STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. BUILDING _____ B. WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

(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) COMPLETION DATE
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code section A of the	F 278	F278 483.20(G)-(j) ASSESSMENT	2/16/17

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

Electronically Signed | 02/10/2017

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F 278	Continued From page 1 Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for one of one resident reviewed as Level II PASRR resident. (Resident #2). Findings included: Resident # 2 was initially admitted to the facility on 11/2/2013 with diagnoses including depression, schizophrenia and bipolar disorder. The review of Residen's PASRR II form dated 7/26/2012 revealed that Resident # 2 had Level II PASRR status. A review of section A1500 Preadmission Screening and Resident Review (PASRR)) of Resident # 2 ' s annual Minimum Data Set (MDS) dated was conducted. Section A1500 indicated the resident was evaluated by Level II PASRR and determined not to have a serious mental illness and/or intellectual disability. The results of this screening and review are used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident # 2 was included among the residents named on the list. During an interview on 1/26/2017 at 8:51 AM, the Admission coordinator confirmed Resident #2 did indeed have a Level II PASRR status. The MDS Coordinator was interviewed on 1/26/2016 at 10:05 AM, regarding the accuracy of Resident # 2's annual MDS. When it was	F 278	ACCURACY/COORDINATION/CERTIFIED Resident #2 MDS was modified on 1/31/17 to reflect accurate coding of the level II preadmission screening and Resident review (PASRR) by the MDS nurses. 100% audit of all current residents' most current MDS was reviewed, to include resident #2, on 2/8/17 by DON to ensure all MDS's completed are coded accurately to include the PASRR level II using a MDS Accuracy QI tool. Modifications will be completed by the MDS nurses during the audit for any identified area of concern with the oversite from the DON. 100% in-service will be completed by 2/15/17 by the MDS Consultant of the with the MDS nurses regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include all PASRR level II. 100% of completed MDS's, to include resident #2, will be reviewed to ensure accurate coding of the MDS to include PASRR level II by the DON 3 X's a week X's 4 weeks, then weekly X's 4 weeks and then monthly X's 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the DON by retraining the MDS nurse and completing necessary modification to the MDS. The Administrator will review and	

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F 278	Continued From page 2 revealed the MDS did not reflect the Level II PASRR determination for this resident, the MDS Coordinator reported the MDS was not coded correctly. On 1/26/2017 at 2:00 PM, the Director of Nursing indicated it was her expectation that the Level II PASRR determination would be coded accurately on each resident's MDS.	F 278	initial the MDS Accuracy QI tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of concerns have been addressed. The Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	