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 _____	C 05/05/2022

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5-2-22 through 5-5-22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 8LRF11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5-2-22 through 5-5-22. Event ID# 8LRF11. The following intakes were investigated NC00184143, NC00188673 and NC00184648. 3 of the 12 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		6/2/22

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

Electronically Signed | 05/23/2022

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to treat a resident with dignity and respect by referring to the resident who required assistance with meals as a "feeder" for 1 of 1 resident reviewed for dignity (Resident #7). Findings included: Resident #7 was admitted to the facility on 7/31/21. Resident #7 ' s minimum data set assessment dated 2/8/22 revealed the resident was assessed as severely cognitively impaired. She had no moods or behaviors and was totally dependent on staff for eating.	F 550	Riverpoint Crest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Riverpoint Crest Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Riverpoint Crest Nursing and	

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F 550	Continued From page 2 Resident #7 ' s care plan dated 2/16/22 revealed she was care planned for hospice care related to progressive and declining disease process. The interventions included to encourage and assist with meals. During observation on 5/2/22 at 12:44 PM Nurse Aide #1 was observed standing next to Resident #7 in the 300-hall dining room and stated to another nurse aide that Resident #7 was a "feeder." There were approximately 10 other residents in the dining room at that time. This statement was able to be heard at the entrance to the dining room approximately 20 feet away. During an interview on 5/2/22 at 12:46 PM Nurse Aide #1 stated she used the term "feeders" for residents who needed assistance with meals and to her knowledge that was just what staff called those residents. During an interview on 5/2/22 at 9:57 AM the Director of Nursing stated the term "feeder" should not be used by staff due to dignity concerns and she began in servicing staff when she was made aware of the concern.	F 550	Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights On 5/2/22, Nurse Aide #1 (NA) was verbally educated by Staff Development Coordinator (SDC) on dignity and respect with emphasis on not using the word feeder to identify residents who require feeding assistance. On 5/23/22, the Director of Nursing (DON) initiated Resident Care Interactions with all nurses and nursing assistants who provide meals to include NA #1. This is to ensure all residents were treated with dignity and respect during meals with emphasis on not calling residents who require feeding assistance a feeder. The DON, SDC and Unit Managers will address all concerns identified during the audit to include education of staff. Audit will be completed by 6/2/22. After 6/2/22, Any nurse or nursing assistant who has not worked or completed the interaction will complete upon next scheduled work shift. On 5/20/22, the Social Worker completed resident questionnaires with all alert and oriented residents regarding Dignity with Meals. There were no concerns identified during the audit.	

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F 550	Continued From page 3	F 550	On 5/2/22, the SDC initiated an in-service with all nurses and nursing assistants to include NA#1 regarding Dignity with Meals. Emphasis is on not using the word feeder to identify residents who require feeding assistance. In-service will be completed by 6/2/22. After 6/2/22, any nurse and/or nursing assistants who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses and/or nursing assistants will be in-serviced during orientation regarding Dignity with Meals. The SDC and Unit Managers will complete 10 resident care observations to include all meals, NA #1 and resident #7 weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Interaction Audit Tool. This audit is to ensure staff treat residents with dignity and respect during mealtime by not calling residents who require feeding assistance a feeder. The SDC and/or Unit Managers will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Resident Care Interaction Audit Tools weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Resident Care Interaction Audit Tools to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Resident Care Interaction Audit Tools to determine trends and/or issues that	

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F 550	Continued From page 4	F 550	may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		6/2/22

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F 578	Continued From page 5 with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to accurately document advanced directives (code status) throughout the medical record for 1 of 1 resident reviewed for hospice care (Resident #7). Findings included: Resident #7 was admitted to the facility on 7/31/21. A review of Resident #7 ' s order dated 8/5/21 revealed she was ordered to be a DNR. Resident #7 ' s minimum data set assessment dated 2/8/22 revealed the resident was assessed as severely cognitively impaired. She was documented as being on hospice care. Resident #7 ' s care plan dated 2/16/22 revealed she was care planned for end-of-life advance directives. The interventions included that the resident was a full code and to receive cardio-pulmonary resuscitation (CPR). During an interview on 5/4/22 at 8:43 AM the MDS Coordinator stated the resident was ordered a DNR for advanced directives and should not be care planned as a full code. She concluded the social worker was responsible for updating	F 578	F578 Request/Refuse/Discontinue Treatment/Formite Advance Directive On 5/4/22, the Director of Nursing (DON) clarified the code status/advance directive order for resident #7. Resident #7 has an order for Do Not Resuscitate. The care plan was updated to reflect resident□s current code status in the electronic record. On 5/23/22, the Social Worker completed an audit of all orders for resident code status and care plans to include resident #7. This audit is to ensure the care plan accurately reflects resident current code status per resident preference. There were no additional concerns identified during the audit. On 5/20/22, the Director of Nursing and Staff Development Coordinator initiated an in-service with all nurses, Social Worker and Admissions Director regarding Code Status/Advance Directive. Emphasis is on notification of the nurse when a resident/resident representative verbalizes a desire to change code status/advance directive, nurse□s responsibility of notifying the physician	

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F 578	Continued From page 6 advanced directives in the resident ' s care plans. During an interview on 5/4/22 at 9:55 AM the Social Worker stated she was responsible for updating advanced directives in the resident ' s care plans. She further stated when Resident #7 requested a DNR instead of being a full code, she was not working at the facility, and she started work a couple of weeks after the request for the DNR. She stated she was not aware she was supposed to go through the orders and miscellaneous documents every three months to update the care plans for residents. She concluded that was why the update to the care plan was missed. During an interview on 5/4/22 at 8:50 AM the Director of Nursing stated advanced directives code status should be accurately reflected in resident care plans and it was not correct for Resident #7.	F 578	immediately for any resident who desires a change in code status/advance directive, obtaining new order when indicated and updating resident care plan in the electronic record. In-service will be completed by 6/2/22. After 6/2/22, any nurse, Social Worker and/or Admission Director, who has not received the in-service will receive in-service upon next scheduled shift. All newly hired Social Worker, Admission Director and nurses will be in-serviced during orientation regarding Code Status/Advance Directive. The IDT team to include Unit Managers, Social Workers, and Admission Director will review care plans for 10 residents to include resident #7 weekly x 4 weeks then monthly x 1 month utilizing the Advance Directive Audit Tool. This audit is to clarify resident code status and to ensure the physician order and the care plan in the electronic record accurately reflects the resident and/or resident representative desired code status/advanced directive. The Unit Managers, Social Workers, and Admission Director will address all concerns identified during the audit to include notification of the physician with changes in desired code status and updating the care plan in the electronic record to accurately to reflect code status. The DON will review and initial the Advance Directive Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Advance Directive Audit Tool to the	

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F 578	Continued From page 7	F 578	Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's	F 640		6/2/22

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F 640	Continued From page 8 assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment for 1 of 1 resident (Resident #1) reviewed for resident assessment. Findings included: Resident #1 was admitted to the facility on 11-5-21. A nursing note dated 12-21-21 at 11:22 was reviewed. The note revealed Resident #1 was discharged to an assisted living facility and was transported by her daughter.	F 640	F640 Encoding/Transmitting Resident Assessments On 5/6/22, the MDS nurse completed the Minimum Data Set (MDS) Assessment for resident # 1 discharge. On 5/13/22, the MDS Consultant completed an audit of all resident discharges from facility to include resident #1 from 3/6/22 to 5/12/22. This audit was to ensure the MDS Assessment for discharge from the facility was completed. No additional concerns identified during the audit	

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F 640	Continued From page 9 Review of the Minimum Data Set (MDS) assessments revealed no discharge MDS had been completed. An interview occurred with the MDS Coordinator on 5-5-22 at 8:57am. The MDS Coordinator confirmed there had not been a discharge MDS completed for Resident #1. She explained the discharge MDS had been overlooked. The Administrator was interviewed on 5-5-22at 11:58am. The Administrator stated there should be a discharge MDS in place for all residents who are discharged from the facility.	F 640	On 5/13/22, the MDS Consultant completed an in-service with all MDS nurses regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing MDS Discharge Assessment. All newly hired MDS nurses will be in-serviced during orientation regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual. 10% audit of all discharges from the facility will be reviewed by the Unit Managers and Quality Assurance Nurse (QA) weekly x 4 weeks then monthly x 1 month utilizing the MDS Audit Tool. This audit is to ensure the MDS Assessment for discharge from the facility was completed. The Unit Managers, MDS nurse and Quality Assurance Nurse (QA) will address all concerns identified during the audit to include completion of assessment when indicated and re-training of the nurse. The DON will review the MDS Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of MDS Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the MDS Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of	

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F 640	Continued From page 10	F 640	monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code a fall on a Minimum Data Set (MDS) Assessment and failed to accurately code the Preadmission Screening and Resident Review (PASARR) on a MDS assessment for 2 of 22 resident MDS assessments reviewed (Resident #26). Findings included: 1. Resident #61 was admitted to the facility on 2/25/19. Her active diagnoses included repeated falls, muscle weakness, other abnormalities of gait and mobility, and dementia. Resident #61 ' s progress note dated 3/4/22 revealed Resident #61 was sitting in chair in dining room. The resident went to get up and became dizzy and slid to floor with no injuries found. Resident #61 ' s MDS dated 4/8/22 revealed she was assessed as severely cognitively impaired. She was assessed to have no falls since admission/entry or reentry or prior assessment. During an interview on 5/5/22 at 10:32 AM the MDS Coordinator stated Resident #61 ' s fall on 3/4/22 should have been captured on the 4/8/22	F 641	F641 Accuracy of Assessments On 5/20/22, the Minimum Data Set Nurse (MDS) made a modification to the MDS assessment for resident # 61 to correctly identify resident falls since admission. On 5/4/22, the Minimum Data Set Nurse (MDS) made a modification to the MDS assessment for resident #26 to correctly identify resident as a level II PASARR. On 5/13/22, Minimum Data Set Nurse Consultant (MDS) initiated an audit of the most recent admission, annual or significant change MDS assessment section A for residents with a level II PASARR. The audit was to ensure that the MDS assessment completed was coded accurately for level II PASARR during the assessment. The MDS Consultant and MDS Coordinator addressed all concerns identified during the audit to include completing a modification to the assessment when indicated. The audit will be completed by 6/2/22. On 5/19/22, the Director of Nursing	6/2/22

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F 641	Continued From page 11 MDS and it was not. During an interview on 5/5/22 at 10:37 AM the Administrator stated falls should be accurately captured on MDS assessments. 2. Resident #26 was admitted to the facility on 9/30/14 with diagnoses which included bipolar and psychotic disorder. The resident's medical record contained a Preadmission Screening and Resident Review (PASARR) Level II Determination Notification dated 7/27/15 with no end date. The annual Minimum Data Set (MDS) dated 3/4/22 indicated Resident #26 was not coded for Level II PASARR. An interview on 5/04/22 at 1:24 PM with MDS Nurse #1 revealed she was responsible for coding the PASARR on Resident #26's MDS. She stated it should have been coded on the annual MDS and she just missed it. An interview on 5/04/22 at 1:36 PM with the Administrator revealed she expected the MDS to be coded correctly.	F 641	initiated an audit of the most recent admission, annual or significant change MDS assessment section J for residents with falls from 2/1/22 to 5/19/22. The audit was to ensure that the MDS assessment completed was coded accurately for all falls identified during the assessment. The MDS Consultant and MDS Coordinator addressed all concerns identified during the audit to include completing a modification to the assessment when indicated. Audit will be completed by 6/2/22. On 5/13/22, the MDS Consultant completed an in-service with the with the MDS Coordinator, MDS Nurse, Director of Nursing regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely for falls and level II PASARR. All newly hired MDS Coordinator, DON and/or MDS nurse will be in-serviced during orientation regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual. The Director of Nursing will complete an audit of 10% of all resident□s most recent MDS admission, annual and/or significant change assessments to include resident #61 and #26 section A and section J weekly x 4 weeks then monthly x 1 month utilizing the MDS Audit Tool. This audit is to ensure all MDS assessments completed are coded accurately for residents with falls and with a level II	

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F 641	Continued From page 12	F 641	PASARR. The Director of Nursing will address all concerns identified during the audit. The Administrator will review and initial the MDS Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of MDS Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the MDS Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		6/2/22

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F 656	Continued From page 13 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to develop comprehensive individualized care plans for 2 of 5 residents (Resident #3 and Resident # 33) reviewed for care plans. Findings included: 1. Resident #3 was admitted to the facility on 11/23/20 with diagnoses which included Diabetes Mellitus and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated	F 656	F656 Develop/Implement Comprehensive Care Plan On 5/4/22, the Minimum Data Set Nurse (MDS) updated care plan for resident #3 to include the diagnosis of Diabetes. On 5/23/22, the Social Worker reviewed discharge plans and plan of care with resident #33 and updated the care plan to accurately reflect residents discharge plan of care. On 5/4/22, the MDS nurse initiated an	

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F 656	Continued From page 14 4/28/22 indicated Resident #3 had moderate cognitive impairment. Review of Resident #3's care plan last revised on 2/02/22 revealed no focus for Diabetes Mellitus. An interview on 5/04/22 at 8:38 AM with MDS Nurse #1 revealed she was responsible for ensuring Resident #3's care plan was accurate and complete. She stated the care plan should have included a focus area for Diabetes Mellitus and she had just missed it. An interview on 5/04/22 at 1:38 PM with the Administrator revealed she expected the care plan to be accurate and complete. 2.Resident #33 was admitted to the facility on 9-10-21 The quarterly Minimum Data Set (MDS) dated 3-25-22 revealed Resident #33 was moderately cognitively impaired. Resident #33 was interviewed on 5-2-22 at 11:10am. The resident discussed concern over not knowing what her discharge plans were. She also stated no one had discussed a care plan that included discharge goals. Review of a Social Work note dated 9-16-21 at 3:03pm revealed the following information: Resident was admitted 9-10-21 with plans to remain long term. During an interview with the Social Worker on 5-4-22 at 2:16pm, the Social Worker explained Resident #33 was admitted for long term care	F 656	audit of all resident care plans to include resident #3. This audit was to ensure all residents were care plan accurately for medical diagnosis of Diabetes. The MDS nurse will address all concerns identified during the audit to include updating care plan when indicated and education of nurse. Audit will be completed by 6/2/22. 5/4/22, MDS nurse initiated an audit of all resident care plans to include resident #33. This audit is to ensure all residents are care planned accurately for discharge planning and that discharge planning was reviewed with the resident and/or resident representative with documentation in the electronic record. The MDS nurse and/or Social Worker will address all concerns identified during the audit to include updating care plan for discharge plan of care and/or reviewing discharge plans with resident and/or resident representative with documentation in the electronic record. Audit will be completed by 6/2/22. On 5/23/22, the Staff Development Coordinator initiated an in-service with all nurses and Social Workers regarding Care Plans with emphasis on ensuring care plans are updated to accurately reflect resident plan of care to include but not limited to medical diagnosis and discharge planning. In-service will be completed by 6/2/22. After 6/2/22, any nurse or Social Worker who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired nurses and Social Workers	

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F 656	Continued From page 15 however, the Department of Social Services (DSS) was currently pursing guardianship of the resident. If DSS was appointed Resident #33's guardian, they had discussed the possibility Resident #33 would be discharged if suitable housing was located. She also stated she was not aware her care plan was not present and stated it should had been since the plan was for Resident #33 to stay in the facility long term. The Administrator was interviewed on 5-5-22 at 11:58am. The Administrator stated she expected each residents individualized care plan to have discharge goals and interventions.	F 656	will be in-service during orientation regarding Care Plans. 10% of residents care plans to include resident #3 and #33 will be reviewed by the Quality Assurance Nurse and/or Staff Development Coordinator weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan accurately reflects resident plan of care to include but not limited to medical diagnoses and discharge planning and that the plan of care was reviewed with the resident/resident representative with documentation in the electronic record. The Assurance Nurse and/or Staff Development Coordinator will address all areas of concern identified during the audit to include updating resident care plan to accurately reflect plan of care, notification of resident/resident representative for changes in plan of care with documentation in the electronic record and re-training of the nurse. The Director of Nursing (DON) will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure completion and that all areas of concerns were addressed. DON will forward the results of the Care Plan Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Care Plan Audit Tool to determine trends and/or issues that may need further interventions	

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F 656	Continued From page 16	F 656	put into place and to determine the need for further and/or frequency of monitoring.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		6/2/22

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F 690	Continued From page 17 possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to keep a urinary catheter bag below a resident ' s bladder level for 1 of 2 residents reviewed for catheter care (Resident #60). Findings included: Resident #60 was admitted to the facility on 6/1/20. His active diagnoses included other neuromuscular dysfunction of bladder, personal history of chronic Urinary Tract Infections (UTI), other retention of urine, and benign prostatic hyperplasia with lower urinary tract symptoms. Resident #60 ' s order dated 4/6/22 revealed he was ordered a catheter for dysfunction of bladder and urinary retention. Resident #60 ' s minimum data set assessment dated 4/12/22 revealed he was assessed as severely cognitively impaired. He had no behaviors and was totally dependent on staff for toilet use and personal hygiene. Resident #60 was assessed to have an indwelling urinary catheter. Resident #60 ' s care plan dated 4/19/22 revealed Resident #60 was care planed for chronic urinary tract infections. The interventions included to administer medications as ordered by physician, encourage adequate fluid intake, observe for signs and symptoms of urinary tract infections such as frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea, vomiting, flank pain, and notify physician for possible	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI On 5/3/22, the hall nurse repositioned Foley drainage bag for resident #60 to ensure bag was positioned below bladder level to prevent urinary tract infections. On 5/3/22, the Director of Nursing initiated an audit of all residents with urinary catheters to include resident #60. This audit is to ensure Foley drainage bags to include leg drainage bags are positioned below bladder level to prevent urinary tract infections. The Unit Managers and/or hall nurse will address all concerns identified during the audit to include repositioning of drainage bag and education of staff. Audit will be completed by 6/2/22. On 5/3/22, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding Urinary Catheters with emphasis on ensuring Foley drainage bags to include leg drainage bags are positioned below bladder level to prevent urinary tract infections. The in-service will be completed by 6/2/22. After 6/2/22, any nurse or nursing assistant who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Urinary Catheters.	

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F 690	Continued From page 18 interventions. He was also care planned for altered pattern of urinary elimination due to indwelling catheter and was at risk for infection and/or trauma. The interventions included to provide catheter care per facility protocol, change catheter per physician orders and/or facility protocol, and ensure adequate fluids are provided. During observation on 5/2/22 at 11:37 AM Resident #60 was observed in his reclining geri chair in the dining room with his legs up in the reclined position. His legs (including his calves) were positioned higher than the level of his bladder. During an interview on 5/2/22 at 11:38 AM Nurse Aide #1 stated Resident #60 had a leg bag for his urinary catheter and that he currently had it on. The nurse aide indicated the location of catheter bag was attached to his left calf under his pants. During an interview on 5/2/22 at 11:43 AM Nurse #1 stated Resident #60 did have a leg bag for his catheter and had a history of recurrent UTIs. During observation on 5/3/22 at 9:54 AM Resident #60 was observed again in his reclining geri chair in the dining room with his legs up in the reclined position. His legs (including his calves) were positioned higher than the level of his bladder. Again on 5/3/22 at 1:44 PM Resident #60 was observed in his reclining geri chair on the 300 hall with his legs up in the reclined position. His legs (including his calves) were positioned higher than the level of his bladder. During an interview on 5/3/22 at 1:45 PM Nurse	F 690	The Unit Managers will complete an audit of all residents with urinary catheters to include resident #60 3 times a week x 2 weeks then weekly x 2 weeks then monthly x 1 month utilizing the Urinary Catheter Audit Tool. This audit is to ensure Foley drainage bags to include leg drainage bags are positioned below bladder level to prevent urinary tract infections. The Unit Managers will address all concerns identified during the audit to include repositioning of drainage bag and education of staff. The DON will review the Urinary Catheter Audit Tool 3 times a week x 2 weeks, weekly x 2 weeks then monthly x 1 month to ensure all concerns were addressed. DON will forward the results of the Urinary Catheter Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Urinary Catheter Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 690	Continued From page 19 Aide #1 stated with leg bag catheters she ensured the leg bag was on the inside of the resident ' s leg to promote drainage. The nurse aide concluded there were no concerns with the location of his catheter bag while he was in his recliner to her knowledge. During an interview on 5/3/22 at 1:47 PM Nurse #2 stated catheter bags were to be kept below the resident's bladder to prevent backflow of urine and urinary tract infections and this included leg bags for catheters. Upon observing Resident #60 the nurse stated Resident #60's catheter bag was above his bladder while he was in the recliner, and he should have his catheter bag lower than his bladder and she would correct the concern and speak with the nurse aide. During an interview on 5/3/22 at 2:31 PM the Director of Nursing stated catheter bags, including leg bags, should be kept below the bladder to prevent backflow and urinary tract infections. She concluded Resident #60 should not have his leg bag level with or higher than his bladder and she would look into options for the resident to avoid this. During an interview on 5/4/22 at 9:11 AM Physician #1 stated he would not want a resident with a catheter to be positioned for an extended period with the catheter bag at or above the level of the resident ' s bladder.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		6/2/22

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F 761	Continued From page 20 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 5 medication carts observed (Memory Care Unit Medication Cart). Findings included: During a continuous observation on 5/2/22 at 12:47 PM the Memory Care Unit Medication Cart was observed to be unlocked and unattended at the nursing station. At 12:49 PM a nurse aide walked past the unlocked medication cart and an activities staff member walked past the unlocked medication cart. At 12:51 PM a nurse aide and	F 761	F761 Label/Store Drugs and Biologicals On 5/2/22, the hall nurse immediately secured medication cart for the Memory Care Unit. On 5/3/22, the Unit Managers initiated an audit of all medication carts. This audit is to ensure all medication carts were locked when not in direct supervision of the nurse or medication aide. No additional concerns identified. On 5/3/22, the Staff Development Coordinator initiated an in-service with all	

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F 761	Continued From page 21 resident went past the unlocked medication cart, and at 12:53 PM a resident walked past the unlocked medication cart. At 12:54 PM Nurse #1 returned to the unlocked medication cart. During an interview on 5/2/22 at 12:54 PM Nurse #1 stated medication carts were to be locked when unattended. She concluded she forgot to lock the cart. During an interview on 5/2/22 at 9:57 AM the Director of Nursing stated medication carts were to be locked when unattended.	F 761	nurses to include nurse #1 and medication aides regarding Medications Storage with emphasis on securing medication cart/treatment cart when not directly supervised by assigned nurse or medication aide. In-service will be completed by 6/2/22. After 6/2/22, any nurse and medication aide who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation regarding Medications Storage. The Unit Managers, Quality Assurance Nurse and/or Staff Development Coordinator will audit all medication carts 3 x a week x 2 weeks then weekly x 2 weeks then monthly x 1 month utilizing the Medication Cart Audit Tool. This audit is to ensure all medication carts were locked when not in direct supervision of the nurse or medication aide. The Unit Managers, Quality Assurance Nurse and/or Staff Development Coordinator will address all concerns identified during the audit to include but not limited to securing medications per facility protocol and/or re-training of the nurse/medication aide. The DON will review and initial the Medication Cart Audit Tool 3 x a week x 2 weeks then weekly x 2 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing will forward the results of the Medication Cart Audit Tool to the Executive QAPI Committee monthly x	

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F 761	Continued From page 22	F 761	2 months. The Executive QA Committee will meet monthly x 2 months and review the Medication Cart Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to label, date personal food items for residents in 1 of 3 nourishment refrigerators observed. (300-Hall Nourishment Refrigerator) Findings included:	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary On 5/2/22, the hall nurse removed all food items not labeled with date and/or resident name or any expired food items from the Nourishment Refrigerator located on 300	6/2/22

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 _____	C 05/05/2022

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 812	Continued From page 23 During observation on 5/2/22 at 3:41 PM the 300-hall nourishment refrigerator was observed. An opened 16-ounce ice cream container (exp 6/2023) approximately half filled with ice cream was observed in the freezer and was not labeled or dated. A half full, opened 2-liter bottle of soda (exp 7/2022) was observed in the refrigerator not labeled or dated, and a half full, opened 2-liter bottle of diet soda (exp 6/2022) was observed in the refrigerator not labeled or dated. During an interview on 5/2/22 at 3:47 PM Nurse #1 stated nursing staff were responsible to label and date resident items in the nourishment refrigerator. She concluded the two opened cokes, and the opened ice cream should have had open dates and be labeled in the nourishment freezer and refrigerator. During an interview on 5/2/22 at 9:57 AM the Director of Nursing stated it was the responsibility of the nurse who opened and then placed the item in the nourishment refrigerator or freezer to ensure it was labeled and dated. The two cokes and ice cream should have been label and dated.	F 812	hall. On 5/2/22, the Dietary Manager completed an audit of all nourishment refrigerators to ensure there were no expired items or items that were not dated/labeled with resident name. The Dietary Manager will address all concerns identified during the audit to include discarding items not dated per facility protocol. On 5/3/22, Staff Development Coordinator initiated an in-service with all nurses, nursing assistants, dietary staff and housekeeping staff in regards to Nourishment Refrigerators to include nourishment room refrigerators must be checked each shift by nurses or nursing assistants to ensure all food items are labeled with resident name/date and expired food/drinks are discarded. Dietary staff are responsible for ensuring all items placed in the nourishment refrigerator supplied by dietary is within date and should monitor all current dietary supplies in the nourishment refrigerator to ensure expired items are discarded promptly. The Dietary staff and nursing staff are responsible for checking nourishment room refrigerators twice a day to ensure food items are labeled with resident name/date and that all expired items are discarded promptly. In-service will be completed by 6/2/22. After 6/2//22, any nurses, nursing assistants, dietary staff and housekeeping staff who has not received the in-service will receive in-service upon next scheduled shift. All	

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F 812	Continued From page 24	F 812	newly hired nurses, nursing assistants, dietary staff and housekeeping staff will in serviced during orientation regarding Nourishment Refrigerators. 100% audit of all nourishment room refrigerators will be completed by the Dietary Manager 3 times a week 2 weeks, weekly x 2 weeks then monthly x 1 month utilizing the Nourishment Room Audit Tool to ensure there are no expired items in the refrigerator and/or expired items are discarded promptly. The Dietary Manager will address all concerns identified during the audit. The DON will review and initial the Nourishment Room Audit Tool weekly x 4 weeks to ensure all concerns were addressed appropriately. The DON will forward the results of Nourishment Room Audit Tool to the Executive QA Committee monthly x 2 month. The Executive QA Committee will meet monthly x 2 months and review the Nourishment Room Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	