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

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MANUE OF PROVIDER OR SUPPLER CYPRESS POINTE REHABILITATION CENTER DAY INMODITION NO. 28401 PROVIDERS AND PROVIDER AND PROVIDERS AND PROVIDERS RUMAN OF CORPECTION. PROVIDERS AND PROVIDERS AND PROVIDERS RUMAN OF CORPECTION. PROVIDERS RUMAN OF CORPECTI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		C	X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CYPRESS POINTE REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 9/17/16. Event STREET ADDRESS, CITY, STATE, ZIP CODE 2006 \$ 16TH STREET WILMINGTON, NC 28401 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETIVE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) F 000 INITIAL COMMENTS F 000 No deficiencies were cited as a result of the complaint investigation of 9/17/16. Event			345002	B. WING			
CYPRESS POINTE REHABILITATION CENTER WILMINGTON, NC 28401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 9/17/16. Event					STREET ADDRESS, CITY, STATE, ZIF	P CODE	09/17/2016
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 9/17/16. Event	CYPRESS POINTE REHABILITATION CENTER						
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complaint investigation of 9/17/16. Event	F 000	INITIAL COMMENTS		F	000		
		complaint investigatio	n of 9/17/16. Event				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE							

Electronically Signed 10/03/2016

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.