

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERPOINT CREST NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 OLD CHERRY POINT ROAD</b> <b>NEW BERN, NC 28563</b>		
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F 000	INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation conducted on 11/30/18. Event #ZF3B11.	F 000			
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 record review and staff interviews, the facility failed to code accurately Minimum data Set (MDS) section E for physical and wandering behaviors for 1 of 1 sampled resident (Resident # 68) and failed to code accurately MDS Section A for discharge home for 1 of 1 sampled resident (Resident # 84).  Findings Included:  1-Record review indicated Resident # 68 was admitted to the facility on 8/7/2018 with diagnoses which included delusional irritability, dementia and Alzheimer's.  The quarterly Minimum Data Set (MDS) dated 11/8/2018 revealed Resident # 68 was severely cognitively impaired, was independent with bed mobility and transfer. The resident also required extensive assist, with dressing and personal hygiene. The MDS did not code behavioral symptoms section E to indicate Resident # 68 behaviors for the month of October 2018.  Review of the Behavioral monitoring sheet for the month of September and October 2018 revealed	F 641	Disclaimer: Riverpoint Crest Nursing and Rehabilitation 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 Corrections is submitted as a written allegation of compliance.  Riverpoint Crest Nursing and Rehabilitation 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 Rehabilitation 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.	12/21/18	

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

TITLE

(X6) DATE

Electronically Signed

12/21/2018

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.

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F 641	<p>Continued From page 1</p> <p>the resident exhibited following behaviors: Grabbing others, pushing others and wandering in other residents' rooms.</p> <p>An interview with the MDS nurse was conducted on 11/29/2018 at 1:56 pm. During this interview she revealed she completed the quarterly assessment for Resident # 68. The MDS nurse stated she did not code the behavioral symptoms because she had already coded behavioral symptoms in the admission MDS.</p> <p>An interview with the Director of Nursing (DON) was conducted on 11/29/2018 at 2:09 pm. During this interview DON stated she expected the MDS to be coded accurately.</p> <p>During the interview with the Administrator on 11/30/2018 at 10:00AM, He stated his expectation was for the MDS to be coded accurately.</p> <p>2-Record review indicated Resident # 84 was admitted to the facility on 9/27/2018 with diagnoses which included heart failure, diabetes and anxiety.</p> <p>The quarterly Minimum Data Set (MDS) dated 10/4/2018 revealed Resident # 84 cognition was intact, she required extensive assist, with dressing and personal hygiene.</p> <p>The discharge MDS dated 10/12/2018 coded the resident inaccurately as discharged to acute hospital. Review of the resident's record revealed the resident was discharged to the community.</p> <p>An interview with the MDS nurse was conducted on 11/29/2018 at 1:56 pm. During this interview she revealed she completed the quarterly</p>	F 641	<p>The process that led to this deficiency was the facility failed to code accurately the Minimum Data Set (MDS) section E for physical and wandering behaviors for 1 of 1 sampled resident (resident #68) and failed to code accurately MDS section A for discharges home for 1 of 1 sampled resident (resident #84)</p> <p>The MDS Coordinator completed a correction on 11/29/18 to the comprehensive assessment for Resident # 68 to reflect accurate coding of physical and wandering behaviors. The MDS Coordinator completed a modification for Resident # 84 on 11/29/18 to reflect accurate coding of discharge home.</p> <p>On 12/20/18 100% audit of sections E and A for all residents most current MDS assessment to include Resident #68 and resident #84 was initiated by the Director of Nursing utilizing the MDS Accuracy QI Tool to ensure all MDS's assessments completed are coded accurately to include all residents that have behaviors and all residents that have been discharged within the past 90 days. Modifications will be completed by the MDS nurse during the audit for any identified area of concern with the oversight from the DON. Audit will be completed by 12/20/18.</p> <p>On 12/13/18 100% in-service on MDS Assessments and Coding was completed by the MDS facility Consultant with all MDS nurses, MDS Coordinator and the DON, regarding proper coding of MDS assessments per the Resident</p>		

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F 641	<p>Continued From page 2</p> <p>assessment for Resident # 84. The MDS nurse stated she coded the MDS inaccurately by not paying attention to the correct code.</p> <p>An interview with the Director of Nursing (DON) was conducted on 11/29/2018 at 2:09 pm. During this interview DON stated she expected the MDS to be coded accurately.</p> <p>During the interview with the Administrator on 11/30/2018 at 10:00AM, He stated his expectation was for the MDS to be coded accurately.</p>	F 641	<p>Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include all residents that have behaviors and all discharged residents, are coded correctly on the MDS assessment.</p> <p>All newly hired MDS Coordinator or MDS nurses will be in-serviced in regards to MDS Assessments and Coding during orientation by the Staff Facilitator to include proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include all residents that have behaviors and all discharged residents.</p> <p>10% audit of completed MDS assessments, to include assessments for resident # 68 utilizing the MDS Accuracy QI Tool will be completed by the DON weekly x 12 weeks, to ensure accurate coding of the MDS assessment to include residents that have behaviors and residents that are discharged. All identified areas of concern will be addressed immediately by the DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The Administrator will review and initial the MDS Accuracy QI Tool weekly X's 12 weeks to ensure any areas of concerns have been addressed. The DON will forward the results of MDS Accuracy Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 641	Continued From page 3	F 641	meet monthly x 3 months and review the MDS Accuracy 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.		