PRINTED: 01/10/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345211	B. WING		12/05/2019
	ROVIDER OR SUPPLIER  NT CREST NURSING AN	ID REHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.
E 000	Initial Comments		E 000		
F 641		3.73, Emergency t ID # 29LM11.	F 641		12/23/19
SS=D	§483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on staff interviacility failed to accurate Data Set (MDS) for hand the use of antips 2 of 40 residents reviate Findings included:  1.Resident # 88 was 3/23/2017 with diagnormal status and the second s	is not met as evidenced iews and record reviews the ately code the Minimum ospice care (Resident # 88) ychotics (Resident # 38) for ewed for MDS accuracy.		Riverpoint Crest Nursing and Rehabilitation Center acknowl-edges receipt of the Statement of Deficiencies and proposes this plan of correction to extent of findings is factually correct ar in order to maintain compliance with applicable rules and provisions of quali of care of residents. The plan of correction is submitted as a written allegation of compliance.	the id
	# 88 expired on 10/18  The latest quarterly Mathebox was not mark received hospice care  A physician order data discontinue comfort of the initial skilled Hos 6/25/2018 revealed R	heimer's disease. Resident 3/2019. 1DS dated 8/6/2019 showed led to indicate Resident #88		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 accura Further, Riverpoint Crest Nursing and Rehabilitation Center re-serves the right 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.	of ate.
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE	(X6) DATE

12/23/2019 **Electronically Signed** 

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345211	B. WING			12/05/2019	
NAME OF P	ROVIDER OR SUPPLIER	·	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CO		12/00/2010	
DI /5000				2600 OLD CHERRY POINT ROAD			
RIVERPO	INT CREST NURSING	AND REHABILITATION CENTER		NEW BERN, NC 28563			
(X4) ID PREFIX TAG	(EACH DEFICIE	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From pa	age 1	F 64	On 12/4/19 the, MDS Coord			
	10/18/2019 revealed	ed 6/27/2018 and revised on ed a plan which focused on o a progressive disease		completed a modification to comprehensive assessment # 88 to reflect accurate codil care. Resident # 88 no long the facility. On 12/20/19 the	for Resident ng of hospice er resides in		
	revealed Resident	of care dated 7/18/2019 # 88 was recertified for rom 7/18/2019 through		Coordinator completed modi comprehensive assessment # 38 to reflect accurate codinate of antipsychotics.	for Resident		
	revealed Resident with interventions p	d nursing note dated 7/30/2019 # 88 was seen by the nurse planned for the next week visit.		On 12/20/19 100% audit was all current residents most cu coding was reviewed for cod for all residents receiving ho	rrent MDS ling accuracy spice care		
	12/4/2019 at 1:00	v with the Nurse Aide # 3 on pm, she stated the Hospice Aide both came to the facility esident # 88.		and receiving antipsychotic include Resident # 38. This initiated by the Director of Nutilizing the MDS Accuracy (ensure that all MDS's asses	audit was ursing (DON) QI Tool to		
	12/4/2019 at 2:11   88 was on hospice expired. MDS # 1 s did not have hospi and she would sub	w with MDS Nurse # 1 on om, she revealed Resident # care a long time before she stated the MDS dated 8/6/2019 ce marked and it was incorrect, omit a correction. The MDS		include hospice services and antipsychotic medications has accuracy to include all reside and/or are currently receiving care or receiving antipsycho medications within facility. A	ave coding ents that have g hospice tic Any identified		
	the resident's cond meeting that she a staff every morning			areas of concerns noted dur will be addressed by the MD include modifications to the comprehensive assessment oversite from the Director of	S nurse to		
	stated Resident # 8 that the resident w 2) Resident #38 w	57 pm, the administrator 88's MDS should have shown as on hospice care. as admitted to the facility on oses included dementia and		On 12/23/19 an in-service we the Director of Nursing with a Coordinator and MDS Nurse accurately coding the MDS, proper coding of MDS assess the Resident Assessment In-	the MDS in regards to to include isments per		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/	12/05/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RIVERPO	NT CREST NURSING AN	ND REHABILITATION CENTER			600 OLD CHERRY POINT ROAD			
			NEW BERN, NC 28563		EW BERN, NC 28563			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 641	Continued From page	e 2	F 6	341				
F 641	A review of the most (MDS) a quarterly rev Resident #38 was mo impaired. The MDS santipsychotic medica days of the look back revealed the section antipsychotics were remarked. The care plan update #38 was care planed drugs having an alter depression and parared dizziness, tremors and A review of the Octob listing revealed Rispe was ordered daily for On 12/5/19 at 1:20 P Resident #38 did recomedications but she in the most of the octob listing revealed Rispe was ordered daily for On 12/5/19 at 1:20 P Resident #38 did recomedications but she in the most of the most of the octob listing revealed Rispe was ordered daily for the octob listing revealed Rispe was ordered by the octob listing revealed	recent Minimum Data Set view dated 10/10/19 revealed oderately cognitively ection N0410 revealed tions were received for 7 period. Additional review N0450 indicated no eceived.  ad 9/25/19 stated Resident for "use of psychotropic ing effect on the mind due to noia with the potential for ad insomnia."  per 2019 monthly orders erdal for psychotic disorder Resident #38.  M the MDS nurse stated		541	(RAI) Manual with emphasis that all MI assessments are completed accurately reflect residents receiving hospice services and or antipsychotics medications. In-Service was completed 12/23/2019  All newly hired MDS Coordinator or MI nurses will be in-serviced in regards to MDS Accuracy QI Tool 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 reflect residents receiving hospice services and or antipsychotics medications. In-Service was completed 12/4/2019.  10% audit of completed MDS assessments resident # 88 utilizing the MDS Accuracy QI Tool will be completed by the DON weekly x 8 weeks, then monthly x 1 month, to ensure accurate coding of the MDS assessment to include residents receive hospice services. 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 of the MDS assessment and initial the MDS Accuracy QI Tool weekly x 8 weeks, then monthly x month, to ensure any areas of concern have been addressed.	to to for cy e that d		
					· · · · · · · · · · · · · · · · · · ·	S		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/	05/2019	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2600 OLD CHERRY POINT ROAD  NEW BERN, NC 28563				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 641	Care Plan Timing and CFR(s): 483.21(b)(2)	d Revision		657	assessments, to include assessments residents receiving hospice services at or antipsychotic medications are acute coded utilizing the MDS Accuracy QI T will be completed by the DON weekly weeks and monthly x 1 month to ensure accurate coding of the MDS assessment All identified areas of concern will be addressed immediately by the DON to include additional training and complete necessary modification to the MDS assessment as indicated. The Administrator will review and initial the MDS Accuracy QI Tool weekly x 8 week and then monthly x 1 month for accurate and to ensure any areas of concerns help been addressed. The Administrator will forward the resure of MDS Accuracy Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 month and review the MDS Accuracy Tool to determine trends and / or issues that in need further interventions put into place and to determine the need for further at / or frequency of monitoring.	nd ly pool c 8 ee nt. ing ks cy ave lts a	12/23/19	
	be- (i) Developed within 7 the comprehensive a	orehensive care plan must  7 days after completion of ssessment. terdisciplinary team, that intention in the completion of the completion						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345211	B. WING		12/05/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
DIV (500.0)				2600 OLD CHERRY POINT ROAD	
RIVERPOI	NI CREST NURSING AN	ID REHABILITATION CENTER		NEW BERN, NC 28563	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 657	Continued From page	e 4	F 6	57	
	<ul><li>(B) A registered nurse resident.</li><li>(C) A nurse aide with</li></ul>	e with responsibility for the responsibility for the			
	resident. (D) A member of food	I and nutrition services staff.			
		cticable, the participation of			
		resident's representative(s). be included in a resident's			
		participation of the resident			
		resentative is determined			
	not practicable for the				
	resident's care plan.				
		staff or professionals in			
		ined by the resident's needs			
	or as requested by th				
		ised by the interdisciplinary			
		ssment, including both the			
	comprehensive and c	quarterly review			
	assessments.	· :			
		is not met as evidenced			
	by:	iews and record review the		On 12/3/19 100% audit of all of	ourront
		the resident's care plan to		resident care plans, by the MD	
		resident's desire for Do not		Coordinator for residents with	
		der (written instructions		for residents with end of life an	•
	` ,	ng health care providers not		directives to ensure the care p	
		monary Resuscitation (CPR)		reflected residents end of life of	
		stops) for 1 of 40 residents		directives regarding Cardiopuli	
	(Resident #88) reviev			Resuscitation or Do Not Resus	
	,	·		utilizing a resident census. Any	y identified
	Findings included:			areas of concerns will be corre	ected by the
				Director of Nursing during the	
		lmitted to the facility on		audit was completed on 12/3/1	
	3/23/2017 with diagno			# 88 no longer resides in the fa	acility.
	diabetes mellitus, der				
		heimer's disease. Resident		On 12/9/19 an in-service was i	
	# 88 expired on 10/18	3/2019 at the facility.		the Staff Development Coordin	
	A physician order dat	ed 7/17/2017 revealed a		the Director of Nursing (DON) Assistant Director of Nursing (	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345211	B. WING			12/05/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL	DE		
RIVERPOI	NT CREST NURSING	AND REHABILITATION CENTER		2600 OLD CHERRY POINT ROAD			
				NEW BERN, NC 28563			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From pa	ge 5	F 6	57			
F 657	DNR status.  The care plan dated which focused on edirectives with the gdirective would be hishowed Resident # the heart or/and breall interventions need heart functioning.)  During an interview (MDS) # 1 on 12/4/2 it was the Social Worthe end of life portionals of stated the Social Socia	d 3/16/2018 revealed a plan and of life planning and goal that Resident # 88's nonored. The intervention 88 as a full code (in the case eathing stops, full code allows eded to restore breathing or with minimum data set nurse 2019 at 2:11 pm, she revealed orker's responsibility to update on of the care plan. MDS #1 ial Worker was out on Medical stated the care plan should and it could have been	F 69	Unit Managers, Social Worker nurses and hall nurses in regressed developing, implementing ancomprehensive care plan for recommendations for end of desired directives regarding Cardiopulmonary Resuscitatis Resuscitates directives. In-secompleted by 1/2/2020 Any DON, ADON, Unit Manager, Nurse or hall nurse will be edithe Staff Facilitator during ori regards to developing, impler revising a comprehensive carecommendations for end of desired directives regarding Cardiopulmonary Resuscitatis Resuscitates directives.  10% of residents care plans and audited using the MDS Care Audit Tool to ensure that developmenting and revising a comprehensive care plan for recommendations for end of desired directives regarding Cardiopulmonary Resuscitatis Resuscitates directives are and the resident's desires utilizing Accuracy audit tool by the Directives of the Di	life and life and life and life and life and lon or Do Not lervice to be newly hired SW, MDS lucated by lentation in menting and re plan for life and lon or Do Not life and lon or Do Not ccurate per gothe MDS rector of len monthly X lon or concerns		
				Nursing during the audit. The review and initial the Care pla weekly x 8 weeks then month for completion and to ensure concern were addressed.	DON will an audit tool nly x 1 month		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/	05/2019
	ROVIDER OR SUPPLIER  NT CREST NURSING AN	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)		3E	(X5) COMPLETION DATE
F 690 SS=D	Continued From page  Bowel/Bladder Incont  CFR(s): 483.25(e)(1)	tinence, Catheter, UTI	F 6		The Administrator will forward the result of the Care Plan Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee meet monthly x 3 months to review the Care Plan Audit Tool to determine trenand/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	e will e	12/23/19
33-0	§483.25(e) Incontined §483.25(e)(1) The factoresident who is continuous admission receives a maintain continence of condition is or become not possible to maintain successive as a comprehensive assessment that (i) A resident who entinuous assessment who is assessed for removal as possible unless the demonstrates that calculated and (iii) A resident who is receives appropriate	nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is ain. esident with urinary on the resident's esment, the facility must eers the facility without an not catheterized unless the dition demonstrates that					

PRINTED: 01/10/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X:	(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/05/2019	
NAME OF PR	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STAT	ΓΕ, ZIP CODE		
				2600 OLD CHERRY POINT R	OAD		
RIVERPOI	NT CREST NURSING	AND REHABILITATION CENTER		NEW BERN, NC 28563			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 690	incontinence, base comprehensive assensure that a resid receives appropriar restore as much no possible. This REQUIREME by: Based on observate Physician interview a catheter drainage with the floor for 2 and Resident #68)  Finding included:  1. Resident #85 w	extent possible.  a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel te treatment and services to ormal bowel function as  NT is not met as evidenced  tions, staff, resident, and ys, the facility failed to prevent to bag from coming in contact of 2 residents (Resident #85 reviewed for catheter care.	F 6	On 12/2/19 resident 68 indwelling urinary bag came in contact A 100% audit was in by the Nursing Supe to include resident # with indwelling urinar census to ensure the urinary catheters we	t # 85 and resident # / catheter drainage with the floor. itiated on 12/2/2019 ervisor of all residents 85 and resident # 68 ry utilizing a resident at the indwelling are not in contact with		
	kidney disease, ne bladder, and urine  A review of the mo Data Set (MDS) da Resident #85 cogn assessed. The resi assistance with be with all other activity	noses which included chronic uromuscular dysfunction of the retention.  st recent Annual Minimum ated 8/6/2019 revealed itive status was unable to be dent required extensive d mobility and total assistance ties of daily living. The MDS 485 had an indwelling catheter.		will be corrected duri include securing the catheters to ensure t does not touch the fl completed on 12/2/2	indwelling urinary that the collection bag loor. The audit was 2019.  in-service on Proper er drainage bag was nistrator and Staff inator for all nurse's	3	
	11/21/2019 focused urinary elimination catheter care per pphysician orders, ed feach shift, indive	d 10/10/2017 and revised on d on an altered pattern of with the interventions of rotocol, change catheter per empty drainage bag at the end elling urinary catheter and and symptoms of urinary tract		catheter drainage ba in-service includes ir and correct tubing pl in-service will be con All newly hired clinic nurses and certified	ag placement, nfection control risks lacement. The mpleted by 1/2/2020		

Facility ID: 923028

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345211	B. WING _		<del></del>	12	/05/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERPOI	NT CREST NURSING AN	ND REHABILITATION CENTER		2	600 OLD CHERRY POINT ROAD		
14172141 01	THE ONLOS HOROMOTH	is new services		N	IEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 690	Continued From page infection.	€ 8	F 6	90	to proper placement of catheter draina		
		2/2/2019 at 10:00 am 5 was resting in bed with his ped was in a low position.			bags to include infection control risk at correct tubing placement  100% audit of all residents requiring a		
	The catheter bag was the bed close to when was on the bed. The	s hanging on the front side of Resident #85's lower leg bottom part of the drainage be touching the floor.			indwelling urinary catheter to include Resident #85 and Resident #68, will b audited by the Director of Nursing and Nurse Administration utilizing Catheter	e /or	
	An observation on 12 revealed the resident with the bed in a low catheter bag was har previously observed. in it and the bottom o	•			Monitoring Tool weekly x 8 weeks and then monthly x 1 to ensure proper placement of the catheter drainage by to include not touching the floor. All identified areas of concern will be addressed immediately by the Directo Nursing to include repositioning the	ags r of	
	closed. The catheter repositioned. The bot drainage in it was on the bag leaning forwa	was in the bed with his eyes			indwelling urinary catheter drainage be ensure ir not touching the floor. The Director of Nursing will review and initi Catheter Monitoring tool weekly x 8 we and monthly x 1 month to ensure completion and that all areas of conce were addressed  The DON will forward the results of	ial eeks	
	position.  During an interview w 12/2/2019 at 3:43 pm catheter bag should r of infection issues. N bed had to be in the I #5 unsuccessfully att	-			Catheter Monitoring Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive Quality Assurance (QA) Committee will meet monthly x 3 months and review the Catheter Monitoring To determine trends and / or issues that it need further interventions put into place and to determine the need for further a / or frequency of monitoring.	A ths ool to may ce	
	Nurse #4, she reveal	pm during an interview with ed the catheter bag should oor because of infection					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345211	B. WING _		<del></del>	12	/05/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2600 OLD CHERRY POINT ROAD  NEW BERN, NC 28563			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	concerns. Nurse #4 NA #5 hung the cath bed without the bag  During an interview 12/5/2019 at 10:00 a dignity bags to put the should have been used the floor.  2.Resident #73 was 6/4/2019 with diagnor of urine, heart failure bladder.  A care plan dated 6/9/20/2019 revealed altered pattern of urintervention for cath change catheter per drainage bag at the urinary catheter and symptoms of urinary  A review of the most Data Set (MDS) date Resident #73 was so The resident require and extensive to total activities of daily living observed resting in indwelling catheter is side of the bed with touching the floor.	raised the foot of the bed and neter bag on the side of the touching the floor.  with the Physician on am, she stated the facility had he catheter bags in that used. The physician also bags should not be touching admitted to the facility on bases which included retention and flaccid neuropathic.  (6/2019 and revised on a plan which focused on inary elimination with the eter care per protocol, aphysician orders, empty end of each shift, indwelling a observe for signs and a tract infection.  It recent quarterly Minimum and 10/22/2019 revealed lightly cognitively impaired. It is deset up assistance for meals all assistance for all other	F	690			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/	05/2019	
	ROVIDER OR SUPPLIER  NT CREST NURSING AN	ND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE  2600 OLD CHERRY POINT ROAD  NEW BERN, NC 28563				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 690			F 6	90				
	catheter bag was atta	room in a wheelchair. The ached to a metal bar under The bottom of the bag was						
	bag should not be on	n, she stated the catheter the floor because of #6 further stated she had						
	Nurse #5 stated Resi	pm during an interview, dent #73's catheter bag ached on the wheelchair to uching the floor.						
	dignity bags to put the should been used. T resident's catheter ba floor especially Resid because he was capa	m, she stated the facility had e catheter bags in that he physician also stated the ag should not be touching the lent #73 catheter bag able of moving his legs.						
F 692 SS=D	Nutrition/Hydration St CFR(s): 483.25(g)(1)		F 6	92			12/23/19	
	(Includes naso-gastri both percutaneous er percutaneous endosc enteral fluids). Based	ssment, the facility must						
	of nutritional status, s desirable body weigh	ins acceptable parameters such as usual body weight or t range and electrolyte esident's clinical condition						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345211	B. WING	<del></del>	12/05/2019
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 692	Continued From page demonstrates that this preferences indicate	s is not possible or resident	F 6	92	
	§483.25(g)(2) Is offer maintain proper hydra	red sufficient fluid intake to ation and health;			
	there is a nutritional provider orders a the	red a therapeutic diet when problem and the health care rapeutic diet.  Tis not met as evidenced			
	Based on record rev			On 12/3/2019 Resident # 68 was provided a nutritional supplement p physician orders by the nursing ass	sistant.
	Findings included:			A 100% audit was initiated on 12/3/ by the Dietary Manager and Treatm Nurse of all residents, to include Re	nent
	on 1/3/2019.	ginally admitted to the facility		# 68 with orders to receive supplem to ensure that all orders were accur entered into Point Click Care and b	rately
	which focused on Re changes due to a his dialysis treatment. Th not experience signifi	1/14/2019 revealed a plan sident #68 risk for weight tory of weight changes and he goal was the resident will cant weight changes with holuded a referral to the		administered per physician orders. identified areas of concerns will be corrected during the audit to include clarifying the diet orders, ensuring t order is documented in the clinical in providing a diet order form to the di	e the diet record,
	dietician for evaluatio	n, a regular no added salt, et diet with a snack at		department. Audit to be completed 12/3/2019.  A 100% in-service was initiated on	by
		admitted to the facility on ses which included heart y disease, and type 2		by the Staff Development Coordina all nurse's, on accuracy of transcrip supplements. In-Service will be con by 1/2/2020. A 100% in-service was initiated on 12/9/19 by the Staff	tor for otion for npleted
	name nutritional supp	hysician ordered a brand blement twice a day. This 0 calories, 16 grams of		Development Coordinator for all die staff regarding only discontinuing a supplement if there is a physician of	

PRINTED: 01/10/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		ATE SURVEY OMPLETED
		345211	B. WING				40/05/0040
NAME OF D	ROVIDER OR SUPPLIER	343211	5: 11::10	STE	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	12/05/2019
NAME OF PI	ROVIDER OR SUPPLIER						
RIVERPO	NT CREST NURSING	AND REHABILITATION CENTER			00 OLD CHERRY POINT ROAD		
				NE	W BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 692	Continued From p	page 12	F 6	692			
	protein, 16 grams	of carbohydrates, 3 grams of			do so. In-service will be completed by	,	
		nins and minerals per 8 ounces			1/2/2020. All newly hired staff to include		
	serving. There wa	as no stop date with the order.			nurses and dietary staff will receive		
	-				education during orientation by the Sta	aff	
		ost recent quarterly Minimum			Development Coordinator to include		
		lated 11/19/2019 revealed			proper transcription of all supplements		
		cognitively intact. The MDS			Point Click Care and only discontinuing	-	
		sident #68 was on a therapeutic			supplement if there is a physician's ord	der.	
		reight loss within the last six					
		S also showed the resident was			400/		
	on dialysis.				10% audit of all residents requiring		
	A ravious of the let	test dietary note dated			supplements with a physician order to include resident #68 will be audited by		
		led continue the plan of care			Director of Nursing, Dietary Manager,	uie	
		itritional supplements, a regular			and/or Nurse Administration utilizing		
		concentrated sweet diet with a			Resident Diet Accuracy QI tool weekly	x 8	
	1	weights, labs, and to monitor			weeks and monthly x 1 month to ensu		
	Resident #68's or	<del>-</del>			that all residents requiring supplement		
					are receiving per physician orders. All		
	Resident #68's we	eight for the months of October			areas of concerns will be corrected by	the	
	2019 through Dec	cember 2019 were 10/24/19 186			Director of Nursing during the audit. The	ne	
	pounds (lbs.), 11/	1/2019 187, 11/30/2019 189 and			Director of Nursing (DON) will review a	and	
	12/3/2019 189 lbs	S.			sign the Resident Diet Accuracy QI too		
					weekly x 8 weeks and monthly x 1 mo		
		urse Aide flow sheet for the			to ensure completion and that all areas	s of	
		per 2019 revealed no			concerns were addressed to include		
		indicate Resident #68 received			retraining of clinical staff and completing	•	
	a nutritional suppi	ement twice a day.			necessary modification to the resident orders. The Director of Nursing will		
	During an intervie	w with Resident #68 on			review and initial the Resident Diet		
	_	0 an, he stated he had an order			Accuracy QI tool weekly x 8 weeks an	d	
		itional supplements twice a day			monthly x 1 month to ensure all areas		
	_	ved one in a long time. The			concerns have been addressed.	٥.	
		ole to give a specific time period.					
		stated that he had mentioned			The Administrator will forward the resu	ılts	
		tritional supplement to the nurse			of Resident Diet Accuracy QI tool to th		
		o and still had not received it.			Executive Quality Assurance (QA)		
					Committee monthly x 3 months. The		
	An interview with	Nurse Aide #4 (NA) on			Executive QA Committee will meet		

Facility ID: 923028

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTR	UCTION		OATE SURVEY OMPLETED
		345211	B. WING _				12/05/2019
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	•	2600 OLD	DDRESS, CITY, STATE, ZIP CODE CHERRY POINT ROAD RN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 692	supplements came fresident's name on the Resident #68 had not supplement from the the computer and the computer and the have a nutritional supplement are gived ocumented in the computer at 2:00 pm, she state supplements are gived ocumented in the computer at 2:10 pm, she state supplements are gived ocumented in the computer at 2:10 pm. Resident #68 had a supplement. The DI could not find the disprogram. She stated been sending Resident which are supplement twice at the computer at the make sure the resident #68 had must be did not put the nutritional supplement the order.  An interview with the pm revealed the prowere to enter the ordar dietary form, give form, and the kitchel	n revealed the nutritional rom the kitchen with the he container. The NA stated of received a nutritional e kitchen. NA #4 checked en stated the resident did not applement on the care guide, one.  With Nurse #2 on 12/3/2019 ed the nutritional en by the nurse aides and omputer.  Dietary Manager (DM) on a revealed she did not think current order for a nutritional et order in her computer the dietary staff had not ent #68 a nutritional	F	month Resid detern need and to	hly x 3 months and review the dent Diet Accuracy QI tool to mine trends and / or issues that further interventions put into po determine the need for further equency of monitoring.	lace	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	COMPLETED
		345211	B. WING _		12/05/2019
	ROVIDER OR SUPPLIER  NT CREST NURSING A	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 692	The DON further sta	ge 14 n to add a dietary preference. ated Nurse #3 should have staff to inform the staff of the	F 6	92	
F 700 SS=E	10:00 am revealed to recommendations for The physician also strecommendation was	as made, and an order was s should have received the ents as ordered.	F 7	00	12/23/19
	alternatives prior to a bed or side rail is correct installation,	ls. empt to use appropriate installing a side or bed rail. If used, the facility must ensure use, and maintenance of bed not limited to the following			
	entrapment from be §483.25(n)(2) Revie bed rails with the re	ess the resident for risk of d rails prior to installation.  ew the risks and benefits of sident or resident obtain informed consent prior			
	are appropriate for t §483.25(n)(4) Follow recommendations a and maintaining bec	re that the bed's dimensions the resident's size and weight.  w the manufacturers' and specifications for installing drails.  IT is not met as evidenced			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		E SURVEY MPLETED
		345211	B. WING		1:	2/05/2019
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL	•	2/00/2013
				2600 OLD CHERRY POINT ROAD		
RIVERPO	NT CREST NURSING	AND REHABILITATION CENTER		NEW BERN, NC 28563		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLÉTION DATE
F 700	Continued From բ	page 15	F 70	0		
	by:					
	•	ations, record review and		On 12/20/2019 Physical Dev	/ice	
		taff and physician interviews the		Evaluations were initiated for		
		sess two of seven residents for		#50, #69, #74, #18, #19, #37		
		dents #74 and #37), and failed		On 12/20/2019 a 100% audit	•	
	,	tives, review the risks and		by the Director of Nursing of	all residents	
		resident or the residents		to include resident #50, #69,		
	representative, ar	nd obtain informed consent prior		#19, #37, and #53 utilizing a		
	to the use of bedr	ails for seven of seven		census to ensure the residen	its have been	
residents reviewed for accident hazards. properly assessed for the use/r		e/removal of				
	(Residents #50, #69, #74, #18, #19, #37, #53) bed rails and care plans updated. The		ated. The			
			Evaluations for Resident #50, #69, #74,			
	Findings included	:		#18, #19, #37, and #53 were		
				on 12/21/2019. Any areas of		
		as admitted to the facility on		be addressed during the aud		
		noses including flaccid		will be completed by 1/2/2020	0.	
		alysis) affecting left				
	non-dominant side			On 12/20/2019 an in-service		
		mum Data Set (MDS)		was initiated by the Staff Dev		
		d 10/25/19 indicated Resident		Coordinator with the Director		
		ely impaired for daily decision		(DON), Assistant Director of		
	_	uate hearing and vision without		(ADON), MDS Coordinator, N		
		s, experienced no hallucinations		Unit Managers and hall nurse to use of bed rails to include:		
		exhibited no behaviors or It further indicated Resident #50		use is indicated for a residen		
	•	assistance of one person for		must assess the resident utili		
		ransfers, did not walk, had		Physical Device Evaluation.	-	
		ROM) impairment of the upper		are to be reviewed quarterly		
		ities on one side, was not able		include completing the Physic		
		t staff assistance, had no falls,		Evaluation. Nurse must ensu		
		not used as restraints.		risk and benefits are explaine		
				resident and/or resident repre		
	On 12/3/19 at 8:1	8 AM Resident #50 was		bed rails are used. If bed rails		
		vith the top half bedrails left and		resident must be care planne		
		view with Resident #50 at that		of the bed rails. In-service to		
		liked his bedrails. He stated		completed by 1/2/2020. All no		
	they helped him to	o reposition in bed and he did		DON, ADON, Staff Facilitator		
	not feel they restr	ained him in any way. Resident		Coordinator, MDS Nurse, Un		
		ted he did not try to get out of		and hall nurses will be in-ser	viced by the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345211	B. WING		12/05/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
RIVERPO	INT CREST NURSING A	AND REHABILITATION CENTER		2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 700	Continued From pag	ge 16	F 700		
	assistance, staff car one in the facility ha with him.	d the call bell if he needed me when he called, and no d ever discussed bedrail use  AM Resident #50 was		Staff Facilitator during orientation in regards to use of bed rails to include bed rail use is indicated for a resider nurse must assess the resident utiliz the Physical Device Evaluation. The rails are to be reviewed quarterly if u	nt the ing bed
	observed in bed with right raised.	n the top half bedrails left and		to include completing the Physical D Evaluation. Nurse must ensure that the risk and benefits are explained to the	the
	indicated she was re and familiar with his residents she cared	PM interview with Nurse #1 esponsible for Resident #50 care. She stated all the for in the facility were using		resident and/or resident representati bed rails are used. If bed rails are us resident must be care planned for th of the bed rails.	ed
	residents were not a repositioning, the be bed space and prov comfort for the resid sure who was respo for bedrail use. She	th repositioning but if able to use the bedrails for edrails were used to define the ide a feeling of safety and lent. She stated she was not ensible for assessing residents indicated bedrail use was not 450's care plan or his care		10 % audit of all residents with use a removal of bed rails to include reside #50, #69, #74, #18, #19, #37, and #8 using the MDS Accuracy of Assessm Bedrails QI Tool, will be completed b Staff Facilitator weekly x 8 weeks, th monthly x 1 month utilizing the Bed F Audit Tool to ensure assessment for use and/or removal of bed rails has be completed. The DON will review the	ent 53, nent – y the en Rail the
	Aide #1 indicated sh #50 and responsible stated Resident #50 reposition in bed, die She went on to say assistance she resp soon as she was ab access to resident of was not on them. Sh she cared for in the raised.	AM an interview with Nurse ne was familiar with Resident e for his care that day. She used his side rails to d not try to get up by himself. When residents called for onded immediately or as le to. She indicated she had are guides, but bedrail use ne stated most all residents facility had their bedrails		Rail Audit Tool weekly x 8 weeks, the monthly x 1 month to ensure comple and that all areas of concern were addressed.  The DON will forward the results of the Bed Rail Audit Tool to the Executive Committee monthly x 3 months. The Executive QI Committee will meet must a months and review the Bed Rail Tool to determine trends and / or issuit that may need further interventions point on place and to determine the needs.	en tion  he QI onthly Audit ues out
	A review of physicia revealed no order for	n orders for Resident #50 or bedrails.		further and / or frequency of monitor	ing.

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345211	B. WING _		1	2/05/2019
	ROVIDER OR SUPPLIER  NT CREST NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 700	indicated Resident # desire to have his be bedrail use were atteright were recomme alternatives to bedra to Resident #50 or home of the Reside	t current Bed Rail r Resident #50 dated 5/8/18 #50 had not expressed a edrails up, no alternatives to empted, half bedrails left and nded, and risks, benefits and ill use had not been explained	F7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
	345211	B. WING _			12/05/2019
NAME OF PROVIDER OR SUPPLIER  RIVERPOINT CREST NURSING AN	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 2600 OLD CHERRY POINT RO NEW BERN, NC 28563		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
Administrator indicate facility came with bee be raised or lowered. not aware of any incide bedrails. He stated to alternatives to bedrairisks and benefits of I discussed with reside and no informed consider obtained prior to the considering of the considering	M an interview with the ed the beds used in the drails attached which could. He went on to say he was dents in the facility involving to his knowledge no. I use in the facility were tried, bedrail use were not ents or their representatives, sent for bedrail use had to use of bedrails.  M interview with the ne facility usually made her family members insisted on tated if staff called her bedrails she instructed staff the residents and families enefits of bedrail use.  Admitted to the facility on sees including Alzheimer's eassessment dated 10/8/19 was severely impaired for good had adequate hearing and the of devices, required the eleperson for bed mobility walk, had no ROM allucinations or delusions, toms including yelling not renoted one to three days of sement period. It further 69 had no falls and bedrails	F7	700		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/05/2019	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		
F 700	Continued From page	e 19	F 7	700			
	right raised. She app television.	eared to be watching the					
	speaking to someone in the room. Her top were raised.  On 12/3/19 at 1:19 P indicated she was reand familiar with her residents she cared for bedrails. She added bedrails to assist with residents were not at repositioning then the define the bed space safety and comfort for she was not sure who assessing residents for the same property of the	ke. Resident #69 was e, but no one was observed half bedrails left, and right  M an interview with Nurse #1 sponsible for Resident #69 care. She stated all the for in the facility were using some residents used n repositioning, but if ble to use the bedrails for e bedrails were used to and provide a feeling of or the resident. She stated to was responsible for for bedrail use. She indicated ound on Resident #69's care					
	Aide #3 indicated she #69 and was respons Resident #69 was no reposition in bed as a staff for her care. She #69 did not try to get further indicated the define the space of hindicated Resident #6 but she checked on hit two hours to see if she went on to say she did which residents used	M an interview with Nurse was familiar with Resident sible for her care. She stated at able to use her bedrails to she was totally dependent on whe went on to say Resident up by herself. Nurse Aide #3 bedrails helped Resident #69 er bed and feel safe. She 69 did not use her call bell, her frequently at least every he needed anything. She id not know how staff knew I bedrails and which did not he care guide. She further					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	, ,	ATE SURVEY DMPLETED
		345211	B. WING			12/05/2019
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	•	12.00.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 700	Continued From pag indicated all resident raised.	e 20 's bedrails were usually just	F 70	00		
		n orders for Resident #69 r bedrails.				
	indicated Resident # desire to have her be bedrail use had beer and right were recon	Resident #69 dated 7/10/18 69 had not expressed a edrails up, no alternatives to n attempted, half bedrails left nmended, and risks, benefits, edrail use had not been				
	nurse indicated she assessment dated 7, stated she had not tr use, had not explain	MM an interview with the MDS completed the bedrail /10/18 for Resident #69. She ried alternatives to bedrail ed the risks or benefits of ent #69 or her representative, redrail use had been				
	of Nursing (DON) indifacility put a perform in place as bedrail usissue at a corporate 11/27/19 the facility in having bedrails in using and have a physical on to say the MDS in Bed Rail Assessment basis and no other sis been assessing residual follow up interview, to place as the property of the prop	PM interview with the Director dicated on 11/27/19 the ance improvement plan (PIP) se had been identified as an meeting. She stated on dentified that all residents se needed to be assessed device evaluation. She went urse had been completing its but not on a consistent taff member in the facility had dents for bedrail use. In a he DON stated most all ty were using bedrails, no				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		345211	B. WING _			12/05/2019
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	•	.= 00.=0.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 700	Continued From pagalternatives to bedrai or benefits of bedrai residents or their reginformed consent has the use of bedrails.  On 12/4/19 at 9:28 Administrator indicar facility came with be be raised or lowered not aware of any incident alternatives to bedrails. He stated the alternatives to bedrails, and benefits of discussed with reside and no informed corbeen obtained prior.  On 12/5/19 at 9:29 A Physician indicated aware if residents or using bedrails. She regarding the use of on the need to educe about the risks and language of the second of the seco	ge 21  fill use had been tried, no risks I use were explained to presentatives, and an and not been obtained prior to  AM an interview with the ted the beds used in the drails attached which could I. He went on to say he was idents in the facility regarding to his knowledge no fill use in the facility were tried, bedrail use were not ents or their representatives, asent for bedrail use had	F 7	DEFICIENCY)		
	decision making. It f had adequate hearin had no hallucination care, exhibited no be extensive assistance mobility, supervision was not steady but a	urther indicated Resident #74 ng and vision, used glasses, s, delusions or rejection of ehaviors, required the e of one person for bed of one person for transfers, able to stabilize with the erson, had no limitations of				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345211	B. WING			12/05/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 700	were not used as re On 12/2/19 at 2:44 I observed in bed with right raised.  On 12/3/19 at 1:05 I observed in her bed right raised. Intervie time indicated she u with transfers and a She stated she did r used her call bell for help her. She indica bedrails interfered w served as a restrain facility had ever spo they had just always  On 12/3/19 at 1:19 I indicated she was re that day and familia the residents she ca	r, had no falls, and bedrails straints.  PM Resident #74 was her top half bedrails left and PM Resident #74 was with top half bedrails left and w with Resident #74 at that used her bedrails to assist her leso with repositioning in bed. In the top the did not feel the with her mobility in any way or t. She indicated no staff in the leken to her about her bedrails,	F 70			
	residents were not a positioning, the bed bed space and prov comfort for the resid sure who was responsive who was responsive who was resident # guide.  On 12/4/19 at 8:38 / #3 indicated she was and responsible for	th repositioning but if able to use the bedrails for rails were used to define the ide a feeling of safety and lent. She stated she was not brisible for assessing residents indicated bedrail use was not 474's care plan or her care  AM interview with Nurse Aide is familiar with Resident #74 her care that day. She stated her side rails to reposition				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE COMP	
		345211	B. WING _		12/0	05/2019
	ROVIDER OR SUPPLIER  NT CREST NURSING A	ND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	bedrails was not fou guide, Resident #74	e Aide #3 added the use of nd on Resident #74's care just usually had them up. n orders for Resident #74	F 7	700		
	#74's medical record On 12/4/19 at 9:10 A nurse indicated she #74 for the use of be not tried alternatives explained the risks of Resident #74 or her consent for bedrail u went on to say about taken away the Bed alternative was given bedrail assessments On 12/3/19 at 1:43 F of Nursing (DON) income	M interview with the MDS had not assessed Resident drails. She stated she had to bedrail use, had not benefits of bedrail use to representative, and no se had been obtained. She ta year ago the company had Rail Assessment form and no in so she stopped doing				
	in place as bedrail us issue at a corporate 11/27/19 the facility in having bedrails in us and have a physical on to say the MDS in assessments but no no other staff membrassessing residents further indicated Resafter the facility stop Assessment form an Resident #74 had be	se had been identified as an meeting. She stated on dentified that all residents is needed to be assessed device evaluation. She went urse had been doing bed rail to on a consistent basis and for in the facility had been for bedrail use. The DON sident #74 had been admitted ped using the Bedrail do no bedrail assessment for the en completed. In a follow up stated most all residents in				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		345211	B. WING	<del></del>	12/05/2019	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	,	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION	
F 700	bedrail use had bee bedrail use were exprepresentatives, and been obtained prior On 12/4/19 at 9:28 A	ge 24  g bedrails, no alternatives to n tried, no risks or benefits of plained to residents or their I an informed consent had not to the use of bedrails.  AM interview with the ted the beds used in the	F 70	00		
	facility came with be be raised or lowered not aware of any inc bedrails. He stated t alternatives to bedra risks and benefits of discussed with resid	drails attached which could I. He went on to say he was idents in the facility regarding o his knowledge no ill use in the facility were tried, bedrail use were not ents or their representatives, nsent for bedrail use had				
	Physician indicated aware if residents or using bedrails. She regarding the use of on the need to educ about the risks and leading	AM interview with the the facility usually made her family members insisted on stated if staff called her bedrails she instructed staff ate residents and families benefits of bedrail use.				
	8/23/17 with diagnost muscle weakness at A review of an MDS dated 9/19/19 indicaseverely impaired for further indicated her adequate without the exhibited no delusion behaviors or rejection extensive assistance.	ses including generalized				

	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  ———————————————————————————————————			(X3) DATE SURVEY COMPLETED		
		345211	B. WING _			12/05/2019
	ROVIDER OR SUPPLIER  NT CREST NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 700	transfers and neede had no functional im falls, and bedrails we On 12/2/19 at 2:14 F observed in bed with right raised She was closed.  On 12/3/19 at 8:11 A observed in bed eati bedrails left and right.  On 12/3/19 at 1:19 F indicated she was rethat day and familiar Resident #18 did no stated all the resider were using bedrails. used bedrails to ass residents were not a positioning, the bedrated she was residents were not a positioning, the bedrated space and provicomfort for the resid sure who was respo for bedrail use. She found on Resident # guide.  On 12/4/19 at 8:38 A #2 indicated she was #18 that day, but was and had provided ca stated at times Residents.	Ik, was not steady during d assistance with balance, pairment of ROM, had no ere not used as restraints.  PM Resident #18 was a top half bedrails left and as resting with her eyes  AM Resident #18 was and preakfast with top half traised.  PM an interview with Nurse #1 esponsible for Resident #18 with her care. She indicated at try to get up by herself. She at she cared for in the facility. She added some residents ist with repositioning but if ble to use the bedrails for rails were used to define the de a feeling of safety and ent. She stated she was not ensible for assessing residents indicated bedrail use was not 18's care plan or her care.  AM interview with Nurse Aide is not assigned to Resident #18 are to her in the past. She dent #18 tried to get out of	F 7			
	Resident #18 from fa access to resident ca	ne bedrails helped keep alling. She indicated she had are guides, but bedrail use ne stated most all residents				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345211	B. WING _	<del>-</del>	12/05/2019		
	ROVIDER OR SUPPLIER  NT CREST NURSING	AND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	•		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		
F 700	Continued From pa	ge 26	F 7	00			
	she cared for in the raised.	facility had their bedrails					
	A review of physicial revealed no order for	an orders for Resident #18 or bedrails.					
	indicated Resident desire to have her I bedrail use were at right were recomme	or Resident #18 dated 7/3/18 #18 had not expressed a pedrails up, no alternatives to tempted, half bedrails left and ended, and risks, benefits and ail use had not been explained					
	nurse indicated she Assessment form d She stated she had bedrail use, had no benefits of bedrail u	AM interview with the MDS completed the Bed Rail ated 7/3/18 for resident #18. not tried alternatives to t explained the risks or use to Resident #18 or her no consent for bedrail use					
	of Nursing (DON) ir facility put a perform in place as bedrail to issue at a corporate 11/27/19 the facility having bedrails in the and have a physical on to say the MDS assessments but no no other staff memble assessing residents interview, the DON the facility were usi	PM interview with the Director adicated on 11/27/19 the nance improvement plan (PIP) use had been identified as an emeeting. She stated on identified that all residents se needed to be assessed I device evaluation. She went nurse had been doing bed rail of on a consistent basis and per in the facility had been a for bedrail use. In a follow up stated most all residents in ng bedrails, no alternatives to en tried, no risks or benefits of					

				) DATE SURVEY COMPLETED		
		345211	B. WING _			12/05/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 700	representatives, and been obtained prior  On 12/4/19 at 9:28 Administrator indica facility came with be be raised or lowered not aware of any indicated alternatives to bedrails. He stated alternatives to bedraiks and benefits or discussed with reside and no informed conbeen obtained prior  On 12/5/19 at 9:29 A Physician indicated aware if residents or using bedrails. She regarding the use or on the need to educate about the risks and 5. Resident #19 was 5/14/97 with diagnorespiratory failure with the side of the side	plained to residents or their d an informed consent had not to the use of bedrails.  AM interview with the ted the beds used in the edrails attached which could d. He went on to say he was cidents in the facility regarding to his knowledge no fail use in the facility were tried, if bedrail use were not lents or their representatives, asent for bedrail use had to use of bedrails.  AM interview with the the facility usually made her refamily members insisted on stated if staff called her for bedrails she instructed staff rate residents and families benefits of bedrail use.	F 7			
	assessment dated 9 severely impaired for if ever understood, 9 no speech, experier delusions, and her vadequate without de Resident #19 requir	at #19's most current MDS bl/20/19 indicated she was been daily decision making, rarely becometimes understands, had bloced no hallucinations or busion and hearing were bevices. It further indicated been detected the total assistance of one business of the state of the control of the contro				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,			(X3) DATE SURVEY COMPLETED	
		345211	B. WING _		,	12/05/2019	
	ROVIDER OR SUPPLIER  NT CREST NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 700	F 700 Continued From page 28 extremities on one side, had no falls, us		F 7	00			
	mobility devices, a restraints.	and bedrails were not used as					
	On 12/2/19 at 12:00 PM Resident #19 was observed awake in bed with the top half bedrails left, and right raised.						
		2 AM Resident #19 was n bed with the top half bedrails ed.					
	indicated she was that day and famili Resident #19 did r stated all the resid were using bedrail used bedrails to a residents were not positioning, the bed space and procomfort for the resure who was respondent use. She found on Resident guide.	PM interview with Nurse #1 responsible for Resident #19 iar with her care. She indicated not try to get up by herself. She lents she cared for in the facility is. She added some residents esist with repositioning, but if t able to use the bedrails for idrails were used to define the ovide a feeling of safety and ident. She stated she was not consible for assessing residents the indicated bedrail use was not the indicated bedrail use was not the indicated bedrail or her care					
	#2 indicated she wand had provided stated Resident #2 assist with repositi total assistance of say she thought R safety. Nurse Aide assisted Resident kept Resident #19	AM interview with Nurse Aide was familiar with Resident #19 care to her in the past. She 19 could not use her bedrails to ioning in bed and required the staff for that. She went on to esident 19's bedrails were for #2 further indicated when staff #19 to turn in bed the bed rails from rolling off the bed. She access to resident care guides,					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			, ,	TE SURVEY MPLETED	
		345211	B. WING	<del> </del>	,	12/05/2019
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  2600 OLD CHERRY POINT ROAD  NEW BERN, NC 28563				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 700	Continued From pag	ge 29	F 70	00		
		not on them. She stated most ed for in the facility for had				
	A review of physicia revealed no order fo	n orders for Resident #19 r bedrails.				
	indicated Resident # desire to have her b bedrail use were attright were recomme	r Resident #19 dated 5/21/18 #19 had not expressed a edrails up, no alternatives to empted, half bedrails left and nded, and risks, benefits and ail use had not been explained				
	nurse indicated she Assessment form da She stated she had bedrail use, had not benefits of bedrail u	AM interview with the MDS completed the Bed Rail ated 7/3/18 for Resident #19. not tried alternatives to explained the risks or se to Resident #19 or her no consent for bedrail use				
	of Nursing (DON) in facility put a perform in place as bedrail ususue at a corporate 11/27/19 the facility having bedrails in usuand have a physical on to say the MDS rassessments, but no other staff membassessing residents interview, the DON staff membassessing residents	PM interview with the Director dicated on 11/27/19 the nance improvement plan (PIP) se had been identified as an meeting. She stated on identified that all residents se needed to be assessed device evaluation. She went nurse had been doing bed rail of on a consistent basis and er in the facility had been for bedrail use. In a follow up stated most all residents in ag bedrails, no alternatives to				

		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345211	B. WING			2/05/2019	
	ROVIDER OR SUPPLIER  NT CREST NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	•	2.00.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 700	Continued From pag	ge 30	F 70	0			
	bedrail use were expresentatives, and been obtained prior	n tried, no risks or benefits of blained to residents or their I an informed consent had not to the use of bedrails.					
	Administrator indicate facility came with be be raised or lowered	AM interview with the ted the beds used in the drails attached which could I. He went on to say he was					
	bedrails. He stated to alternatives to bedra	aware of any incidents in the facility regarding rails. He stated to his knowledge no ratives to bedrail use in the facility were tried, and benefits of bedrail use were not					
		ents or their representatives, sent for bedrail use had to use of bedrails.					
	Physician indicated aware if residents or using bedrails. She regarding the use of on the need to educate	AM interview with the the facility usually made her family members insisted on stated if staff called her bedrails she instructed staff ate residents and families penefits of bedrail use.					
	7/26/19 with diagnos	admitted to the facility on ses including non-traumatic hemorrhage (bleeding).					
	assessment dated 1 #37 was severely immaking, rarely if evenunderstands, had acceptated delusions and had not care. It further indicates the severe assistance of the severe indicates as the severe i	t #37's most recent MDS 0/10/19 indicated Resident spaired for daily decision r understood, sometimes dequate hearing with no no hallucinations or o behaviors or rejection of ated Resident #37 needed e of two people for bed es, did not walk, was only able					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345211	B. WING _		1	2/05/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 700	had no falls, had RO lower extremities or were not used as reserved in bed with traised.  On 12/3/19 at 8:22 observed in bed awand right raised.  On 12/3/19 at 1:19 indicated she was resident #37 did no stated all the reside were using bedrails used bedrails to asserved in the day and familiar Resident #37 did no stated all the reside were using bedrails used bedrails to asserved in the desident were not a positioning, the bed bed space and provided the provided in the residence of the desident was responsible.	f assistance during transfers, DM impairment upper and n both sides, and bedrails	F 7	,		
	#2 indicated she wa and had provided of stated Resident #37 assist with reposition say she thought Re also used for safety around in the bed a falling out. Nurse Ai	as familiar with Resident #37 are to him in the past. She 7 could use his bedrails to ning in bed. She went on to sident #37's bedrails were because he could move nd they prevented him from de #2 further indicated of try to get up by himself. She				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345211	B. WING			2/05/2019	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 700	Continued From pag	je 32	F 70	00			
	but bedrail use was all residents she car their bedrails raised.	n orders for Resident #37					
	nurse indicated she #37 for the use of be not tried alternatives explained the risks of Resident #37 or his consent for bedrail uwent on to say about taken away the Bed	AM interview with the MDS had not assessed Resident edrails. She stated she had to bedrail use, had not or benefits of bedrail use to representative, and no use had been obtained. She ta year ago the company had Rail Assessment form and no in so she stopped doing so.					
	of Nursing (DON) inclinating put a perform in place as bedrail usual issue at a corporate 11/27/19 the facility having bedrails in usual have a physical on to say the MDS rassessments, but no other staff membassessing residents further indicated Resafter the facility stop Assessment form ar Resident #37 had be interview, the DON stop the facility were using the stage of the stage	PM interview with the Director dicated on 11/27/19 the ance improvement plan (PIP) se had been identified as an meeting. She stated on identified that all residents se needed to be assessed device evaluation. She went curse had been doing bed rail of on a consistent basis and er in the facility had been for bedrail use. The DON sident #37 had been admitted ped using the Bedrail and no bedrail assessment for een completed. In a follow up stated most all residents in g bedrails, no alternatives to in tried, no risks or benefits of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345211	B. WING		12/05/2019	
NAME OF PROVIDER OR SUPPLIER  RIVERPOINT CREST NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563	, .=	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
representatives, and been obtained prior  On 12/4/19 at 9:28 A Administrator indicated facility came with been obtained or lowered not aware of any incomplete and aware of any incomplete and have a seen obtained prior.  On 12/4/19 at 11:58 with Resident #37's one from the facility regarding the risks a alternatives to be drait consent for bedrail to the complete aware if residents or using bedrails. She regarding the use of on the need to educe about the risks and I 7.Resident #53 was 12/11/15 with diagnor disease.  A review of the most #53 dated 10/29/19 impaired for daily devision and hearing ware in the complete aware in the complete are seen as a seen as	plained to residents or their I an informed consent had not to the use of bedrails.  AM interview with the ted the beds used in the drails attached which could I. He went on to say he was idents in the facility regarding to his knowledge no full use in the facility were tried, bedrail use were not ents or their representatives the sent for bedrail use had	F 700			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		345211	B. WING _			12/05/2019
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	the extensive assistant mobility, the extensive for transfers which or during the assessment impairment of the upp both sides, had no fall used as restraints.  On 12/2/19 at 3:06 Plobserved in bed asled and right raised.  On 12/3/19 at 1:12 Plobserved in bed awal and right raised. Interthat time indicated ship stated she used them and repositioning in brecall anyone in the fabedrails, but she did nor interfered with her Resident #53 further get out of bed without On 12/3/19 at 1:19 Plindicated she was restrated all the resident were using bedrails. Sused bedrails to assist residents were not abpositioning, the bedrabed space and provide comfort for the reside sure who was responsitor bedrail use. She in	ed Resident #53 required note of two people for bed a assistance of one person curred only once or twice not period, had mobility per and lower extremities on alls, and bedrails were not.  M Resident #53 was ap with top half bedrails left wiew with Resident #53 at a liked her bedrails. She are to assist staff with turning ped. She stated she did not accility ever asking her about not feel they restrained her mobility in any way.	F 7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		345211	B. WING		12/0	05/2019
	ROVIDER OR SUPPLIER  NT CREST NURSING AN	STREET ADDRESS, CITY, STATE, ZIP CODE  2600 OLD CHERRY POINT ROAD  NEW BERN, NC 28563		,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 700	#3 indicated she was and had provided car stated Resident #53 of staff when reposition indicated Resident #54 unassisted. Nurse Aid access to resident car was not on them. She she cared in the facility raised.  A review of physician revealed no order for the most Assessment form for indicated Resident #54 desire to have her be bedrail use were atteright were recommental ternatives to bedrait to Resident #53 or her the provided of the provided she can be stated she had no bedrail use, had not be benefits of bedrail use representative, and in had been obtained.  On 12/3/19 at 1:43 Prof Nursing (DON) indifacility put a performation indicated she can be stated she had no be stated she had no bedrail use the provided she can be stated she had no bedrail use the provided she can be stated she had no bedrail use the provided she can be stated she had no bedrail use the provided she can be stated she had no bedrail use the provided she can be stated she had no bedrail use the provided she can be stated she had no bedrail use the provided she can be	M interview with Nurse Aide familiar with Resident #53 re to her in the past. She used her bedrails to assisting in bed. Nurse Aide #3 re guides. Nurse Aide #3 re guides, but bedrail use re stated most all residents re for Resident #53 bedrails.  Current Bed Rail Resident #53 bedrails.  Current Bed Rail Resident #53 had not expressed a drails up, no alternatives to mpted, half bedrails left and ded, and risks, benefits and I use had not been explained er representative.  M interview with the MDS completed the Bed Rail red 5/1/18 for Resident #53. Not tried alternatives to	F 70			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345211	B. WING		12	/05/2019
NAME OF PROVIDER OR SUPPLIER  RIVERPOINT CREST NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 700	11/27/19 the facility ichaving bedrails in use and have a physical contosay the MDS not assessments, but not no other staff member assessing residents from the facility were using bedrail use had been bedrail use had been bedrail use were exprepresentatives, and been obtained prior to the facility came with bedrails. He stated to alternatives to bedrail risks and benefits of discussed with reside and no informed considered on the facility of the facility of the stated to alternatives to bedrails. He stated to alternatives to bedrails and no informed considered with resideral facility of the facility of the stated to alternatives to bedrails. She stated to the facility of the facility of the stated to alternatives to bedrails. She stated to the facility of the the fa	meeting. She stated on dentified that all residents a needed to be assessed device evaluation. She went urse had been doing bed rail at on a consistent basis and or in the facility had been for bedrail use. In a follow up that all residents in a bedrails, no alternatives to tried, no risks or benefits of the use of bedrails.  Moreover in the facility had been for bedrails attached which could have the beds used in the death of the beds used in the death of the head of the facility regarding of the highest of the highest or their representatives, and the facility were tried, bedrail use were not the entire that of the head	F 70			12/22/10
F 809 SS=E	Frequency of Meals/3 CFR(s): 483.60(f)(1)- §483.60(f) Frequency	(3)	F 80	09		12/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/05/2019	
NAME OF PROVIDER OR SUPPLIER  RIVERPOINT CREST NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 809	facility must provide regular times compared the community or in needs, preferences,  §483.60(f)(2)There is hours between a subbreakfast the followin nourishing snack is shours may elapse be meal and breakfast group agrees to this  §483.60(f)(3) Suitab meals and snacks in who want to eat at nof scheduled meals the resident plan of This REQUIREMEN by:  Based on resident of staff interviews and failed to offer a nour residents when the timeal and the followithan 14 hours.  The findings include  During the resident of 2:04 PM the resident diabetes received a name on it but the of offered a bedtime site.  A review of the "Line of the staff in the resident of the staff in the staff in the resident of the staff in the resident of the staff in the resident of the staff in the	esident must receive and the at least three meals daily, at rable to normal mealtimes in accordance with resident requests, and plan of care.  must be no more than 14 estantial evening meal and and day, except when a served at bedtime, up to 16 etween a substantial evening the following day if a resident meal span.  Ite, nourishing alternative must be provided to residents on-traditional times or outside ervice times, consistent with care.  To is not met as evidenced evolutional meeting interviews, record review the facility ishing bedtime snack to ime between the evening me morning meal was greater decouncil meeting on 12/3/19 at the said those residents with bedtime snack with their ther residents were not tack.	F 8	On 12/4/2019 the facility, initial supplying a nourishing protein-bedtime snacks for each reside consistent with the resident's provide a HS Snack to? 2. Whe HS Snacks located? Following	chased ent con chand Staff chall RN's, les on the snacks, (s), where Il residents ck. swered a 9. The Who do you ere are the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345211	B. WING _		<del></del>	12/0	05/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DIVED DO	NT ODEST NURSING AN	ID DELIABILITATION OFNITED		260	00 OLD CHERRY POINT ROAD		
RIVERPOI	NI CREST NURSING AN	ND REHABILITATION CENTER		NE	EW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 809	#2 on 12/4/19 at 4:57 residents get specific example she provided diabetes who had assother residents received on them. NA #2 then requested a snack shack which she obtated as an ack shack which she obtated as an ack shack which she obtated in the or cookies and juice in the or cookies and juice in the or cookies and juice in the or cookies and juice. Observations of the modification	with Nursing Assistant (NA)  I PM she stated some snacks at bedtime. The d was residents with signed snacks and some wed snacks with their name stated if other residents he would provide them with a sined from the nourishment e snack was usually crackers if the resident wanted juice.  Hourishment rooms with the in 12/5/19 at 12:09 PM stors contained ice cream, in-refrigerated items were shment room.  With the dietary manager on she reviewed the "Line Cart there was more than 14 r and breakfast. She then is delivered to the as graham crackers, sugar cream. She added protein regularly stocked in the  with the dietary manager on the assistant dietary esent. The assistant dietary	F8	309	questions, available space was provided to explain if re-training was needed and provided by the Staff Development Coordinator. The questionnaire include staff, auditor (Staff Development Coordinator) and Administrator signatures. A 100% in-service was initiated on 12/11/19 by the Staff Development Coordinator with all dieta staff on preparing a nourishing protein-based bedtime snack such as a ham, turkey or peanut butter sandwich or oth protein-based snack as requested. Thin-services and staff questionnaires will completed by 1/2/2020. Any newly hire Nurses, Certified Nursing Assistants, a Dietary Staff will be educated during orientation by Staff Development Coordinator on location of HS snacks, different types of HS snacks, who receives HS snacks, preparing a nourishing protein-based bedtime snac and any other relevant information regarding resident HS snacks.  10% of all residents requiring a nourish protein based snack will be audited by by the Administrator utilizing the HS Protein Based Snack Audit Tool weekly 8 weeks and monthly x 1 month to ens that all residents have access to a nourishing protein-based bedtime snac All areas of concerns will be corrected the Administrator during the audit. The Administrator will review and sign the F Protein Based Snack Audit Tool weekly 8 weeks and monthly x 1 month to ens completion and that all areas of concerns will be corrected the Administrator will review and sign the F Protein Based Snack Audit Tool weekly 8 weeks and monthly x 1 month to ens completion and that all areas of concerns will areas of concerns will be corrected the Administrator will review and sign the F Protein Based Snack Audit Tool weekly 8 weeks and monthly x 1 month to ens completion and that all areas of concerns will areas of concerns will areas of concerns and that all areas	s ry ler e l be d nd k ling the x ure ck. by HS x ure	
	She said they did not				Protein Based Snack Audit Tool weekly	x ure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345211	B. WING _			12/05/2019	
NAME OF PROVIDER OR SUPPLIER  RIVERPOINT CREST NURSING AND REHABILITATION CENTER			·	STREET ADDRESS, CITY, STATE, Z 2600 OLD CHERRY POINT ROAL NEW BERN, NC 28563			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATI IENCY)	(X5) COMPLETION DATE	
F 809	Continued From page	e 39	F 8	The Administrator will for of HS Protein Based Sneck Alexecutive Quality Assur Committee monthly x 3 Executive QA Committee monthly x 3 months and Protein Based Snack Aletermine trends and / need further intervention and to determine the need / or frequency of monitors.	nack Audit Tool HS udit Tool to the rance (QA) months. The ee will meet d review the HS udit Tool to or issues that ma ns put into place eed for further and	y y	