

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL078111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/30/2026
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE OF LUMBERTON		STREET ADDRESS, CITY, STATE, ZIP CODE 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 on 01/28/26 through 01/30/26.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training (Staff B, Staff F) prior to administering medications. The findings are: 1. Review of Staff B's personnel record on 01/30/26 revealed: -Staff B was hired as a personal care aide (PCA) and medication aide (MA) on 09/17/25. -Staff B's clinical skills checklist was completed on 12/17/25. -There was a 5-hour medication administration training certificate with Staff B's name on it and the date of 12/15/25 with no signature from a	D 125		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 125	Continued From page 1 trainer. -There was a 10-hour medication administration training certificate with Staff B's name on it and the date of 12/22/25 with no signature from a trainer. -There was no documentation Staff B passed the MA test. Interview with Staff B on 01/30/26 at 9:07am revealed: -She was a MA/PCA. -She was a MA in training. -A nurse performed a "skills check off" but she did not remember when it was done. -She was in the process of scheduling the North Carolina medication aide test and had not taken the test yet. Refer to interview with the Business Office Manager (BOM) on 01/30/26 at 10:35am. Refer to interview with the Administrator on 01/30/26 at 10:24am. Refer to second interview with the Administrator on 01/30/26 at 10:40am. 2. Review of Staff F's personnel record on 01/30/26 revealed: -Staff F was hired as a PCA on 08/06/25. -Staff F's clinical skills checklist was completed on 10/26/25. -There was a 5-hour medication administration training certificate with Staff F's name on it and the date of 12/15/25 with no signature from a trainer. -There was a 10-hour medication administration training certificate with Staff F's name on it and the date of 12/22/25 with no signature from a trainer.	D 125			

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D 125	Continued From page 2 -There was no documentation that Staff F passed the MA test. Telephone interview with Staff F on 01/30/26 at 12:08pm revealed: -She used to work as a medication aide (MA) but was currently working as a personal care aide (PCA) at the facility. -She had taken the North Carolina medication aide test in December 2025 but did not pass the test. -She was not currently working as a MA at the facility. -She had trained for a while to be a MA. -She remembered a nurse watching her administer medications before administering medications independently, but did not remember when it was performed. Refer to interview with the Business Office Manager (BOM) on 01/30/26 at 10:35am. Refer to interview with the Administrator on 01/30/26 at 10:24am. Refer to second interview with the Administrator on 01/30/26 at 10:40am. Interview with the Business Office Manager (BOM) on 01/30/26 at 10:35am revealed: -She was responsible for staff records. -The facility had always used a company for online training and never had signed medication aide training certificates. -She did not know the 5- and 10-hour medication administration training certificates had to be signed by a registered nurse (RN) or pharmacist. Interview with the Administrator on 01/30/26 at	D 125			

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D 125	Continued From page 3 10:24am revealed: -The BOM was responsible for staff records. -The facility utilized a company that provided online 5- and 10-hour medication aide training and then sent a nurse to complete the skills checkoff portion of the training with staff. -The company the facility utilized for training did not provide signed certificates of completion. Second interview with the Administrator on 01/30/26 at 10:40am revealed: -She did not know that the 5 and 10, or 15-hour medication administration training certificates had to be signed by a trainer. -She did not know that a RN or pharmacist had to provide training and then print and sign the certificate for training to be completed.	D 125		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a) (1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior	D 161		

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D 161	Continued From page 4 to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff E) had Licensed Health Professional Support (LHPS) skills competency validation for catheter care. The findings are: Review of Staff E's personnel record revealed: -Staff E was hired as a personal care aide (PCA) on 05/17/24. -Staff E had a Licensed Health Professional Support (LHPS) skills competency validation dated 06/26/24. -On the section titled positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter, "NA" (not applicable was documented above and below the section). Interview with Staff E on 01/30/26 at 10:17am revealed: -She did not remember being checked off on catheter care. -She had been performing catheter care on residents. -Residents with catheters had catheter cleaning performed in the shower three times a week. -Residents did not have bed baths performed on the non-shower days. -She washed around residents' catheters with soap and water. -She had never removed or replaced a resident's	D 161			

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D 161	Continued From page 5 catheter drainage bag. Interview with the Business Office Manager (BOM) on 01/30/26 at 10:35am and 11:25am revealed: -She reviewed all staff folders quarterly, and she was not sure of the last review date. -The medication aides (MA) and PCAs had LHPS skills competency evaluations performed before they started to work. -She had not reviewed the LHPS evaluations placed in their staff folder. -The LHPS evaluations were not repeated unless the staff left employment and were rehired. -If a staff member was performing catheter care they should be checked off on the LHPS. -She did not know that Staff E was not checked off to perform catheter care. -She was responsible for ensuring that all the staff were checked off to perform catheter care. -She was concerned that Staff E was not validated to perform catheter care. Interview with the LHPS nurse on 01/30/26 at 11:50am revealed: -When she completed the LHPS skills competency she had the staff to demonstrate catheter care. -She was not sure if Staff E had been validated for catheter care. -She was not sure if all staff had been validated for catheter care. Interview with the Administrator on 01/30/26 at 8:40am revealed: -She was not sure if the LHPS nurse had checked off the staff to perform catheter care. -The BOM was responsible for ensuring that the LHPS nurse completed the LHPS skills competency for staff.	D 161			

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D 161	Continued From page 6 -She was responsible for ensuring that the staff had been checked off and validated for the personal care they were providing the residents.	D 161		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 1 of 2 residents (#2) sampled who needed catheter care. The findings are: Review of the facility's undated catheter policy revealed: -The facility will ensure that residents receive appropriate catheter care. -Administrator/designee will ensure proper health care professionals are maintaining/replacements of the catheter as prescribed by the provider. -Administrator/designee will perform quarterly or as needed in-service for staff. Review of the facility's in-service sheets revealed: -The staff had not been in-serviced on catheter care since 10/25/25. -There were five staff signatures on the	D 269		

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D 269	Continued From page 7 attendance sheet. -The topics reviewed were elder abuse, reporting elder abuse, catheter care, cell phones, clocking in late, and tone of voice. -There was no information related to what the staff were educated on related to catheter care . Review of Resident #2's FL2 dated 05/04/25 revealed: -Diagnoses included blind, end stage renal disease, dialysis, intellectual disability, hyperkalemia, pressure ulcer, polyneuropathy, and hypertension. -He required staff assistance with indwelling suprapubic catheter, bathing and dressing. Review of Resident #2's Resident Register revealed an admission date of 01/05/21. Review of Resident #2's care plan dated 05/08/25 revealed: -He required limited assistance with eating (blind), ambulation (blind), and transferring (blind). -He required extensive assistance with dressing (blind). -He was totally dependent on toileting (has a catheter and blind), bathing (blind), and grooming/personal hygiene (blind). Review of Resident #2's Licensed Health Professional Support (LHPS) dated 12/23/25 revealed: -Resident #2 was total care because he was blind. -Personal care tasks present were listed as positioning and emptying of urinary catheter bag and cleaning around the urinary catheter. -Resident has a suprapubic foley catheter. -Resident #2 was on a 1000ml fluid restriction.	D 269		

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D 269	Continued From page 8 Observation of Resident #2's catheter leg bag on 01/29/26 at 11:20am revealed: -The catheter leg bag was attached to Resident #2's left thigh with one strap. -The catheter leg bag was twisted once in the middle of the bag. -There was no urine noted in the catheter leg bag. Interview with Resident #2 on 01/29/26 at 9:40am revealed: -His catheter had been changed at the first of this month. -He only wore a catheter leg bag. -He only produced a small amount of urine. -The staff at the facility emptied his catheter bag every few days. -He never emptied his catheter leg bag because he was blind. -He was placed on an antibiotic recently but he was unsure what it was for. Interview with Resident #2 on 01/29/26 at 11:25am revealed: -The staff emptied the catheter leg bag. -The catheter leg bag was strapped to his left thigh. -Resident #2 could not empty the catheter leg bag because he was blind. Observation of Resident #2's stoma on 01/30/26 at 1:00pm revealed: -There was not a dressing around Resident #2's stoma. -Resident #2's catheter was in place. -The skin around Resident #2's stoma was intact. -There was no drainage, odor, or redness noted around Resident #2's stoma.	D 269		

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D 269	Continued From page 9 Review of Resident #2's home health resident notes dated 12/04/25 revealed: -The Registered Nurse (RN) was there for Resident #2's routine monthly catheter change. -The catheter leg bag was attached upside down with clamp end attached to the catheter and other end exposed and open which prevented the catheter from draining. -When the catheter was removed from the suprapubic stoma, urine began draining from the opening. -The urine appeared thick, opaque, mucoid, and greenish yellow. -The facility Administrator and the primary care provider (PCP) were notified related to the findings. -The PCP was going to send orders to the facility. -She inserted a 16 French catheter and inflated the balloon with 10ml of sterile water. Review of Resident #2's physician orders dated 12/04/25 revealed: -There was an order for Bactrim DS 800mg/160mg, to be administered every 12 hours for 10 days (Bactrim DS is a double strength combination antibiotic used to treat bacterial infections and urinary tract infections). -There was an order for Triamcinolone 0.1% cream dated 12/04/25 apply thin layer topically around the catheter stoma and groin twice daily for 2 weeks (Triamcinolone 0.1% cream is a medium to strong potency topical corticosteroid used to treat dermatitis and skin rashes). Review of Resident #2's home health resident notes dated 01/07/26 revealed: -The RN was there for Resident #2's routine monthly catheter change. -His catheter leg bag was attached upside down with clamp end attached to the catheter and other	D 269			

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D 269	Continued From page 10 end exposed and open. -The catheter was changed without difficulty with a 16 French catheter. -The Administrator was notified of the findings. Review of Resident #2's physician orders dated 01/14/26 revealed: -There was an order for Sulfamethoxazole-TMP DS administer one tablet every 12 hours for 10 days (Sulfamethoxazole-TMP DS is a double strength combination antibiotic used to treat bacterial infections and urinary tract infections). -There was an entry for Cefdinir 300mg administer one every 12 hours for 7 days (Cefdinir is an antibiotic used to treat bacterial infections). Telephone interview with the facility's contracted home RN on 01/29/26 at 10:16am revealed: -She had been Resident #2's home health nurse for 4 months. -The facility had never called her related to Resident #2's catheter. -She changed Resident #2's suprapubic catheter each month. -On 12/04/25 she changed Resident #2's suprapubic catheter and found the leg bag connected upside down. -No urine output was noted. -There was dried urine noted on Resident #2's incontinence pull up from catheter leaking. -There was a red rash with bumps noted around Resident #2's stoma and groin area. -When the catheter was removed it pooled on his abdomen. -She notified the Administrator and the PCP that the catheter bag was connected upside down. -She found the catheter leg bag attached upside down a second time on 01/07/26 when she arrived to change Resident #2's suprapubic	D 269		

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D 269	Continued From page 11 catheter. -She did not know how long the catheter leg bags had been attached upside down. -She was concerned that the catheter bag was not sealed. -An unsealed catheter bag was an open portal for bacteria to enter and could cause an infection. -Resident #2 was compromised due to his end stage renal failure and he was on dialysis three times weekly. -Resident #2 was blind and depended on the facility's staff to care for him properly. -Resident #2 chose to wear a catheter leg bag. -The facility had not requested her to provide catheter care education for the staff. Interview with a personal care aide (PCA) on 01/29/26 at 10:00am revealed: -She did not remember if she had been checked off to perform catheter care. -She had cleaned Resident #2's catheter with soap and water when she showered him and emptied his catheter bag. -The facility did not require documentation of the amount of urine emptied or that catheter care was performed. -She had never changed Resident #2's catheter bag. Interview with a second PCA on 01/29/26 at 10:10am revealed: -She did not remember being checked off to perform catheter care. -She emptied catheter bags when she made rounds every 2 hours. -She emptied Resident #2's catheter bag when she showered him. -She had never changed Resident #2's catheter bag. -The facility did not require documentation of the	D 269		

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D 269	Continued From page 12 amount of urine emptied or that catheter care was performed. -She cleaned the drainage spout of the catheter bag with soap and water when she emptied the catheter bag. Interview with a third PCA on 01/30/26 at 10:17am revealed: -She did not remember being checked off to perform catheter care. -Residents were showered three times weekly. -Residents did not receive bed baths, if soiled they took the residents to the shower to clean them. -She cleaned Resident #2's catheter with soap and water. -She could not remember emptying Resident #2's catheter leg bag. Interview with a medication aide (MA) on 01/29/26 at 9:50am revealed: -MAs and personal care aides (PCA) could perform catheter care, cleaning and emptying. -She thought that she had been checked off to perform catheter care. -When she emptied Resident #2's catheter bag she cleaned the drainage spout with alcohol. -The PCAs normally emptied Resident #2's catheter bag. -If she found an issue with Resident #2's catheter she would notify the Administrator and she would call the home health nurse. -She did not know if Resident #2 had any recent issues with his catheter. -The facility did not require documentation of the amount of urine emptied or that catheter care was performed. Interview with a second medication aide (MA) on 01/29/26 at 11:20am revealed:	D 269			

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D 269	Continued From page 13 -Resident #2's catheter leg bag was strapped to his left thigh with one strap. -The MA did not remember but one strap used to connect to Resident #2's thigh. -This was the first time she had discovered the catheter leg bag twisted. Interview with the Administrator on 01/30/26 at 8:40am revealed: -She was not sure if the staff had been checked off on catheter care by the LHPS nurse. -The Business Office Manager (BOM) was responsible for ensuring all staff had been validated to perform catheter care by the LHPS nurse. -She did not have a procedure for catheter care. -She would pull up Resident #2's pants leg to demonstrate how to empty his catheter leg bag. -The staff would clean around Resident #2's catheter and empty the catheter leg bag. -The staff were not required to document catheter care or the amount of urine emptied. -Resident #2's stoma was cleaned three times weekly in the shower and during his bed bath the other days. -The catheter leg bag was not routinely changed unless there was an issue. -Resident #2's catheter leg bag should be attached to his lower leg. -She did know that the home health RN had found Resident #2's leg bag attached upside down twice. -She was concerned that urine could have backed up in him and cause an infection. -She notified the PCP related to both incidents of the catheter leg bag attached upside down. -The PCP placed Resident #2 on antibiotics after both incidents. -There had not been any training on catheter care provided since the two incidents of the catheter	D 269		

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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE OF LUMBERTON		STREET ADDRESS, CITY, STATE, ZIP CODE 550 BAILEY ROAD LUMBERTON, NC 28359		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 14 leg bag attached upside down. -She provided education to the staff quarterly. -She was not sure why she had not reeducated the staff after the two incidents of the catheter leg bag being attached upside down. -She had not requested hospice or home health to provide education on catheter care. Interview with the BOM on 01/30/26 at 10:35am revealed: -She performed quarterly staff record reviews looking for education, immunizations, and basic life support (BLS). -The PCAs and MAs were checked off for LHPS before they started to work on the floor. -A LHPS was not repeated unless the staff quit and was rehired. -If a staff member was performing catheter care, then they should have been checked off. -She was responsible for ensuring that all the staffs documents were completed. Telephone interview with the LHPS nurse on 01/30/26 at 11:50am revealed: -When she completed an LHPS initial or review and a resident had personal care tasks like catheter positioning, emptying, and cleaning around the catheter she made sure to document staff competency validated see staff files. -She was not sure if all staff had been validated to perform catheter care. -When she completed an LHPS skill/competency checklist for the staff she had the staff to demonstrate how to perform catheter care. -She had not been asked to provide education for the staff on catheter care. -She was concerned about Resident #2's potential for infection if the staff were not performing catheter care correctly. -She was concerned about fluid overload with his	D 269		

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D 269	Continued From page 15 compromised health and being on dialysis. Interview with Resident #2's contracted dialysis clinic's RN Manager on 01/30/26 at 9:13am revealed: -Resident #2 had dialysis performed three days per week, Monday, Wednesday, and Friday. -Dialysis staff inspected Resident #2's lower legs for edema. -Dialysis staff did not pull Resident #2's pants legs up high enough to observe his catheter leg bag. -The dialysis clinic had not changed or emptied Resident #2's catheter leg bag. -There was no reason for dialysis staff to observe Resident #2's catheter leg bag. Telephone interview with Resident #2's PCP on 01/29/26 at 10:25am revealed: -Resident #2 had minimal urine output. -He was followed by a Urologist yearly. -He had end stage renal disease and was on dialysis three times weekly. -She was not sure how long his catheter leg bags had been connected incorrectly. -She was concerned that he could have become septic which could have sent him to the hospital for treatment (Sepsis is a life-threatening medical emergency caused by the body's extreme, dysfunctional immune response to an infection instead of fighting the infection locally which can lead to organ failure, tissue damage, and potentially death). -She ordered antibiotics both times the catheter leg bag was attached upside down and a medication for the rash on 12/04/25. -She was concerned that there were no clinically trained staff at the facility and they had a high turnover rate for caregivers.	D 269		

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D 269	Continued From page 16 Attempted telephone interview with a second LHPS nurse on 01/30/26 at 11:45am was unsuccessful. Refer to Tag 161 10A NCAC 13F .0504 (a & b) Competency Evaluation & Validation for LHPS Tasks. _____ The facility failed to provide personal care assistance for a resident who was blind, had end stage renal disease, and was on dialysis (#2). The resident was totally dependent on staff for toileting and had a suprapubic catheter. On two occasions a home health nurse found the resident's catheter leg bag attached to his catheter upside down which prevented the urine from draining properly and leaving an open portal for bacteria to enter. On one of these occasions the resident's urine was noted to be thick and greenish yellow in color. The resident was subsequently placed on antibiotic therapy on both due to the primary care provider's concern that the resident could become septic. This failure placed the resident at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 01/30/26 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED March 1, 2026.	D 269			
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310			

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D 310	Continued From page 17 (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 ensure therapeutic diets were served as ordered for 1 of 4 residents sampled (#7) with physician orders for a no concentrated sweets diet. The findings are: Review of Resident #7's current FL-2 dated 06/03/25 revealed: -Diagnoses including dementia, moderate risk chest pain, bipolar disorder, gastro-esophageal reflux disease, hypertension, and long-term insulin use in type 2 diabetes. -There was a physician's order for a no concentrated sweets diet (NCS). Review of Resident #7's Resident Register dated 01/21/25 revealed the resident was admitted to the facility on 01/21/25. Review of Resident #7's care plan dated 01/21/25 revealed the resident required limited assistance with eating. Review of the facility's resident diet order list revealed: -The diet order list was updated 01/28/26. -Resident #7's diet was listed as no concentrated sweets. Observations of the lunch meal on 01/28/26 from	D 310		

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D 310	Continued From page 18 12:06pm to 12:35pm revealed: -Resident #7's served meal included an approximate sized 3-inch by 3-inch cake square with yellow icing. -Resident #7 fed herself. -Resident #7 ate the entire cake serving. Interview with a personal care aide (PCA) on 01/28/26 at 12:32pm revealed: -She served the food delivered to the Special Care Unit (SCU) for the residents as plated by the kitchen. -Resident #7 was a diabetic. -Resident #7 could be served sweets but could not have a second serving of a sweet item. -She did not know Resident #7 was prescribed a NCS diet. Review of the facility's menu extensions spreadsheet for a NCS diet revealed sweetened desserts were to be avoided and substituted for sugar free items or fruit in water/juice. Interview with the cook on 01/28/26 at 12:37pm revealed: -She served cake with lemon pudding for lunch today, 01/28/26. -Diabetics could have cake with lemon icing. -The resident could have been served fruit, but she served what was listed on the menu printed by the Administrator. -She always used the daily menu list prepared and provided to her by the Administrator. -She did not know why she did not use the dietician prepared menus. Interview with the Special Care Coordinator (SCC) on 01/29/26 at 10:12am revealed: -She did not know why Resident #7 was served cake with icing at lunch on 01/28/26.	D 310		

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D 310	Continued From page 19 -Resident #7 was usually served a different dessert at meals. -She had not observed the lunch meal delivery for 01/28/26 because she was working in the medication room. -Resident #7's fingerstick blood sugar reading was 140 at 4:00pm on 01/28/26. Interview with the Administrator on 01/28/26 at 12:42pm revealed: -All residents were served the same food items because no extra sugar was added. -There were 22 grams of sugar per ½ cup serving of the lemon pudding. -The label on the lemon pudding did not indicate the pudding was sugar free. -She had not noticed the printed instructions on the menu extension sheets indicating sweetened desserts were to be avoided and substituted with sugar free items or fruit in water. Second interview with the Administrator on 01/30/26 at 8:07am revealed: -The dietician prepared menus were kept in the kitchen. -The cooks were supposed to use the dietician prepared menus for guidance when plating residents' food. -The facility started serving diabetic residents' sugar free fruits and sugar free pudding on 01/28/26. -Prior to 01/28/26, the diabetic residents were served the same snacks as other residents at the facility. Based on observations, interviews and record reviews, it was determined that Resident #7 was not interviewable. Attempted telephone interview with the primary	D 310			

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D 310	Continued From page 20 care provider (PCP) on 01/30/26 at 3:40pm was unsuccessful.	D 310			
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medications were administered as ordered related to a medication used to treat blood pressure for 1 of 7 sampled residents (#4). The findings are: Review of the facility's undated Medication Administration policy revealed: -Medications, prescriptions and non-prescription, and treatments would be administered in accordance with the prescribing practitioner's orders. -Documentation would be provided by the staff that administered medications and performed treatments to the resident on the facility medication administration record (MAR). -In the event of medication errors and adverse reactions to medications, facility staff charting would identify if documentation errors, unavailability of medications, or resident's refusal	D 358			

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D 358	Continued From page 21 of medication may have led to the error. -Staff who had demonstrated competence according to State rules could prepare and administer medications and perform treatments. Review of Resident #4's current FL-2 dated 10/16/25 revealed diagnoses included unspecified dementia with behavioral disorder, anxiety, atrioventricular block, second degree paroxysmal atrial fibrillation, and essential primary hypertension. Review of the Resident Register for Resident #4 dated 10/15/25 revealed Resident #4 was admitted to the facility on 10/18/25. Review of the Care Plan and Assessment for Resident #4 dated 10/21/25 revealed Resident #4's task included daily medication administration as ordered by the physician. Review of physician orders (PCP) for Resident #4 dated 10/16/25 revealed there was a physician's order for Hydralazine (used to lower the blood pressure) 10mg tablet every eight hours and hold for systolic blood pressure less than 110 (systolic blood pressure is the first number (top number) of the blood pressure reading and measures the force of the blood flow when the blood is pumped out of the heart) . Review of the December 2025 electronic medication administration records (eMAR) for Resident #4 revealed: -There was a printed entry for Hydralazine 10mg tablet every eight hours (hold for systolic blood pressure less than 110) and scheduled at 6:00am, 2:00pm, and 10:00pm. -On 12/09/25 at 10:00pm, Resident #4's systolic blood pressure was documented as 103, and	D 358			

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D 358	Continued From page 22 Hydralazine 10mg was administered at 10:00pm on 12/09/25. -On 12/20/25 at 2:00pm, Resident #4's systolic blood pressure was documented as 109, and Hydralazine 10mg was administered at 2:00pm on 12/20/25. -On 12/24/25 at 2:00pm, Resident #4's systolic blood pressure was documented as 91, and Hydralazine 10mg was administered at 2:00pm on 12/24/25. Interview with a personal care aide (PCA) on 01/30/26 at 9:07am revealed: -She was a medication aide (MA) in training during the week of 12/20/25 and she had just started administering medications alone when she documented administration of the Hydralazine 10mg tablet to Resident #4 at 2:00pm. -She checked Resident #4's blood pressure prior to administering the Hydralazine 10mg tablet to determine if the Hydralazine 10mg tablet needed to be administered. -If she did not administer the Hydralazine 10mg tablet, she would document on the eMAR the medication was withheld according to PCP orders. -If her initials were not circled on the eMAR, it meant she administered the medication. -She did not remember ever withholding Resident #4's Hydralazine blood pressure medication. Telephone interview with a second PCA on 01/30/26 at 12:08pm revealed: -She used to work as a MA at the facility. -She was no longer a MA because she liked working as a PCA more than working as a MA. -She identified her initials that populated on the eMAR when she administered medications. -She was trained to find the medication in the	D 358		

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D 358	Continued From page 23 medication cart and review the medication with the eMAR three times before administering a medication. -She checked Resident #4's blood pressure before administering medication to the resident. -She did not remember ever having to hold Resident #4's Hydralazine 10mg tablet. -She did not know for sure if she administered the Hydralazine 10mg tablet to Resident #4 on 12/09/25 at 10:00pm and 12/24/25 at 2:00pm. -If her initials were on the eMAR, it meant she administered the medication. Interview with the Special Care Coordinator (SCC) on 01/30/26 at 10:58am revealed: -If MA initials were circled on the eMAR, it meant the medication was withheld. -If MA initials were not circled on the eMAR, it meant the medication was administered. -Resident #4 should not have been administered the Hydralazine 10mg tablet on 12/09/26 at 10:00am, on 12/20/25 at 2:00pm, and on 12/24/25 at 2:00pm because of the documented systolic blood pressure of less than 110. -She was not aware Resident #4's Hydralazine 10mg tablet was administered when it was not supposed to be administered. -If she had been made aware of Resident #4's Hydralazine 10mg tablet being when not supposed to have been administered, she would have notified the Administrator of the medication error. Telephone interview with Resident #4's PCP on 01/29/26 at 4:06pm revealed: -Resident #4's blood pressure had trended low. -There had been fluctuations in Resident #4's blood pressure since the resident was admitted to the facility. -She had recently discontinued the Hydralazine	D 358			

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D 358	Continued From page 24 10mg tablet for Resident #4. -She expected some fluctuations of Resident #4's blood pressure. -Resident #4's blood pressure tended to drop on some days. -She did not know if documented blood pressure readings were accurate. -The resident could become unresponsive with low blood pressure. -Resident #4 was easily arousable and she was not aware of any significant concerns with the resident. -She looked at the eMARs during her visits and made necessary interventions. Interview with the Administrator on 01/29/26 at 9:52am revealed the facility staff did not document any progress notes on residents. Second interview with the Administrator on 01/30/26 at 9:50am revealed: -She expected the MAs to follow the directions printed on the eMAR when administering medications. -If a medication was supposed to be held, she expected the medication to be held. -The resident's blood pressure could drop causing the resident to be sleepy by administering a blood pressure medication that was supposed to be held.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any	D 451		

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D 451	Continued From page 25 accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) of 2 of 5 reportable accidents/incidents for 1 of 2 sampled residents (#5) resulting in an injury requiring emergency medical evaluation and treatment. The findings are: Review of Resident #5's current FL-2 dated 08/05/25 revealed: -Diagnoses included dementia, chronic kidney disease, dehydration, and failure to thrive in adult. -Resident #3 was ambulatory. -The resident was a wanderer. -The resident was intermittently disoriented. Review of Resident #5's Resident Register dated 08/21/24 revealed the resident was admitted to the facility on 08/21/24. Review of Resident #5's current care plan and assessment dated 08/05/25 revealed: -Resident #5 fought care staff sometimes which made it hard when performing care to the resident. -Resident #5's gait was unsteady. -The resident required extensive assistance for eating, toileting, ambulation, bathing, dressing, grooming, and transferring.	D 451		

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D 451	Continued From page 26 Observation of Resident #5 on 01/28/26 at 9:05am revealed: -Resident #5 was seated on a sofa and asleep in the day room. -There were intact sutures to the right side of Resident #5's forehead. Interview with a personal care aide (PCA) on 01/28/25 at 9:05am revealed: -Resident #5 fell a couple weeks ago. -She did not know the exact date of the fall. Review of an Incident/Accident Report for Resident #5 dated 11/04/25 revealed: -Resident #5 leaned forward and fell out of a wheelchair while being transported by an unidentified PCA. -The resident hit the front of his head on the floor. -The resident sustained a small red knot in the middle of his forehead, a scrape on the right knee, and a small skin tear on the back of the right hand. -The resident was transported to a local hospital emergency department for further evaluation. -There was no documentation for notification to the local county DSS of Resident #5 being sent to the local hospital for evaluation and treatment for the injury sustained. Review of an Incident/Accident Report for Resident #5 dated 12/10/2025 revealed: -Resident #5 lost his balance when walking in the hall of the facility. -Resident #5 sustained a laceration over the right eye. -The resident was sent out for further evaluation. -There was no documentation for notification to the local county DSS of Resident #5 being sent to the local hospital for evaluation and treatment for the injury sustained.	D 451			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL078111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/30/2026
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE OF LUMBERTON			STREET ADDRESS, CITY, STATE, ZIP CODE 550 BAILEY ROAD LUMBERTON, NC 28359		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 451	Continued From page 27 Interview with the Administrator on 01/29/26 at 9:52am revealed: -The facility did not document incidents in facility progress notes. -Any information regarding an incident/accident was documented on the facility Incident/Accident Report. Second interview with the Administrator on 01/29/26 at 10:59am revealed: -She was responsible for sending incident/accident reports to the local county DSS. -She sent incident/accident reports via email to the county DSS within 24 hours of the occurrence. -She did not have documentation for sending the reportable incident/accident reports for Resident #5 that occurred on 11/04/25 and 12/10/25. -She thought the reportable incident/accident reports for 11/04/25 and 12/10/25 were sent by email but realized on 01/29/26 that the email did not send. -She checked her email outbox sometimes but did not check it until 01/29/26 after she was requested to provide verification of sending reportable incident/accident reports to the local county DSS. Telephone interview with the local county DSS Adult Home Specialist (AHS) on 01/29/26 at 11:20am revealed: -She had not received the reportable incident/accident reports for Resident #5 dated 11/04/25 and 12/10/25. -The county DSS was supposed to be notified within 48 hours if a resident was sent to the hospital for treatment of an injury beyond first aid.	D 451			