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

PRINTED: 07/26/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  CYPRESS POINTE REHABILITATION CENTER  DISCUSSION OF SUPPLIER  CYPRESS POINTE REHABILITATION CENTER  REGULATORY OR LSC IDENTIFYING INFORMATION)  EACH DEPOSITION WIS TE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000 Initial Comments  The survey team entered the facility on 06/21/21 to conduct a Recertification and Complaint Investigation survey. The survey team was onsite 06/21/21-06/24/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event IDM FPLQ11.  F 000 INITIAL COMMENTS  The survey team entered the facility on 06/25/21. Therefore, the exit data was 06/25/21. The facility was 60/25/21. The facility was 60/25/21. The facility was 60/25/21. Therefore, the exit data was 06/25/21. The facility was 60/25/21. Therefore, the exit data was 06/25/21. Therefore, the exit data was 60/25/21. Therefore, the exit da	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
MANE OF PROVIDER OR SUPPLIER  CYPRESS POINTE REHABILITATION CENTER  (MULMINOTON, NC 24401  (MA) D  (MA			0.47000				_		
CYPRESS POINTE REHABILITATION CENTER   2006 SOUTH 16TH 5TREET   WILMINGTON, NC 28401	L			B. WING _			06/25/2021		
CYPRESS POINTE REHABILITATION CENTER   CACH DEPICIENCY MUST BE PRÉCEDED BY FULL RESOLUTION OF U.S.C. IDENTIFYING INECRNATION)   PREFIX TAG.   PROVIDERS PLAN OF CORRECTION SHOULD BE CONSSABERERED TO THE APPROPRIATE DEPICE TO THE APPROPRIATE DEPCRATE DEPCRATE TO THE APPROPRIATE DEPCRATE TO THE APPROPRIATE DEPCR	NAME OF PI	ROVIDER OR SUPPLIER							
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		interviews the facility dental status of a res reviewed for dental confined findings included:  Resident #3 was adm 6/30/17.  Resident #3's dental	failed to accurately code the ident for 1 of 2 residents are (Resident #3).  nitted to the facility on care visit documentation			Cypress Pointe Nursing and Rehabilita Center wishes to point out to any person who reviews this document that we do necessarily agree with this citation in which we were cited. However the law requires us to prepare a plan of correct for the citations regardless of whether agree with them. Thus, we have prepare	on not tion we		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						<u> </u>		2(0) 5.47	

Electronically Signed 06/30/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L ADENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345002	<b>345002</b> B. WING			C <b>06/25/2021</b>		
NAME OF PROVIDER OR SUPPLIER				S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2021	
				20	006 SOUTH 16TH STREET			
CYPRESS	POINTE REHABILITATION	ON CENTER		W	/ILMINGTON, NC 28401			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 641	Continued From page 1		F 6	641				
	assessed by the dent teeth. Resident #3's minimu			note, though that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establi				
	dated 3/18/21 reveale "no" for the question natural teeth or tooth			any standard of care, contract, obligation or position and Cypress Pointe reserve the rights to raise all possible contention and defense in any civil or criminal claim.	s ins			
	_	servation on 6/22/21 at 11:43 AM #3's mouth was observed to not have			action or proceeding. Please accept Ju 30, 2021 as our allegation of compliance	ine		
	Nurse #1 stated the r assessment dated 3/	n 6/22/21 at 11:52 AM MDS ninimum data set 18/21 for Resident #3 was dent did not have any teeth.			HOW WILL THE CORRECTIVE ACTION ME ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?			
	_	n 6/22/21 at 12:25 PM the he minimum data set should dent dental status.			1. Resident #3 had a corrected assessment submitted June 22, 2021 following identification of the clerical er Resident #3 did not have a negative outcome as a result of this finding.  2. Root Cause: A clerical error occurred when completing the assessment for Resident #3.			
					HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY TH SAME DEFICIENT PRACTICE?  3. An audit was conducted by the DON/Designee June 22, 2021 following identification. There were no similar findings as a result of this audit.	the		
					WHAT MEASURES WILL BE PUT INT PLACE OR SYSTEMIC CHANGES	0		

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F 641	Continued From page	e 2	F6	541	MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?  4. The DON/Designee will conduct re-education with the MDS nurses on June 29,2020.  HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?  5. Audits will be conducted three times a week for eight weeks by the center DON or Designee regarding accurate coding of Edentulous Resider The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained and implement any changes to this auditing/monitoring recommended/appropriate. Subsequer plans of correction will be implemented deemed necessary/appropriate by this committee.	nts. t j if nt	