can contaminate your hands with potentially deadly bacteria. -Those bacteria can be spread to food or utensils if you do not wash your hands afterwards. -Here are some examples of when to wash your hands: -Before handling or preparing food, clean dishes and utensils. -After touching any part of your body. -After using the toilet. -After touching animals. -After coughing, sneezing, eating or using tobacco. -After taking the garbage out, handling dirty dishes or equipment, or cleaning the kitchen. -After preparing raw meat/poultry/seafood. -After touching anything that would contaminate your hands when they are clean, including	D 282		

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D 282	Continued From page 9 contact with residents in the facility or objects that are not clean. -Personal hygiene is also a part of preventing the spread of harmful bacteria. Observation of the breakfast meal on 08/14/24 in the Special Care Unit (SCU) dining room revealed: -The personal care aides (PCAs) were serving residents their breakfast meals with gloves on their hands. -After residents were through eating their breakfast meals, the staff removed the used plates, cups, utensils, napkins from the tables. -The PCAs returned to serving residents their coffee and touched the rims of the cups with their gloved hands. -The PCAs did not remove their gloves and perform hand hygiene between the "dirty" task of cleaning up the used plates, cups, utensils, napkins from the tables before starting a "clean" task of serving plates of food and cups of drink to residents who arrived to the dining room for breakfast. -When all the residents from the first seating of breakfast had finished eating and had exited the SCU dining room, the PCAs cleared the tables by removing the used plates, cups, utensils, napkins; then cleaned the tables with a spray cleaner and cloth, swept up needed areas, and set the tables with fresh napkins and utensils without doffing gloves and performing hand hygiene. -The PCAs were observed picking up the utensils by the bowl of the spoon not the handle when removing it from the plastic storage container. Observation of the breakfast meal on 08/14/24 in the Assisted Living (AL) dining room revealed: -The personal care aides (PCAs) were serving	D 282		

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D 282	Continued From page 10 residents their breakfast meals with gloves on their hands. -After residents were through eating their breakfast meals, the staff removed the used plates, cups, utensils, napkins from the tables. -The PCAs returned to serving residents their coffee and touched the rims of the cups with their gloved hands. -The PCAs did not remove their gloves and perform hand hygiene between the "dirty" task of cleaning up the used plates, cups, utensils, napkins from the tables before starting a "clean" task of serving plates of food and cups of drink to residents who arrived to the dining room for breakfast. -When all the residents from the first seating of breakfast had finished eating and had exited the AL dining room, the PCAs cleared the tables by removing the used plates, cups, utensils, napkins; then cleaned the tables with a spray cleaner and cloth, swept up needed areas, and set the tables with fresh napkins and utensils without doffing gloves and performing hand hygiene. Observation of the breakfast meal on 08/15/24 in the SCU revealed: -The administrator was assisting the PCAs serve the breakfast meal to the residents. -She was observed picking up cereal bowls three at a time by "pinching" her fingers inside the bowls to remove them from the food cart and placed them on the residents dining room tables. -She was observed picking up the water glasses and juices glasses three at a time by "pinching" her fingers inside the cups to remove them from the food cart and placed them on the residents dining room tables. Interview with a PCA on 08/15/24 at 10:15am	D 282		

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D 282	Continued From page 11 revealed: -She had been employed previously in food service, so she was familiar with proper serving. -She had been trained at the facility as well and had taken a test after training. -She knew not to touch "dirty" items like used plates, cups or utensils and then touch a clean plate of food without washing her hands or at least using hand sanitizers. -She did not use gloves to serve or clean up but knew to wash her hands when gloves were removed. Interview with the Administrator on 08/15/24 at 9:20am revealed: -The dietary staff were expected to wash their hands and practice sanitary handling of food in the dining rooms. -She was not sure why the dietary staff did not wash their hands or use hand sanitizer when serving the residents their plates or when they removed their gloves. -She was concerned that the residents may be exposed to germs that could cause them to get sick.	D 282	Administrator and Dietary Manager reviewed all resident's diet orders to ensure all diets are being received as prescribed by the physician 8/16/2024 Staff in service on the importance of following the menu to ensure all residents receive the proper diets. The Administrator/Designee will perform weekly/as needed checks with dietary manager to review changes with diet orders and new residents.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve a therapeutic diet as ordered for 1 of 4 sampled residents a	D 310		

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D 310	Continued From page 12 chopped meat diet (#7). The findings are: Review of Resident #7's current FL-2 dated 09/28/23 revealed: -Diagnoses included dementia, neurocognitive disorder, chronic obstructive pulmonary disease, disorder of the salivary gland, and fibro myositis. -She was constantly disoriented. -Her level of recommended care was listed as Special Care Unit (SCU). Review of Resident #7's diet order dated 02/19/24 revealed a regular diet with chopped meat. Review of Resident #7's Licensed Health Profession Service (LHPS) review dated 07/31/24 revealed feeding assistance. Observation of the breakfast meal on 08/14/24 revealed: -Residents were served scrambled eggs, one strip of crisp bacon, one slice of bread, grits, milk, water, juice and coffee. -Resident #7 was served the same breakfast items as the other residents in the SCU dining room. -She received a strip of crisp bacon. Interview with the dietary manager on 08/15/24 at 9:00am revealed: -She had an updated list of all the residents and their current ordered diets. -She followed the extensions included with the facility's diet menu. -The facility did not normally serve bacon, and she did not think the bacon being served was not suitable for the chopped meat diet for Resident	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078111	A. BUILDING: _____ B. WING _____	R-C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE OF LUMBERTON	560 BAILEY ROAD LUMBERTON, NC 28359

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D 310	Continued From page 13 #7. Interview with the Administrator on 08/15/24 at 9:20am revealed: -The dietary staff were expected to follow the diet orders ordered by the primary care providers. -Resident #7 should not have been given bacon. -The facility did not normally order bacon for serving but ordered sausage, either patty or link. -She was concerned that the bacon could have caused choking and possibly aspiration for her due to her difficulty swallowing. -She was not sure why the dietary staff gave Resident #7 bacon. Attempted interview with primary care provider on 08/15/24 at 9:30am was unsuccessful.	D 310		