STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 9/6/23 through 9/7/23. Event ID# SEHN11. The following intakes were investigated: NC00206461, NC00205914, NC00204806, NC00204245, NC00206034, NC00206161, NC00205804, NC00205720, NC00205355, NC00204202. 7 of 27 allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		10/5/23

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

Electronically Signed | 09/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, staff, and dialysis staff interviews, the facility failed to maintain a resident's dignity by failing to pick up Resident #3 from a dialysis appointment which resulted in the resident feeling terribly upset and angry for 1 of 1 sampled resident reviewed for dialysis (Resident # 3). The findings included: Resident #3 was admitted to the facility on 8/6/23, with diagnoses of congestive heart failure and end stage renal disease. The admission Minimum Data Set(MDS) dated 8/9/23, coded Resident #3's cognition was intact and received dialysis three times a week. Review of the dialysis appointment book revealed, Resident #3 did not go to dialysis on 8/7/23 and 8/9/23 and rescheduled on 8/11/23. An interview was conducted on 9/6/23 at 2:00 PM	F 550	Initial intervention included termination of the contract agency transportation services to the dialysis center. Only Cypress Valley transportation staff will transport the residents to and from the dialysis center. The dialysis schedule was provided to all nursing unit managers and department heads by the Medical Record Director. The Medical Record Director updates the dialysis schedule weekly. All dialysis residents have the potential to be affected. Interviews of all alert and oriented dialysis residents and non-alert and oriented resident's responsible parties will be conducted by the nursing unit coordinators. They will inquire to determine if there are any facility concerns with the new process and the relation to resident dignity. The Staff Development Coordinator will educate all transportation department staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 2 with Unit Manager #2 who stated she had left the facility for the day (8/11/23) and received a call from Nurse #7 around 5:45 PM stating Resident #3 had been left at the dialysis center. The Unit Manager stated she instructed Nurse #7 to contact the dialysis center and get the status of the resident while she contacted the Administrator, Van Driver and the Scheduler to find out what happened. Several attempts were made to reach the Van Driver by everyone and there was no response. The Administrator called the Maintenance Director who had the spare keys to the van and asked if he would come back to the facility to get the van and pick up the resident. According to Nurse #7, Resident #3 was not reporting any physical distress when she spoke with the family about the situation. The resident was terribly upset about the situation and hungry since she missed lunch and dinner. The Scheduler who lived closer to the dialysis center offered to pick the resident up in her personal vehicle since no one could reach the Van Driver. The Administrator gave approval for the Scheduler to pick the resident up since it was not company policy to transport residents in a personal vehicle. Unit Manger #2 stated she had been communicating with the Scheduler from 6:30 PM until the resident returned to the facility. She was uncertain the exact time the resident returned to the facility since the staff member had taken the resident to get something to eat. Nurse #7 oversaw the situation from that point. A telephone interview was conducted on 9/6/23 at 3:56 PM with the former Director of Nursing who stated she had been made aware via telephone Resident #3 had been left at the dialysis appointment during the evening hours. The Administrator oversaw the situation and arranged	F 550	and drivers on resident rights and promotion of dignity. The education will include the new process of communication including each individualized dialysis form in the binder, revised dialysis weekly schedule form, and proper completion of the forms. The dialysis transportation binder includes individualized resident forms with their dialysis appointment time of return to facility that is signed and dated by the transportation driver kept in the transportation van. The Staff Development Coordinator or unit coordinator will educate all nurses on the new process to include the revised dialysis schedule form. The Staff Development Coordinator will include this education in orientation. This education will be completed by 10/5/23. The Medical Record Director will conduct audits weekly times 4 weeks, then every 2 weeks times 4 weeks, and monthly times 4 weeks. If there are any abnormalities found in the transportation dialysis binder the Administrator will immediately be notified by the Medical Record Director. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 3	F 550		

for the resident to be picked up by an off-duty staff member because the van keys were not available in the facility. The Administrator implemented some recent changes for the scheduling process and transportation changes. The former Director of Nursing stated the resident had been assessed by the nursing staff upon return and offered pain medication but refused.

A telephone interview was conducted on 9/6/23 at 4:29 PM with Resident #3 who stated she had an appointment at dialysis on 8/11/23 at 11:00 AM and finished around 3:30 PM. The dialysis center called the facility around 3:45 PM and told them she was ready to be picked up. The dialysis nurse told her the van driver would be there in 15 minutes; she told the housekeeping staff of the center she would wait outside on the front porch because it was cold inside the center. However, no one came. The housekeeping staff came back out around 4:30 PM and she was still sitting there. Resident #3 further stated she did not have any telephone numbers or information to the facility or the driver. She reported the dialysis staff came out around 5:00 PM and saw me there and stated they thought I had already left. She stated the dialysis staff called the facility again and no-one responded to the call. "I was wondering why the facility had not called back to check on me or return to pick me up when dialysis called the 1st time. I was so upset, frustrated and mad that the facility forgot about me, leaving me with no lunch or dinner, only to eat the few snacks the dialysis staff offered. No one had the decency to come back when they realized I had not been picked up. I felt angry being stranded for 4 hours." She reported she called a family member to tell them what happened and to get help and the family ended up reaching somebody at the facility to tell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 4	F 550		

them that she was left at the dialysis center. Resident #3 further stated, "It was a horrible experience." We were told on admission the facility would be responsible for transportation to and from the dialysis appointments. The dialysis staff stayed until the facility staff came around 7:00 PM. She further stated she was picked up by a staff member who was in her personal car because the van driver had left for the day and there were no keys available to the van. Resident #3 indicated she was very hungry and the staff member that picked her up did take her to get something to eat. Resident #3 further stated the van driver came on the weekend (8/12/23) to apologize for not picking her up, because of misinformation he had received. She stated it was a very awful situation to be in and extremely uncomfortable physically.

An interview was conducted on 9/7/23 at 7:30 AM with Nurse #7 who stated Resident #3 had left for her dialysis appointment a little after noon in no distress on 8/11/23. Nurse #7 stated she was not aware the resident had been left at dialysis until a family member of Resident #3 called terribly upset, angry and frustrated that Resident #3 had been stranded for 4 hours with no contact from anyone from the facility. She indicated she was unaware the dialysis center had called the driver or the facility earlier to say the resident was ready for pick-up. Once she learned of the situation, she called the Administrator, Unit manager, Scheduler, and the Van Driver. She spoke with the Dialysis Center Nurse who stated the resident was doing ok and she shared with them arrangements were being made to pick up the resident. When the Van Driver could not be reached, the Scheduler offered to transport the resident in her personal vehicle. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 5	F 550		

Administrator gave approval for the transport since it was not company policy to use personal cars for resident transport. Resident #3 returned to the facility about 7:45 PM, incredibly angry, upset and agitated.

An interview conducted on 9/7/23 at 8:00AM with the Scheduler revealed she was off on 8/11/23 when she received a phone call from Unit Manager #2 around 6:28 PM. Unit Manager #2 stated that she could not reach the Van Driver who had left Resident #3 at dialysis. She reported she tried to contact the Van Driver as well, and he never answered. She called the Unit Manager back who was also in contact with the Administrator deciding how to pick up the resident since the van keys were not available in the building. The sSheduler stated she lived closer to the dialysis center and offered to pick the resident up. She stated she received approval from the Administrator to transport the resident in her personal car. When she arrived at the dialysis center the resident was seated outside under a covered porch extremely mad, upset, and angry, stating she was hungry and very unsatisfied about what happened. Resident #3 reported her family was very unhappy and disgusted about the situation. The resident did not report she was in any discomfort or pain during the ride back to the facility. Resident #3 was returned to the facility around 7:45 PM after she got the resident something to eat. The Scheduler stated she was responsible for the appointment schedule and transportation arrangements. She reported she had spoken with the Van Driver the following day to determine how the situation occurred. The Van Driver reported he was called earlier by the dialysis center, and he was confused about the pickup location and times, resulting in Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 6	F 550		

#3 being left at the center for several hours. She stated a department heading meeting was held to discuss the events and review and revised the transportation schedule for facility transportation and community provided services to ensure the situation did not occur again.

An interview was conducted on 9/7/23 at 8:29 AM with the Van Driver who stated he had dropped off residents at two different locations and was confused of which resident he had dropped off when he received a call the dialysis center resident was ready for pick-up. There had been some confusion as to whether he or the community transportation provider would be picking up the resident because he was told not to pick up a resident. He could not recall which dialysis center cancelled the pick-up. The Van Driver stated he picked up a resident from the second location and had forgotten about picking up Resident #3. He returned to the facility and clocked out for the day. He did not take his cell phone with him and went home for the day. He was unable to recall the time he left for the day. He further stated he found out the following morning when the Administrator informed him that a resident had been left at the dialysis appointment. He reported he immediately went Resident #3 and apologized because that had never happened before, and he felt extremely bad about the situation. The Administrator, nursing, Scheduler and transportation team met and developed a new system with each department and the community transportation provider to ensure transportation arrangements were arranged week prior and confirmed to prevent this incident from occurring again.

A telephone interview was conducted on 9/7/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 7	F 550		

8:41 AM with the Dialysis Nurse who stated she called the driver around 4 or 4:14 PM, to let him know Resident #3 was ready to be picked up. The driver stated he would be there in 15 minutes. The Dialysis Nurse stated she also spoke with a staff person at the facility around 5:00 PM. The Nurse stated she could not recall the name of the person and informed them Resident #3 had not been picked up. The facility staff person stated they were trying to reach the van driver and the floor nurse who had not responded to their calls. The Nurse stated the center normally closed at 5:00 PM, unless they were still treating patients. The resident was offered to come inside because the center staff could not go outside with the resident while there were other residents receiving treatment. The resident was on her cell phone and declined. The resident was seated under a covered porch and was offered fluids and light snacks while she waited. The resident did not state she was in any physical discomfort. She was obviously terribly upset, mad and angry about being left so long. She further stated the facility scheduler picked the resident up between 6:00-6:30 PM in a personal vehicle.

An interview was conducted 9/7/23 at 9:30 AM with Nurse #6 who stated Resident #3 left for her appointment later than her scheduled time on 8/11/23. Nurse #6 could not recall the exact time. Nurse #6 stated she had noticed around 4:30 PM, that Resident #3 had not returned from her appointment. She stated she had spoken with the assigned Nurse #7 about the whereabouts of Resident #3. The resident's family was calling at the same time as the inquiry and it was discovered the Van Driver had forgotten to pick the resident up and the resident was terribly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 8	F 550		

upset. Nurse #7 had been trying to reach the Van Driver who had not responded. The Administrator, Unit Manager and the Scheduler were also contacted for assistance to figure out how to pick the resident up since the van driver had the van keys and it was against policy to transport residents in personal vehicles. Nurse #7 had been in contact with everyone around 6:00 PM. The resident did return after the Scheduler picked her up and she was terribly upset and angry about the situation.

A telephone interview was conducted on 9/7/23 at 3:42 PM with the Family Member who stated when Resident #3 was admitted they were told arrangements would be made for Resident #3 to be taken to and from dialysis appointments three days a week. The Family Member reported Resident #3 called terribly upset and crying, stating she had been left at the dialysis center for several hours and had not eaten lunch or dinner. The facility was not responding to the calls made by the dialysis center. The Family Member stated she maintained contact with Resident #3 until she could reach a nurse at the facility and inform them of the situation. She reached a nurse between 6 :00 and 6:30 PM, who told her they would be sending a staff member to pick Resident #3 up.

An interview was conducted on 9/7/23 at 4:00 PM with the Maintenance Director who stated he had the extra keys to the van. He stated he received a call from the Administrator around 6:00 PM, to go to the facility to get the van and pick up a resident who had been left at the dialysis center. He indicated he lived a good distance from the facility and it would have taken some time to get to the facility. He received a second call a few minutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 550	Continued From page 9 later stating not to come because another staff would be picking the resident up who lived closer to the dialysis center. An interview was conducted with the Administrator on 9/7/23 at 4:20 PM, and the Administrator stated he was made aware Resident #3 was left at dialysis on 8/11/23 around 6:00 PM. He tried to contact the Van Driver several times who did not respond to the calls or messages. He called the Maintenance Director who had the backup keys and asked him to go the facility to pick up the resident. The facility Scheduler lived closer to the dialysis center and offered to pick the resident up in her personal car; approval for pick-up was granted to make sure the resident got back to the facility. The Administrator stated the following day a meeting was held with nursing, scheduling, and transportation to review and revise the current transportation process to prevent the situation from occurring again.	F 550		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		10/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 10 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and family and staff interviews, the facility failed to protect a resident's right to be free from abuse for 1 of 4 residents reviewed for physical abuse (Resident # 10). The findings included: Resident #10 was admitted to the facility on 4/14/23 with diagnoses of neurogenic bladder, cognitive communication deficit, gastrostomy, chronic kidney disease, diabetes, and wounds on the heels. The admission Minimum Data Set (MDS) dated 4/19/23 indicated Resident #10 was severely cognitively impaired. He required two-person assistance with personal hygiene and had an indwelling catheter. Resident #11 was admitted to the facility on 12/29/22 with the diagnoses of benign prostatic hyperplasia dementia, psychotic and mood disturbance, and cognitive communication deficit. The quarterly Minimum Data Set (MDS) dated 6/18/23, indicated Resident #11 was severely cognitively impaired and had no behaviors. The quarterly care plan was updated on 6/15/23 and revisions were added on 6/20/23 to include Resident #11 revealed the problem as Resident #11 had the potential to be physically aggressive related to Dementia. He was found on 6/20/23 with his hands placed on roommate's neck. No	F 600	Initial intervention included all staff were re-educated on resident to resident abuse on 9/28/23. When a resident is observed with increased agitation the facility will immediately intervene with one on one activity, attempt non-pharmacological comfort measures, and separate agitated residents from other residents. All residents with dementia have the potential to be affected. The facility identified residents at risk for aggressive, physical behavior by evaluating all residents with a diagnosis of dementia and related behaviors. When identified, the nurse practitioner will be notified. Staff will request a med review. Resident #10 and #11 will have a medication review of record by 10/6/23 and intervene as necessary. Care plans will be updated to reflect any aggressive behaviors and recommended interventions. The interdisciplinary team will discuss residents that exhibited aggressive behaviors the following day in clinical meeting. Dementia related behaviors will be added to new hire orientation. The designee will audit by observing 10 residents with a diagnosis of dementia and if they had behaviors. The designee will conduct audits daily Monday-Friday times 4 weeks, 3 days a week Monday-Friday times 4 weeks, and 2 days a week Monday-Friday times 4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 11 visible injury noted. The goal included Resident #11 would not harm self or others. The interventions included staff would administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Assess and address contributing sensory deficits. Assess and anticipate residents' needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Monitor/document/report PRN any signs and symptoms of resident posing danger to self and others. Move the resident away from the room where altercation occurred. Notify MD of altercation and consult psychiatric/Psychogeriatric consult as needed. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Resident #11 also had periods of delirium or acute confusion episodes related to acute disease process. The resident would be free of signs/symptoms of delirium (changes in behavior, mood, cognitive function, communication, level of consciousness, restlessness). Engage the resident in simple, structured activities that avoid overly demanding tasks. Monitor for and address environmental factors recent change in environment, environmental noise, and commotion. The initial facility investigation summary dated 6/20/23, revealed the alleged victim was Resident	F 600	The Administrator or designee will bring these audits to the Quality Assurance Committee Meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 12	F 600		

#10, his roommate Resident #11 was the perpetrator. Resident #11 was observed by staff with both hands placed around Resident #10's neck. Staff immediately intervened and were able to remove Resident #11's hands from Resident #10's neck. Resident #10 had no signs or symptoms of pain or discomfort. There were no other alterations in Resident #10's skin integrity. Resident #10 was observed 15 and 30 minutes later and there were no visible changes to the neck area. Resident #10 and Resident #11 Minimum Data Set(MDS) were coded as severely cognitively impaired. Neither resident could explain what happened or if there had been a disagreement. Resident #11 had general agitation but had not been involved in any physical altercation prior to this incident. The physical behavior toward another resident was unusual and unforeseen. Both residents were separated by staff and nursing did a head-to-toe evaluation on both residents. The responsible person and medical director were notified on behalf of both residents. Resident #10's responsible person agreed to a room change. Resident #10 declined feelings of being unsafe or demonstrated any changes in behaviors. Resident #11 was placed by himself in a room and provided with 1:1 support for observations until he could be seen by psychiatry services.

The 5-day Investigation Report dated 6/25/23 read in part: revealed on 6/20/23 it was reported to the Director of Nursing that two roommates had an altercation. Staff were doing their rounds when staff heard yelling and noticed Resident# 11 standing over roommate Resident #10 with both hands placed on the side of Resident #10's neck. Staff immediately separated the two and Resident # 10 was checked for injuries. There

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 13	F 600		

were no visible marks, redness or bruising were noted. Resident# 11 was agitated but unable to state what happened. He was relocated to a private room. Resident# 11 was a long-term care resident with severe cognition impairment and diagnosed with dementia, communicative cognitive deficits, major depression disorder and anxiety. He had a behavior of agitation, but it was usually focused on staff attempting to redirect him. Resident #11 had not attempted to touch or harm another resident prior to the incident. Since the incident he has had no further attempts to harm anyone, and his agitation was focused on "going home." He was being followed by psych services and would be seen on 6/27/23. Psychiatry services were aware of the incident and made no changes to Resident #11's medication routine. Resident #10 was also a long-term care resident with severe cognition impairment and diagnosed with dementia, nontraumatic intracerebral hemorrhage, contractures of bilateral knees, dysphagia, and a pacemaker. Resident #10 had a behavior of yelling out at times and falling. There was no aggressive behavior noted. He was examined several times post incident, and no injuries were noted. He has been at his baseline since the incident.

Nursing note and Medication Administration Record (MAR) dated 6/20/23 revealed Nurse #6 was notified that Resident #11 had one hand around roommates' neck and the other hand holding the right wrist. Nurse #6 assessed Resident #10. Nurse Practitioner #2 assessed and notified Nurse Practitioner #3 was informed of the incident. Received a one-time verbal order for Resident #11 to receive 5 milligrams of Haldol. Resident #10 was moved to another room and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 14	F 600		

Resident #11 was provided with a one-to-one sitter.
Review of the skin assessment on 6/20/23 for Resident #10 and Resident #11 revealed there was no documented evidence of any description of any physical or skin condition changes.

An interview on 9/7/23 at 7:17 AM with Nurse #6 revealed she and Nurse Aide #16 were doing their rounds on the hall on 6/20/23 when they heard loud yelling in the hall. Nurse Aide #16 was close to the room and asked her to come to the room immediately. When she entered the room, she saw Resident #11 sitting in a wheelchair next to Resident #10. Resident #11 had his left-hand place on the front part of Resident #10's neck and the right hand on the wrist. Resident #11 was just yelling where is my money, but he was not squeezing or pressing on Resident #10's neck or wrist. Resident #10 was just sitting in his chair very calmly just making his normal unusual sounds. Resident #11's hands were removed from around Resident #10's neck. Nurse Aide #16 stayed with the resident talking with the resident until he calmed down. She sat with Resident #11 while Resident #10 was taken to another room for an assessment. Resident #10 did not have any physical marks, bruises, no visible handprints, or changes in skin condition around his neck or wrist. Resident #10's responsible person was on her way to the facility when she was informed of the incident. The responsible person was informed Resident #10's room was changed and physical assessment was done. The responsible person stated she was fine with the room change. Resident #10's responsible person visited with Resident #10 following the incident and did not report any concerns. Nurse #6 stated she returned to check on Nurse Aide #16 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 15	F 600		

Resident #11 and did a head-to-toe assessment. Resident #11 did not have any physical injuries or skin condition changes. Resident #11 was still verbally agitated, but not physically aggressive. Nurse Aide #16 remained with the resident while she contacted the Director of Nursing and informed her of the situation. The Director of Nursing instructed her to contact the nurse practitioner and get behavior management medication. She contacted Nurse Practitioner #2. The Nurse Practitioner #2 assessed the resident and gave a verbal order for a one-time dose of Haldol. The medication was given and effective. Resident #11 began to settle down and eventually went to sleep. The responsible person was informed of the situation and indicated they were ok with the one-time dose of Haldol and the 1:1 supervision. Nurse #6 further stated the behavior had not occurred between the two residents prior to this incident. Neither resident could recall what triggered the behavior or even what happened. Resident #11 was monitored for 72 hours for any further behaviors and there were none and Resident #10 was observed for any mental and physical changes for 72 hours and there were no changes, both residents were at baseline.

An interview was conducted on 9/7/23 at 10:34 AM with Nurse Aide #16 who stated she was doing rounds on the hall on 6/20/23 when she heard someone yelling. When she approached the resident's room, Resident #11 was seated in a wheelchair next to Resident #10 with one hand placed on the front of Resident #11's neck and the other somewhere on the wrist. Resident #11 was not squeezing or applying pressure, Resident #11 was just yelling where is the money. Resident #10 was just sitting in the chair very calmly and did not move or say anything. Resident #11 likes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 16	F 600		

to yell out when he gets agitated or did not sleep well the night before. She called for Nurse #6 and Nurse #6 removed Resident #11's hands from Resident #10 and she moved Resident #10 to another room to do her assessment. Nurse Aide #16 stated she stayed with Resident #11 who was just randomly yelling things until Nurse #6 returned with medication. Resident #11 did not have any physical injuries, nor did Resident #10. Nurse Aide #16 reported Resident #11 would be verbally aggressive toward staff. She had not seen this behavior toward other residents. Nurse Aide #16 reported Resident #11 would normally calm down when he was taken to another environment or rolls around in the facility away from others. Nurse Aide #16 stated she gave a verbal statement to the Administrator and Director of Nursing.

An telephone interview was conducted on 9/6/23 at 3:56 PM with the former Director of Nursing who stated she received a call from Nurse #6 on 6/20/23 stating that two residents had an altercation, and the residents were moved to separate rooms. The nurse reported she and a nurse aide heard some yelling while they were doing their rounds and when they entered the room both observed Resident #11's hand was around Resident #10's neck and one on the wrist. The Director of Nursing stated the nurse did not state Resident #11 was squeezing or choking the resident, it was more like it was placed on the front of the neck and wrist. The nurse reported she immediately separated the two residents moving Resident #11 to another room with a 1:1 sitter while she did a head-to-toe assessment of Resident #10. There were no visible bruising , marks, or injuries on Resident #10. Resident #11 would get verbally riled up but had not presented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 17	F 600		

any physical harm to any other resident. His verbal aggression was more toward staff. Resident #11 could easily be redirected by changing his environment to a calmer location. She indicated this behavior had not happened prior to the incident between Resident #11 or any other resident. Both residents' cognition was impaired due to dementia and neither resident could recall the events. Resident #10 was very confused and had periods of yelling out which may have triggered Resident #11, no one could be sure exactly what triggered the incident. Nurse #6 was instructed to contact the nurse practitioner and inform them of the situation. A nurse practitioner had come to the facility and checked Resident #10 and #11 and there were no documented injuries on either resident. Both residents' responsible persons were contacted and informed of the incident and Resident #10's responsible person agreed to the room change and Resident #11 responsible person agreed to the 1:1 until resident could be re-evaluated by psych services. Psych service reviewed Resident #11's medication regimen and did not make any recommended changes. Based on both residents limited cognition the nursing staff acted swiftly in separating and assessing both residents when they heard the noise and saw what was going on.

An interview was conducted on 9/7/23 at 10:00 AM with Resident #10's family member who stated she was on her way to the facility when she received a call from the facility regarding Resident #10 and his roommate. The family member stated she did not see any physical marks on Resident #10 and was fine with the room change and the action the nurse aide and nurse had taken. She further stated the facility had taken good care of Resident #10. She was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 18	F 600		

aware that Resident #10 had periods of yelling that may agitate others. She stated there had not been any problems between Resident #10 and his roommate prior to this incident. The family member stated she spoke with the nurse and nurse practitioner on the day of the incident to make sure Resident #10 was fine. She reported there had been no further incidents since then. She reported she felt Resident #10 was safe and received good care.

A telephone interview was conducted on 9/7/23 at 3:00 PM with Nurse Practitioner #2 who stated he received a call from Nurse #6 regarding the altercation between Resident #11 toward Resident #10. The nurse informed him that Resident #11 was observed to have his hand around the neck of Resident #10 and he was very agitated. When he arrived too the facility to assess the residents both residents were in separate rooms. Resident #10 was assessed for injuries and there was no evidence of any marks, bruising or fingerprints around the resident's neck. Resident #10 was unable to recall the incident that happened, nor did he present himself in a fearful manner. Nurse Practitioner #2 stated he had spoken with the responsible person for Resident #10 as well and went over the incident and assessment and she did not have any concerns with the action the nursing staff had taken. The responsible person did not report she or Resident #10 felt unsafe. Nurse Practitioner #2 further stated he assessed Resident #11 as well and there was no evidence of any injury. The one-time dosage of Haldol and the 1:1 supervision was effective during the 72-hour monitoring period. The Nurse Practitioner #2 further stated Resident #11 continued to receive medication for mood disorder related to dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 19	F 600		

and there were no medication changes recommended by psych services. There had been no evidence of aggressive behavior toward residents prior to the incident. Resident #11's mood disturbances had been managed with alternate activities and redirection.

An interview was conducted on 9/7/23 at 7:30 AM with the Administrator who stated he received a call from the former Director of Nursing regarding the altercation between Resident #11 and Resident #10. The Administrator stated it had been reported that Resident #11 had his hands around Resident #10's neck. During the investigation he and the Director of Nursing spoke with the staff who observed the incident and both staff stated Resident #11 had a hand place in front of Resident #10's neck and the other hand on his wrist. There were no reports of force or squeezing by Resident #11 when they went into the room. The nurse stated she separated the residents immediately and did not find any injuries on either resident. The Nurse Practitioner also assessed the resident on the same day and did not find any injuries. A discussion was held between the Director of Nursing and psych services regarding Resident #11's behaviors and medication. There were no recommended changes in Resident #11's medication. The responsible persons for both residents were informed of the incident and agreed with the changes that were made for the safety of all residents. The Administrator further stated both residents were protected immediately. The Administrator explained during his investigation it was discovered that Resident #11 was agitated and yelling without a known cause. Both residents had severe cognitive impairment and could not state what triggered the altercation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 600	Continued From page 20 The Administrator stated the mental status, behavior pattern and medical status of both residents were reviewed to determine if there were any changes in the resident health or behaviors that would warrant a medication adjustment. The Director of Nursing along with the nursing team reviewed both resident's medical health status prior to the incident and there was no indication of a health issue. The Nurse Practitioner assessed both residents on the day of incident and there were no visible injuries to either resident.	F 600		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		10/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 690	Continued From page 21 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview the facility failed to ensure a resident's urinary catheter bag was positioned below the bladder and secured in a manner to keep it from laying on the floor rather for 1 of 1 sampled resident with a urinary catheter (Resident #10). The findings included: Resident #10 was admitted to the facility on 4/14/23 with diagnoses of neurogenic bladder. The admission Minimum Data Set (MDS) dated 4/19/23 assessed Resident #10 was severly cognitively impaired. He required two-person assistance with personal hygiene with no behaviors during the assessment. A review of the care plan dated 4/25/23 indicated the resident had indwelling foley catheter due to neurogenic bladder. The goal included the resident would remain free from catheter related trauma and the resident would show no signs or symptoms of urinary infection. The interventions included staff would monitor and document	F 690	Initial intervention included ordering a new product with all catheter bags and the catheter cover attached to it. The former product is no longer utilized or purchased. Nursing staff and central supply was educated on 9/28/23 by the Staff Development Coordinator and the unit coordinator on the purpose of the catheter bag cover and proper placement of the drainage bag. All residents with use of a catheter have the potential to be affected. Interviews of all alert and oriented residents and non-alert and oriented resident's responsible parties with catheters will be interviewed by nursing unit coordinators or designee by 10/5/23 on catheter coverings with no concerns identified. The Staff Development Coordinator will educate all nursing staff and central supply by 10/5/23. Staff will be educated of the purpose of the catheter bag cover and proper placement of the drainage bag. New hires will receive this education in orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 690	Continued From page 22 pain/discomfort due to catheter. Monitor/record/report to MD for signs and symptoms of urinary tract infection. During a continuous observation on 9/7/23 from 9: 45 AM to 11: 10 AM, Resident #10 was lying on his left side and the bed was in the lowest position on the floor. The urinary catheter drainage bag did not have a privacy bag and could be seen from the hall. The urinary catheter drainage bag was detached from the bed lying on the floor and the urinary drainage bag position was located toward the middle of the resident's back closest to the resident's head. The urinary drainage bag was not secured to Resident #10 or the bed frame. Several staff entered the room to provide care and obtain vital signs for the resident. Staff did not check Resident #10's urinary catheter drainage bag lying on the floor. Resident #10's wife was visiting when Nurse #6 entered the room at 10:00 AM to reposition the resident in bed but did not pick the urinary catheter drainage bag off the floor or secure the urinary bag below the bladder to the resident or the bed frame. An interview was conducted on 9/7/23 at 11:30 AM with Nurse #6 who stated Resident #10 was readmitted to the facility at 8:30 AM and put in bed by the emergency medical service team. When she did her assessment and vital signs the urinary catheter drainage bag was secured and in place. Nurse #6 was asked when she repositioned Resident #6 in bed around 10:00 AM had she checked the placement of the urinary catheter drainage bag for proper position or had she noticed the drainage bag was not below the bladder, on the floor and not secured. Nurse #6's response was everything was fine when she	F 690	The certified nursing assistants will make rounds every 2 hours and educated to observe catheter bag proper placement. Audits to include all residents that have indwelling catheters with bag covers and proper placement of drainage bag. The nursing designee will conduct audit 5 days a week Monday-Friday times 4 weeks, 3 days a week Monday-Friday times 4 weeks, and 2 days a week Monday-Friday times 4 weeks. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting for three consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
F 690	Continued From page 23	F 690		

checked. Nurse #6 stated the expectation was for the nurse aides and nursing staff to make sure the urinary catheter drainage bag was placed below the bladder and secured off the floor and covered for privacy.

During an observation and interview on 9/7/23 at 11:07, Nurse Manager #2 was asked to assess the resident's positioning in the bed. Nurse Manger #2 acknowledged the urinary catheter drainage bag was uncovered on the floor and not properly secured below the bladder. Nurse Manager #2 proceeded to reposition the resident and change the urinary catheter drainage bag. Nurse Manager #2 stated the drainage bag should be secured and below the bladder. The expectation would be for all staff to ensure the drainage bag was properly placed and secured after care was provided and checked periodically for correct placement.

An interview was conducted on 9/7/23 at 11:40 AM with the Regional Nurse who stated the urinary catheter drainage bag should be below the bladder and secured to resident or bed. The tubing nor the bag should be on the floor. All urinary catheter bags should have a privacy cover.

An interview was conducted on 9/7/23 at 11:50 AM with the Administrator who stated the expectation was for nursing to ensure the urinary catheter drainage bags should not be on the floor, privacy covers should in place and the drainage bags were secured and positioned correctly.