STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345512	A. BUILDING _____ B. WING _____	06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS GLEN RETIREMENT COMMUN	1000 HICKORY STREET GREENVILLE, NC 27858

(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)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 06/03/19 through 06/04/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XQUE11	E 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640		7/8/19

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

Electronically Signed | 06/21/2019

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F 640	Continued From page 1 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment to the Centers for Medicare and Medicaid Services (CMS) system within the required timeframe for 1 of 1 resident assessments reviewed (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/6/18 with diagnoses including hypotension and pneumonia. Review of Resident #1' s MDS assessments revealed a completed discharge assessment dated 12/14/18 that had not been transmitted to CMS as of 6/1/19. An interview was conducted with the MDS Nurse	F 640	This plan of correction is submitted in compliance with statutory and regulatory requirements and should not be construed as an admission or agreement with the findings, scope or severity of any of the deficiencies cited. Cypress Glen will transmit discharge Minimum Data Set assessments to CMS within the required timeframe. Immediate Action: The MDS Coordinator placed a work request with the Electronic Health Records (EHR) vendor on June 4, 2019 to determine why the discharge assessment which was completed on December 14, 2018 for Resident #1, who was a private payor, did not transmit to CMS within the	

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F 640	Continued From page 2 on 6/1/19 at 3:36 PM who stated Resident #1 was admitted to the facility on 12/6/18. She stated she was unsure why the resident ' s discharge assessment dated 12/14/18 was not transmitted as of 06/01/19. An interview was conducted with the Administrator on 6/1/19 at 5:15 PM who indicated assessments should be submitted in compliance with MDS manual.	F 640	required timeframe. The EHR vendor stated the discharge did not transmit because Resident #1 transferred to a non-certified bed prior to the next scheduled transmission. The discharge assessment was transmitted on June 5, 2019. Widespread Corrective Action and Systemic Change: An MDS schedule is completed for all residents admitted to certified beds regardless of the payor type. The MDS Coordinator placed a service request with the EHR vendor to ensure assessments for private pay patients in non-certified beds are transmitted. All MDS transmissions will be triple checked monthly regardless of payor type. The Medicare Tracking Log will be completed for all residents in certified beds regardless of payor type and a copy turned in at triple checks. The MDS Assessment Responsibilities Policy will be amended to include all payor types for certified beds. Monitoring: The MDS Coordinator will submit a transmission audit to the QAPI Committee for review and trend analysis. The QAPI Committee will monitor results until 100% compliance has been maintained for three consecutive months. The next QAPI Committee meeting is scheduled for July 8, 2019. The triple check audit will be reviewed by the Corporate Compliance Committee quarterly. The next meeting is scheduled for July 1, 2019.	

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code an entry tracker Minimum Data Set (MDS) for 1 of 1 resident assessments reviewed for accuracy (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/6/18 with diagnoses including hypotension and pneumonia. Review of Resident #1 ' s MDS entry tracker with an Assessment Reference Date (ARD, the date used to base MDS coding responses) of 12/6/18 was coded with an entry date of 11/30/18. An interview was conducted with the MDS Nurse on 6/1/19 at 3:36 PM who stated Resident #1 was admitted to the facility on 12/6/18 and confirmed Resident #1 ' s entry tracker MDS contained an inaccurate entry date of 11/30/18. She reported Resident #1 had a bed hold in the facility from 11/30/18 until 12/6/18. The MDS Nurse stated the system must have taken the bed hold date of 11/30/18 and populated it as the admission date. An interview was conducted with the Administrator on 6/1/19 at 5:15 PM who indicated assessments should be completed accurately.	F 641	Cypress Glen will ensure assessments accurately reflect the resident's status. Immediate Action: On June 5, 2019 the MDS Coordinator created and transmitted a modification of the tracking/entry to show the correct admission date rather that the bed hold date for Resident #1. There were no other errors or omissions in the comprehensive assessment. Because this was a private payor, the error did not result in billing discrepancies and there was no potential for harm. Widespread Corrective Action and Systemic Change: An MDS is accurately completed for all residents admitted to certified beds regardless of the payor type. The MDS Coordinator will review all software-populating fields to ensure accuracy prior to locking the MDS. All dates on the MDS will be verified during the monthly triple check audit. Monitoring: The MDS Coordinator will submit a transmission audit to the QAPI Committee for review and trend analysis. The QAPI Committee will monitor results until 100% compliance has been maintained for three	7/8/19

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F 641	Continued From page 4	F 641	consecutive months. The next QAPI Committee meeting is scheduled for July 8, 2019. The triple check audit will be reviewed by the Corporate Compliance committee quarterly. The next meeting is scheduled for July 1, 2019.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to cover refuse and food debris in 2 of 2 open trash cans and close the lids of 1 of 1 dumpster present in the facility's dumpster area. Findings included: On 06/03/19 at 3:55 pm an observation was made of the facility's dumpster area with the Food and Beverage Manager. Observations revealed two opened trash cans were present in the dumpster area. The first opened trash can contained a clear plastic liner ¾ full of refuse closed at the top but not covered. The second opened trash can contained a clear plastic liner open at the top, not covered and full of refuse and food debris. Closer observations of the second trash can revealed numerous live ¼ inch black flying insects were visible on the food debris in the trash can. Additionally, a large brown dumpster was present in the area. Observations of this dumpster revealed it contained 4 clear plastic bags of refuse and the dumpster's lids were not closed.	F 814	Cypress Glen will dispose of garbage and refuse properly. Immediate Action: Upon observation on June 3, 2019, the Director of Dining Services instructed the utility worker to empty the trash into the dumpster and close the dumpster lid. Management verified lids were available for the trash cans. The observed findings were isolated and do not constitute a pattern of non-compliance. Widespread Corrective Action and Systemic Change: All departments responsible for disposing trash were in-serviced on proper disposal procedures. The procedure was posted at the dumpster area for reference. Monitoring: The Director of Dining Services or designee will inspect the dumpster area three times weekly to ensure proper disposal procedures are followed.	7/8/19

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F 814	Continued From page 5 During an interview on 06/03/19 at 3:55 pm the Food and Beverage Manager stated the food service staff who brought the two trash cans to the dumpster area should have emptied the trash that was in the cans into the dumpster. She further indicated that the trash cans should not have been left uncovered without lids in the dumpster area by staff. She went on to specify the dumpster lids should have been closed. On 06/04/19 at 11:41 am, in an interview, dietary aid #1 stated he left the two uncovered trash cans in the dumpster area on 06/03/19 at 3:30 pm. He stated the dumpster was not present at the time he left the trash cans. He also said he should have tied the trash bags to close them and covered the trash cans with lids before leaving them in the dumpster area. He further specified trash can lids were available for him to cover the cans to prevent the trash from attracting insects, but he did not use them. In an interview on 06/04/19 at 11:42 am the facility's Executive Director indicated it was her expectation that trash in the dumpster area be secured and covered. She further indicated this was to prevent insects and odors and just general good sanitation practice.	F 814	Results of the inspections will be submitted to the QAPI Committee for review and trend analysis. The QAPI Committee will monitor results until 100% compliance has been maintained for three consecutive months. The next QAPI Committee meeting is scheduled for July 8, 2019.	