| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345211 | A. BUILDING _____ B. WING _____ | C 09/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **RIVERPOINT CREST NURSING AND REHABILITATION CENTER** | **2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563** |

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| E 000 | Initial Comments<br><br>An unannounced COVID-19 Focused Survey and complaint investigation was conducted on 9/14/21 through 9/16/21. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# U2G011. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 9/14/21 through 9/16/21. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations and had not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.<br><br>One of the 23 complaint allegations were substantiated resulting in a deficiency F790. | F 000 | | |
| F 790 SS=D | Routine/Emergency Dental Srvcs in SNFs<br>CFR(s): 483.55(a)(1)-(5)<br><br>§483.55 Dental services.<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br>A facility-<br><br>§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an | F 790 | | 10/8/21 |

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

Electronically Signed | 10/01/2021

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| F 790 | Continued From page 1<br>additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to obtain dental care for a resident with broken dentures for 1 of 1 resident reviewed for dental services (Resident #1).<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on 4/09/21.<br><br>Review of the 5-day admission Minimum Data Set dated 4/15/21 revealed Resident #1 had severe cognitive impairment and required | F 790 | Affected Resident:<br>Resident #1 is no longer a resident in the facility.<br><br>Other Residents:<br>Utilizing the resident census, a 100% audit of all current residents wearing dentures was initiated by the Director of Nursing and was completed on 10/1/21. This was to ensure all residents who wear dentures have the dentures and they are intact with no issues. One issue was identified and has been addressed. All | |

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| F 790 | Continued From page 2<br>supervision for eating, had a regular texture diet order and there were no dental concerns.<br><br>Review of Resident #1's care plan initiated on 4/09/21 revealed a focus on the activities of daily living (ADL) with no interventions related to dental care or dentures.<br><br>Review of nurses' progress notes revealed a note by Nurse #1 dated 5/07/21 which read in part that she had found Resident #1's broken false teeth.<br><br>An interview on 9/16/21 at 7:18 AM with Nurse #1 revealed she was aware Resident #1's dentures were broken after a conversation with the resident's daughter about the broken dentures. Nurse #1 stated she had not notified the Director of Nursing (DON) or the Administrator about the broken dentures. She stated she had forgotten to notify the DON or Administrator.<br><br>Review of ST daily treatment note dated 5/07/21 revealed that Resident #1's bottom denture plate was broken, and her diet texture was downgraded to puree solids.<br><br>The ST was unavailable for interview.<br><br>An interview on 9/16/21 at 12:18 PM with the Unit Manager revealed she could not locate any additional information related to Resident #1's dentures. She also revealed she was responsible for making dental appointments and she had not been notified of the resident's broken dentures.<br><br>An interview on 9/15/21 at 4:33 PM with the Director of Nursing (DON) revealed she was unaware of Resident #1's broken dentures. She stated if they were broken, the facility should have | F 790 | residents are scheduled for routine dental visits as appropriate.<br><br>Systemic Changes:<br>On 9/27/21 a 100% in-service of licensed nurses and C.N.A.'s was initiated regarding any resident identified with lost or damaged dentures must immediately be reported to the DON or Nursing Supervisor so that a dental referral can be initiated, and; while awaiting repair or replacement of dentures, interventions must be implemented to ensure the resident could still eat and drink adequately and that all interventions are documented. All newly hired nurses and C.N.A.'s will receive this inservice upon orientation.<br><br>Monitoring:<br>The Unit Manager will audit 10% of residents wearing dentures utilizing the Denture Audit tool to identify any residents who may have lost or broken dentures and to ensure interventions are in place so that the resident could still eat and drink adequately. This will be done weekly x 4 weeks and monthly x 1 month. The Director of Nursing will review the Denture Audit Tool weekly x 4 weeks, then monthly x 1 month for completion and to assure all areas of concerns are addressed. The Director of Nursing will forward the results of the Denture Audit to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Denture Audit Tool to determine trends and / or issues that may need further | |

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| F 790 | Continued From page 3<br>made arrangements to get them fixed or replaced.<br><br>An interview on 9/16/21 at 8:11 AM with the Administrator revealed she was not the Administrator at the facility while Resident #1 was there. She also stated the nurse should have notified the Administrator or DON to get the dentures fixed or replaced. | F 790 | interventions and to determine the need for further and / or frequency of monitoring. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F 880 | | 10/8/21 |

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| F 880 | Continued From page 4<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by: | F 880 | | |

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| F 880 | Continued From page 5<br>Based on observations, interviews, and record review the facility failed to maintain infection control precautions when 1 of 1 staff member (Accounts Payable) failed to wear personal protection equipment (PPE) while in a room designated as Enhanced Droplet Contact precautions during a facility outbreak of COVID-19. This failure occurred during a COVID-19 pandemic.<br><br>The findings included:<br><br>A review of the Inservice Training Report dated 8/23/21 revealed all staff received education. The subject covered was "Staff must don PPE prior to entering Isolation room and doff PPE prior to exiting isolation room. Full PPE must be worn in Quarantine room."<br><br>During the entrance conference with the Director of Nursing on 9/14/21 at 8:30 AM she reported there were 2 newly admitted residents on quarantine in room 501. She reported neither of the residents were fully vaccinated so were required to be quarantined.<br><br>On 9/14/21at 3:30 PM room number 501 was observed to have a sign designating the room as Enhanced Droplet Contact Precautions. A container holding isolation gowns and gloves was observed hanging on the outside of the door.<br><br>On 9/15/21 at 3:10 PM the Accounts Payable staff member was observed in room 501. She was talking to the resident in the bed closest to the door. She was wearing a KN-95 face mask. She was not wearing a gown, gloves, or eye protection. She was within 6 feet of the resident who was laying flat in the bed. | F 880 | See attached DPOC for further detail.<br><br>Staff member was educated on the importance of donning appropriate PPE while on the quarantine unit on 9/15/2021. All other non-clinical staff were also in-serviced on 9/15/2021 regarding PPE on the quarantine unit.<br><br>Systemic Changes:<br><br>The following plan below will address the deficient practice and root cause analysis. 100% quizzes will be completed by the SDC with all staff (to include nonclinical staff) to ensure that staff can successfully validate knowledge and understanding of proper donning and doffing of full PPE in the quarantine unit.<br>On 10/1/21 a 100% audit was completed by the Director of Nursing of all nursing staff and potential nonclinical staff currently working in the quarantine unit to ensure proper use of PPE. There were no additional identified areas of concern during the audit.<br>An Inservice will be initiated with all staff (to include nonclinical staff) and completed by the Director of Nursing regarding proper Donning and Doffing of full PPE to include gown, gloves, mask, and eye protection in the quarantine unit and the new alert banner in the hallway. The Inservice will be completed by 10/8/21.<br>An In-service will be initiated by the Director of Nursing with all staff on the CDC video regarding “Keep Covid Out”. In-service will be completed by 10/8/21. | |

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| F 880 | Continued From page 6<br><br>On 9/15/21 at 3:15 PM the Accounts Payable staff member was observed coming out of room. She stated she was aware the residents in room 501 were on quarantine. She said there was a sign on the door and PPE was available on the door holder. She said she just forgot to put on her PPE when she entered the room.<br><br>During an interview on 9/15/21 at 4:45 PM the Director of Nursing (DON) stated before any staff enter an isolation room, they must wear full PPE. She said the Accounts Payable staff member told the Administrator she did not wear PPE while in room 501 today but did wear PPE when she talked to the residents when they were first admitted.<br><br>During an interview with the corporate nurse consultant on 9/15/21 she reported the facility had educated staff on wearing appropriate PPE prior to entering any isolation rooms. She said they were monitoring staff to ensure PPE was worn. She did not remember if the information was discussed in a Quality Assurance meeting. | F 880 | A larger banner was placed at the beginning of the Quarantine Unit as an initial alert to staff and visitors to don appropriate PPE prior to entering the unit. Signs will remain on each resident door in the quarantine unit as a second alert.<br><br>Monitoring:<br><br>The Infection Preventionist will observe 10 staff/resident care interactions on the quarantine unit, weekly x 4 weeks then monthly x 1 month to include non-clinical staff, utilizing the PPE Quarantine Audit Tool. This audit is to ensure staff (including non-clinical staff) are utilizing appropriate PPE to include gown, N95 mask, eye shield and gloves per facility protocol in the Quarantine unit. The Infection Preventionist will address all areas of concern during the audit to include providing use of appropriate PPE and/or re-education of staff/residents. The DON will review and initial the PPE Quarantine Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.<br>The DON will forward the results of the PPE Quarantine Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the PPE Quarantine Audit Tool to determine trends and /or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. | |