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	09/26/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48295 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of falls (Resident #17), oxygen (Resident #56), and discharge status (Resident #93). This was for 3 of 3 residents reviewed for Minimum Data Set assessments. The findings included: a. Resident #17 was admitted to the facility on [DATE] with diagnoses that included diabetes, chronic kidney disease, and hypertension. A review of a nurse progress note written by Nurse #1 dated 4/2/24 revealed Resident #17 had a fall. A review of Resident #17's Quarterly Minimum Data Set assessment dated [DATE] did not indicate she had a fall. In an interview with MDS Nurse #1 on 9/24/24 at 11:17 AM she stated changes in resident conditions were discussed with the interdisciplinary team (IDT) (a group of healthcare professionals who work together to treat a resident) each morning. MDS Nurse #1 stated the MDS assessment completed on 6/20/24 should have indicated Resident #17 had a fall. She stated she was not sure how the error occurred. In an interview with MDS Nurse #2 on 9/24/24 at 11:18 AM she stated the MDS assessment completed on 6/20/24 should have indicated Resident #17 had a fall. She stated she failed to code the fall related to human error. In an interview with the DON on 9/24/24 at 11:24 AM she stated all falls were reviewed with IDT team each morning and when the MDS Nurse's received the information, they should have coded it in the MDS. In an interview with the Administrator on 9/25/24 at 4:08 PM she stated the MDS assessment should accurately reflect resident falls. 48230 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident #56 was admitted to the facility on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD). A review of Resident #56's medical record revealed a Physician's order dated 8/23/24 for oxygen to be delivered at 2 liters per minute via nasal cannula continuously. A review of the admission Minimum Data Set (MDS) dated [DATE] did not indicate Resident #56 used oxygen. A review of Resident #56's Medication Administration Record revealed she had been receiving oxygen at 2 liters per minute continuously since admission. An interview with MDS Nurse #1 on 9/24/24 at 2:52 PM revealed changes in resident conditions were discussed with the interdisciplinary team (IDT) (a group of healthcare professionals who work together to treat a resident) each morning. MDS Nurse #1 stated the MDS assessment completed on 8/29/24 should have indicated Resident #56 used oxygen. She indicated coding for oxygen was missed due to human error. In an interview with the Administrator on 9/24/24 at 2:57 PM she stated the MDS assessment should have accurately reflected Resident #56's oxygen use. In an interview with the Director of Nursing (DON) on 9/25/24 at 12:55 PM she stated Resident #56's MDS should have been coded for oxygen use. 37468 c. Resident #93 was admitted to the facility on [DATE]. Her active diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. Review of Resident #93's progress note dated 9/12/24 revealed she was discharged home. Review of Resident #93's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed she was coded as discharged to a short-term general hospital. During an interview on 9/24/24 at 2:38 PM MDS Nurse #2 stated Resident #93 was discharged home and the discharge MDS dated [DATE] was marked in error. During an interview on 9/24/24 at 2:57 PM the Administrator stated MDS assessments should accurately reflect residents' discharge status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff interviews the facility failed to develop a comprehensive care plan that included the diagnosis of diabetes mellitus and the use of hypoglycemic medication for 1 of 5 residents (Resident #61) reviewed for unnecessary medication. Findings included: Resident #61 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. A review of his quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was taking hypoglycemic medication. A physician's order dated 1/25/24 indicated to give Resident #61 one 500 milligram tablet of metformin extended release (a hypoglycemic medication) once daily in the morning related diabetes mellitus. A review of his comprehensive care plan dated last reviewed on 7/26/24 did not reveal any focus area, goals, or interventions related to Resident #61's diagnosis of diabetes mellitus or his use of hypoglycemic medication. On 9/25/24 at 8:11 AM an interview with MDS Nurse #1 indicated she was the MDS Coordinator. She stated Resident #61's comprehensive care plan was last reviewed by the interdisciplinary team from 7/2/24 through 7/9/24. She stated she did not see Resident #61's diabetes mellitus or his use of hypoglycemic medication addressed in his current comprehensive care plan. She reported it would have been her responsibility to include this, she should have caught it on his last care plan review, and she had missed it. MDS Nurse #1 stated this was a human error. On 9/25/24 at 4:05 PM an interview with the Director of Nursing indicated Resident #61's diabetes mellitus and his use of hypoglycemic medication were things that should be included in his comprehensive care plan. On 9/26/24 at 9:50 AM an interview with the Administrator indicated Resident #61's diabetes mellitus and use of hypoglycemic medication should have been reflected in his comprehensive care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on observations, record review, and resident and staff interviews the facility failed to provide incontinence care to a severely cognitively impaired dependent resident. This was for 1 of 3 residents (Resident #45) reviewed for activities of daily living. This placed Resident #45 at risk for skin integrity impairment. Findings included: Resident #45 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (disrupted blood supply to the brain). A review of Resident #45's care plan last updated 5/30/24 revealed a focus area for activities of daily living. The goal was for Resident #45's activities of daily living to be completed with staff support. An intervention was dependence for toileting hygiene and incontinence of bladder. A review of Resident #45's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He had functional impairment in range of motion on both sides of his upper and power extremities. He was dependent for toileting hygiene. He was always incontinent of bowel and bladder. He had no pressure ulcers, skin conditions, or moisture associated skin damage. A review of Resident #45's full body skin assessment dated [DATE] completed by Nurse #5 did not indicate any skin redness, irritation, or breakdown. On 9/25/24 at 2:02 PM Resident #45 was observed lying in his bed. A portion of the bottom of his blanket was pulled back and the edge of his incontinence pad visible. This pad was observed to have a yellowish wet ring. There was the slight odor of urine. An interview with Resident #45 at that time indicated he was doing fine. He stated he had already had his bath that morning and he did not need anything. On 9/25/24 at 2:12 PM an interview with Nurse Aide (NA) #1 indicated she was assigned to care for Resident #45 on the 7AM-3PM shift that day. She stated she was familiar with Resident #45. She reported Resident #45 did not use his call bell for assistance, and he was always incontinent of bowel and bladder. NA #1 went on to say Resident #45 had not had his bath yet, and she had not been in his room to check him for incontinence or provide him with any incontinence care since she began her shift at 7:00 AM that morning. She stated she had a really demanding resident who had taken up a lot of her time that day, and she had not had a chance to get to Resident #45. She reported she had not asked anyone to help her, or let the nurse know she had not been able to get to Resident #45. NA #1 reported she felt if she had asked the nurse for help, the nurse would have helped her. She went on to say Resident #45 should have been checked for incontinence at least every 2 hours and incontinence care provided to him if he needed this. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 2:18 PM an observation of Resident #45's incontinence care was conducted with the Director of Nursing (DON) and NA #1. The DON stated Resident #45's incontinence pad was wet, and his incontinence brief was saturated with urine and the odor of urine was present. No redness, irritation, or skin breakdown was observed to Resident #45's perineal area or buttocks. During the observation, NA #1 confirmed to the DON that she had not checked Resident #45 for incontinence since she started her shift at 7 AM that morning or provided him with incontinence care yet that day. The DON stated she was very upset and disappointed and could not understand why NA #1 had not provided Resident #45 this care. The DON reported Resident #45 was always incontinent and didn't use his call bell. She went on to say NA #1 should have checked Resident #45 for incontinence at least every 2 hours and provided him with incontinence care if he needed it. She stated going 7 hours without this care put Resident #45 at risk for skin breakdown. The DON reported if NA #1 had not been able to provide Resident #45 with care for whatever reason, NA #1 should have asked a nurse, a unit manager, or herself and someone would have gladly assisted. On 9/25/24 at 2:23 PM an interview with Nurse #4 indicated she was assigned to care for Resident #45 on the 7AM-3PM shift that day. She stated she was not aware that Resident #45 had not received any incontinence care yet that day, and NA #1 had not asked her for any help providing this or she would have gladly assisted. Nurse #4 did not indicate she checked Resident #45 for incontinence or provided any incontinence care to Resident #45 that day. On 9/25/24 at 3:26 PM an interview with Unit Manager #2 indicated she was the Unit Manager for the hall where Resident #45 resided. She stated she had been on Resident #45's hall at both the breakfast and lunch meals that day, and NA #1 had not asked her for any assistance with providing incontinence care to Resident #45. On 9/26/24 at 9:58 AM, a follow-up interview with Unit Manager #2 indicated she had been in Resident #45's room on 9/25/24 to deliver his breakfast and lunch meals. She stated she had not checked him for incontinence or provided him with any incontinence care. She went on to say she had not noticed any urine odor, and Resident #45 had not requested any care. On 9/25/24 at 3:41 PM an interview with Nurse #5 indicated she conducted Resident #45's full body skin assessment dated [DATE]. She stated Resident #45 had no skin redness, irritation or breakdown observed during this assessment. On 9/26/24 at 7:55 AM a telephone interview with NA #2 indicated she had been assigned to care for Resident #45 on 9/24/24 at 11:00 PM until 9/25/24 at 7:00 AM. She stated she had last provided Resident #45 with incontinence care at 5:00 AM on 9/25/24 before she finished her shift at 7:00 AM that morning. On 9/26/24 at 9:50 AM an interview with the Administrator indicated she would have expected Resident #45 to be provided with incontinence care in a timely manner. She stated although Nurse #4 had been in Resident #45's room to administer his morning and lunch time medications, and Unit Manager #2 had been in his room during his breakfast and lunch meals, and he had not indicated he needed anything; he should have received incontinence care every 2 hours as needed

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing siderails for 2 of 2 residents (Resident #27, Resident #56) reviewed for accidents. Findings included: 1. Resident #27 was admitted to the facility on [DATE] with a diagnosis of vascular dementia and chronic obstructive pulmonary disease (COPD). A review of Resident #27's record revealed an assessment titled physical device use evaluation dated 7/23/24 and completed by Unit Manager (UM) #1 indicated no alternatives to one quarter siderails were attempted before use. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 was severely cognitively impaired. The MDS indicated Resident #27 required partial to moderate assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #27 had an impairment of both upper and lower extremities. The MDS indicated Resident #27's siderails were not used as a restraint. A care plan with the latest review date of 8/14/24 revealed a problem of use of siderails for increasing or maintaining current bed mobility. The goal was Resident #27 would continue to use siderails safely for facilitating bed mobility and transfers through next review. Interventions included: use of siderails to assist resident to enter and exit the bed independently and use of siderails to assist resident to turn and reposition when in bed. An observation on 9/24/24 at 2:35 pm revealed Resident #27 lying in bed with bilateral one-quarter length siderails in the up position on the bed. An observation 9/25/2024 at 2:04 PM revealed Resident #27 sitting in her wheelchair next to her bed. The siderails were observed to be in the raised position. An interview with Nurse #2 on 9/25/24 at 9:25 AM revealed the Nurses completed the physical device use evaluation on admission and quarterly. Nurse #2 stated this form was used for siderail screening. She further stated she always answered no to the question Of these alternatives, which have been attempted (i.e. rehab screening, restorative nursing program, toileting schedule, activity programming, assistive devices, medication review, pain management, room change, etc.)? Nurse #2 indicated siderails were on the beds on admission. Newly admitted residents began using the siderails immediately. She further indicated Nursing did not try alternatives to siderails before they were used. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with UM #1 she stated she recalled completing the physical device use evaluation for Resident #27. She further stated she was not aware of a time the facility tried alternatives to siderails. UM #1 revealed siderails were always on the beds unless they were removed by request of the resident, the residents responsible party or physical therapy. She was not aware alternatives to side rails needed to be attempted before using them. In an interview with the Director of Nursing (DON) on 9/25/24 at 12:55 PM she stated Nursing completed the physical device use evaluation on admission and quarterly. She further stated they did not try interventions before using siderails as she was not aware this was a requirement. The DON indicated that siderails were only taken off the beds if found to be contraindicated for a resident or if a resident or resident representative declined them. In an interview with the Administrator on 9/25/24 at 8:45 AM she stated siderails were not removed from the beds unless the resident or their representative declined them, or if they were found to be a danger to the resident. She further stated alternative interventions to the siderails were not tried first. 2. Resident #56 was admitted to the facility on [DATE] end stage renal disease with dependence on renal dialysis, Chronic Obstructive Pulmonary Disease (COPD) and fracture of the right femur (upper leg bone). A review of Resident #56's record revealed an assessment titled physical device use evaluation dated 8/23/24 and completed by Nurse #3 indicated no alternatives to one quarter siderails were attempted before use and a medical symptom for use of siderails was not found. A 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #56 was moderately cognitively impaired and had no impairment of upper extremities and did have impairment in lower extremities. The Resident required substantial assistance with rolling in bed, sitting to lying and sit to stand. The MDS indicated Resident #56's siderails were not used as a restraint. A care plan with the latest review date of 8/23/24 revealed a problem of use of siderails for increasing or maintaining current bed mobility. The goal was Resident #56 would continue to use siderails safely for facilitating bed mobility and transfers through next review. Interventions included: Use of siderails to assist resident to increase ability to enter and exit the bed at highest practical mobility level and use of siderails to assist resident to turn and reposition when in bed. An observation on 9/23/24 at 9:38 AM revealed Resident #56 in bed with the one-quarter length siderails in the raised position. An observation 9/25/2024 at 2:28 PM revealed Resident #56 in bed with bilateral one-quarter length siderails in the up position on the bed. Nurse #3 could not be reached for an interview. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse #2 on 9/25/24 at 9:25 AM revealed the Nurses completed the physical device use evaluation on admission and quarterly. Nurse #2 stated this form was used for siderail screening. She further stated she always answered no to the question Of these alternatives, which have been attempted (i.e. rehab screening, restorative nursing program, toileting schedule, activity programming, assistive devices, medication review, pain management, room change, etc.)? Nurse #2 indicated siderails were on the beds on admission. Newly admitted residents began using the siderails immediately. She further indicated Nursing did not try alternatives to siderails before they were used. In an interview with the Director of Nursing (DON) on 9/25/24 at 12:55 PM she stated Nursing completed the physical device use evaluation on admission and quarterly. She further stated they did not try interventions before using siderails. The DON indicated that siderails were only taken off the beds if found to be contraindicated for a resident or if a resident or resident representative declines them. She was not aware alternative interventions to siderails needed to be tried before implementation of siderails. In an interview with the Administrator on 9/25/24 at 8:45 AM she stated siderails were not removed from the beds unless the resident or their representative declines them, or if they were found to be a danger to the resident. She further stated alternative interventions to the siderails were not tried first. The Administrator was not aware alternatives to siderails needed to be attempted before siderail use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41009 Based on observations, record review and staff interviews, the facility failed to handle soiled linen in a manner to prevent the spread of infection. This was for 1 of 2 staff members observed for infection control practices during activities of daily living care (Nurse Aide #1). Findings included: A review of the facility's policy titled: Linen Handling dated 4/2023 revealed in part: All soiled linen should be considered as contaminated. The risk of actual disease transmission from soiled linen with pathogenic microorganisms is insignificant if handled, transported, and laundered in a way that avoids the transfer of microorganisms. Soiled linen should be bagged or placed in containers at the location where it is used. Wet and/or soiled linens should be placed and transported in leak proof bags. On 9/25/24 at 10:29 AM an continuous observation of bathing activity was conducted for Resident #1 with Nurse Aide (NA #1). At the conclusion of the activity at 11:25 AM NA #1 removed her soiled gloves, performed hand hygiene and applied clean gloves. NA #1 was observed to pick the soiled linen up from the floor while wearing her gloves, open Resident #1's room door, transport the linen out into the hallway, and place it into the soiled laundry hamper which was positioned outside the door to Resident #1's room. NA #1 then removed her gloves and performed hand hygiene. An interview with NA #1 at that time, after leaving Resident #1's presence, indicated the linen on the floor of Resident #1's room was the soiled linen from Resident #1's bath. NA #1 stated sometimes she placed resident's soiled linen into a bag after their bath if she needed to transport the soiled linen down the hallway, but if the linen hamper was outside the room like it was today, she would pick the linen up from the floor and place into the laundry hamper without putting it into a bag first. On 9/25/24 at 4:05 PM an interview with the Director of Nursing (DON) indicated she was also serving as the facility's Infection Preventionist. She stated NA #1 should not be placing soiled linen directly on the floor in resident's rooms. She went on to say this was an infection control issue because it could result in the cross contamination of microorganisms. The DON reported NA #1 should be placing soiled linen directly into a bag for transport. On 9/26/24 at 9:50 AM an interview with the Administrator indicated soiled linen should be bagged for transportation unless it could be placed directly into the soiled linen hamper and should not be placed on the floor in resident's rooms.