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 08/04/2023

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 The survey team entered the facility on 7/24/23 to conduct a recertification and complaint investigation survey and exited on 7/27/23. Additional information was obtained remotely on 8/3/23 and 8/4/23. Therefore, the exit date was changed to 8/4/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QE5D11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 7/24/23 to conduct a recertification and complaint investigation survey and exited on 7/27/23. Additional information was obtained remotely on 8/3/23 and 8/4/23. Therefore, the exit date was changed to 8/4/23. Event ID# QE5D11. The following intakes were investigated NC00191987, NC00201696, NC00197672 and NC00194826. 2 of the 7 complaint allegations resulted in deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		8/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/10/2023

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F 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interviews with resident, vendor company, and staff, the facility failed to clean a black substance on and around the ceiling vents (diffusers) for 3 of 4 resident rooms (Rooms #501, #505 & #508) and 1 of 4 nursing station areas (500 hall nursing station) observed for environment. In addition, the facility failed to initiate testing of the black substance to ensure it was not hazardous to residents. Findings included:	F 584	Date of Compliance: 8/14/2023 Vents in 500 hall, to include 501, 505, 508, and 500 hall nurse station were cleaned prior to survey exit. Resident who reside in rooms 501, 505, and 508, which include residents # 52, 79, 25, 34, 71, and 37, continue to reside in the facility and remain in stable condition with no acute respiratory concerns. Nursing Home Administrator (NHA) and Maintenance Director completed a	

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F 584	Continued From page 2 Observation on 7/24/23 at 11:23 AM, during the initial tour revealed Room #501's ceiling vent had a dark substance on the vent and on the ceiling around the vent. An interview on 7/26/23 at 9:54 AM with a resident who resided in Room #501. The resident was alert and oriented to person, place, time, and situation. He stated he had noticed the black area on and around the ceiling vent but had not reported it to anyone. He also stated he thought it was dirty and needed to be cleaned. Observation on 7/24/23 at 11:31 AM, during the initial tour revealed the occupied resident room, Room #505, had a ceiling vent with a dark substance on the vent and on the ceiling around the vent. An interview and observation on 7/25/23 at 1:21 PM with Nurse #1 revealed she had noticed the black substance on the ceiling vents in a few areas and verbally notified the Maintenance Director. She did not remember when she had first noticed the black substance or when she had notified him. She stated that there was a black substance on the ceiling diffuser at the nurses' station on the 500 hall and that she had seen it in other areas of the building but did not remember specifically locations. During this interview at the nurses' station on the 500 hall a black substance was observed on the ceiling diffuser. An interview on 7/26/23 at 9:33 AM with Nurse Aide (NA) #2 revealed she reported any maintenance concerns she observed to the unit nurse. She stated she had noticed some of the ceiling vents and had reported the black substance on the ceiling vents to the nurse a	F 584	facility-wide audit on 8/7/2023 to identify vents that are noted to have a black substance. No additional areas were identified. In addition, as a proactive measure, maintenance director performed the following throughout the facility to include areas previously identified by surveyor: removed and cleaned all vents, treated vents with mold inhibiting spray, repainted all vents, cleaned and sprayed areas around the vents with mold inhibiting spray, and replaced vents. No black substance currently present throughout the facility. If new areas of concern are identified, maintenance director will contact contractor for further recommendations on testing and treatment. Contractor has been approved for installation of new air flow fans (between roof and inside ceilings). Fans have been ordered, received, and installation will begin the week of 8/21/2023. NHA provided education to maintenance director and maintenance assistant on 8/7/2023 regarding informing NHA of any issues identified in the facility and keeping NHA up to date on issues that may arise with repair, construction, and/or orders. NHA provided education to Housekeeping Supervisor to ensure all facility vents are placed on a regular cleaning schedule and are additionally cleaned as needed. After 8/7/2023, if new maintenance and/or housekeeping personnel are hired, they will be educated in orientation on this process. NHA will perform 10 room audits per week x4 weeks to ensure no black substances	

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F 584	Continued From page 3 couple of months ago. She stated she did not remember specifically which ceiling vents on which hall she had observed or which nurse she informed. An observation and interview on 7/25/23 at 10:46 AM with the Housekeeping Director revealed she checked the resident rooms daily for cleanliness. She stated the ceiling vents in Rooms #501 and #505 needed to be cleaned and repaired due to the black substance on and around the vent. An additional interview on 7/26/23 at 9:23 AM with the Housekeeping Director revealed they inspected and cleaned the ceiling vents if necessary, during their monthly room deep cleaning. An additional interview on 7/26/23 at 8:37 AM with the Maintenance Director revealed that he was expecting a private vendor company to examine the building and potentially add more exhaust fans to the ventilation system. He also stated that the 100 hall and 500 hall rooms and areas had the worse black substance on the ceiling diffusers. He stated that they had taken most of the diffusers down on the 100 hall where they cleaned, painted and replaced them since 6/28/23. An observation and interview were conducted on 7/25/23 at 10:13 AM with the Maintenance Director and the Administrator in Rooms #501 and #505. The Maintenance Director confirmed that the ceiling vents, which were called diffusers, had a dark substance on and around them which he believed was caused by condensation due to the hot weather temperatures. He stated he first	F 584	are noted on room or hallway vents. Audits will continue x4 weeks then 10 rooms a month x1 month. NHA will present results of audits to QAPI Committee monthly x1 month for further review and recommendations for the duration of the auditing.	

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F 584	Continued From page 4	F 584		

became aware of the extent of the black substance on 6/28/23 and he contacted the corporate office on 6/28/23. He also stated that he was unaware the black substance on the ceiling diffuser was "that bad" in Rooms #501 and #505. The Maintenance Director stated the black substance had not been tested and he could not specifically state what it was. The Administrator stated she was aware of the dark substance on the ceiling vents but was not specifically aware of the vents in Rooms #501 and #505.

An additional observation and interview on 7/25/23 at 10:30 AM with the Maintenance Director he revealed the ceiling diffusers throughout the facility were 16 inches by 16 inches. He stated the dark area around the ceiling diffuser in Room #501 measured about 6 inches by 8 inches. The observation continued in Room #505 where the black substance around that ceiling diffuser measured 3 inches by 5 inches. A further observation continued in Room #508 where the ceiling diffuser had a brown substance located at all four corners of the diffuser. There was no brown or black substance located on the ceiling around the diffuser in Room #508. Room #508 was occupied by a resident.

An interview was conducted on 7/25/23 at 10:30 AM with the resident who resided in Room 508. He was alert and oriented to person, place, time, and situation. He indicated he had not noticed the brown substance located at all four corners of the diffuser in his room.

A phone interview was conducted on 8/03/23 at 11:44 AM with the Maintenance Director. The Regional Vice President of Operations, Nursing Consultant, and Administrator were present on

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F 584	Continued From page 5	F 584		

the phone call during the interview. The Maintenance Director revealed he first became aware of the black substance on the ceiling diffusers on 6/28/23 when a nursing staff member informed him of a room on the 400 hall. He stated he did not remember the exact room number. He then contacted the Administrator, the Senior Regional Maintenance Director, and the facility management company through the electronic maintenance system. He stated the vendor came the same day (6/28/23) and assessed the problem and made a recommendation to clean the hot water coil on one of the air conditioning systems in an attempt to improve air flow and improve the condensation in the ceiling diffusers. The Maintenance Director stated the coil cleaning was approved and completed within a few days but did not resolve the condensation in the ceiling diffusers. The vendor returned to the facility on 7/19/23 and recommended a larger heating and air conditioning system be installed which was ordered and installation was completed on 8/1/23. He clarified the condensation was on the exterior of the vents and was not inside of the duct work. He stated the black substance was not tested and he believed that it was not in the facility management company's protocol to do testing. He stated that he cleaned the ceiling diffusers with the cleaning product recommended by the facility management company.

A phone interview was conducted on 8/03/23 at 12:46 PM with the Vice President (VP) of the facility management company. The Senior Regional Maintenance Director, Nursing Consultant, Maintenance Director, Administrator, and Regional Vice President of Operations were also present on the phone call during the interview. The VP of the facility management

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F 584	Continued From page 6	F 584		

company revealed she became aware of the ceiling vent condensation and black substance at the facility on 6/28/23. She stated she contacted a vendor the same day for a service call. She stated the vendor completed the service call on 6/28/23 and made a recommendation to clean the hot water coil on the heating and air conditioning unit. They later recommended that the heating and air conditioning unit be upsized to a larger unit which was completed on 8/01/23. The VP of the facility management company stated the black substance was not tested and that "out of an abundance of caution, they recommended the facility use a cleaning product for mold control to clean regardless of what the substance was to remove and remedy any potential problems." She stated that the facility management company did not have a protocol for testing.

A phone interview was conducted on 8/03/23 at 1:19 PM with the Vendor Company President. The Vice President (VP) of the facility management company, Maintenance Director, Senior Regional Maintenance Director, Administrator, Nursing Consultant, and Regional Vice President of Operations were present on the phone call during the interview. The Vendor Company President revealed he had gone to the facility for the first service call on 6/28/23. He had recommended the hot water coil be cleaned which was completed on 7/07/23. Another service call on 7/19/23 revealed no real improvement in the air flow and the technician recommended a larger heating and air conditioning unit be installed. The Vendor Company President stated this was completed on 8/01/23. He stated that condensation can occur without proper air flow. He also stated he had not observed the black

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F 584	Continued From page 7 substance and he was not a mold specialist and would not have made any recommendations. A phone interview was conducted on 8/03/23 at 2:38 PM with the corporate Regional Vice President. The Administrator, Nursing Consultant, and Vice President of the facility management company were present on the phone call during the interview. He revealed that they did not have a testing policy or procedure on when to test or not test black substances. He stated they did not automatically assume it was mold and were using the same chemicals to clean as if it had been tested and determined to be mold. He also stated there were filters in place to ensure clean air was recirculated in the duct work.	F 584		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		8/14/23

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F 657	Continued From page 8 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have quarterly care plan meetings for 2 of 4 residents reviewed for care planning (Resident #23, Resident #11). Findings included: 1. Resident #23 was admitted to the facility on 5/14/21. His active diagnoses included chorea, psychomotor deficit following cerebral infarction, type 2 diabetes, and psychophysiological insomnia. Review of a social narrative progress note dated 6/17/22 revealed the social worker spoke with Resident #23's case worker. The Case Worker asked the social worker to send over the care plan as well as medical records for her status report. The Case Worker indicated she had not had the chance to schedule a care plan meeting. Once the Case Worker had finished all status reports, the Case Worker would call the social worker to schedule a proper care plan meeting. There was no further documentation of a care plan meeting in Resident #23's facility records. During an interview on 07/24/23 10:11 AM Resident #23 stated he had not been invited to	F 657	Date of Compliance: 8/14/2023 Residents # 11 and 23 continue to reside in the facility and remain in stable condition. On 7/28/2023 an invitation was sent to both Resident #23 and his resident representative and care plan was held on 8/8/2023. On 7/28/2023 an invitation was sent to both Resident #11 and resident representative for care plan scheduled to be held on 8/15/2023. Facility Consultant and Nursing Home Administrator (NHA) completed facility-wide audit on 8/7/2023 of all current residents to ensure care plans were held for each resident at least every quarter and that care plan meeting invitation was sent out to resident and resident representative. Any areas of concern were addressed by Social Service. Nursing Home Administrator provided education on 8/7/2023 to Social Service and MDS regarding resident rights of inclusion of resident/responsible party for care plan meetings and the need to conduct care plans at least quarterly. After 7/28/2023 new social service and/or MDS will be educated on orientation.	

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F 657	Continued From page 9 care plan meetings. During an interview on 7/25/23 at 10:01 AM the Social Worker stated care plan meetings were held quarterly. The social worker looked in the medical record and found in Resident #23's medical record that on 6/17/22 the previous social worker noted having a care plan meeting with the case worker. She stated she did not have any documentation of a care plan meeting for Resident #23 since that date. She concluded she did not know how he was missed and had not had a care plan meeting since 6/17/22. During an interview on 7/26/23 at 8:23 AM Case Manager #1 stated she was Resident #23's Case Worker. She further stated she had attended care plan meetings in the past but had not attended a care plan meeting in a long time. She concluded she could not remember the last time she had been invited to a care plan meeting. During an interview on 7/26/23 at 9:11 AM the Administrator stated care plan meetings should be conducted quarterly. 2. Resident #11 was admitted to the facility on 8/2/2019 with a diagnosis of diabetes mellitus. A review of Resident #11's medical record revealed her last documented care plan meeting was on 3/2/23. A review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated 5/14/23 revealed she was severely cognitively impaired. A review of Resident #11's current comprehensive care plan revealed it was last reviewed on 5/23/23.	F 657	MDS and Social Work will maintain a quarterly calendar regarding residents quarterly care plan in correlation to residents quarterly assessments. Social Worker will provide notification of upcoming care plan meetings in writing to resident and resident representative no less than one week prior to the scheduled meeting. SW/Designee will discuss upcoming care plan meeting schedule in Cardinal IDT and provide administrator and Director of Nursing with a copy of care plan meeting schedule. Social Service will provide Nursing Home Administrator and/or Director of Nursing all care plan meeting attendance logs to ensure inclusion of residents/responsible party. The Social Worker will document in resident record, the participation of resident and/or family in the care plan meeting. Nursing Home Administrator and/or Director of Nursing will audit 5 care plan meeting attendance sheets per week for a period of 4 weeks and then audit 5 care plan meeting attendance sheets per month for a period of 1 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing.	

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F 657	Continued From page 10	F 657		

In a telephone interview on 7/24/23 at 2:03 PM Resident #11's Representative (RP) stated she liked to be very involved in Resident #11's care. She went on to say she used to receive invitations to attend Resident #11's care plan meetings every 3 months. She further indicated she had not gotten an invitation to attend Resident #11's care plan meeting in several months.
In an interview on 7/25/23 at 3:52 PM the Social Worker (SW) stated she was responsible for scheduling care plan meetings with resident's and their RPs. She stated care plan meetings were conducted at least every 3 months in conjunction with a resident's MDS assessment and more frequently as needed. She went on to say she had been mailing out invitations to RPs to schedule care plan meetings but had not been getting consistent responses, so she had begun calling to schedule them. The SW stated Resident #11's last documented care plan meeting was 3/2/23. She went on to say if she had called Resident #11's RP to schedule a care plan meeting since then, it would have been documented in Resident #11's medical record. She further indicated she used the dashboard on her computer to create the care plan meeting schedule. The SW stated according to this dashboard, Resident #11's next scheduled care plan meeting would be in August 2023. She went on to say Resident #11 should have had a care plan meeting between the 3/2/23 meeting and the next care plan meeting in August but Resident #11 had not. She further indicated she could not explain why this had not occurred.

In an interview on 7/27/23 at 8:30 AM the Director of Nursing (DON) stated Resident #11's RP was

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F 657	Continued From page 11 very involved in Resident #11's care. She went on to say care plan meetings with residents and their RPs normally occurred at least every 3 months and more frequently as needed.	F 657		