		AND HUMAN SERVICES			FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345002	B. WING			C 01/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CYPRES	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 2	41		10/6/15
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.				
	by: Based on observa resident and staff in provide care in a m leaving 2 of 6 resid during the night wh assist with toileting failed to maintain a cover the resident of	NT is not met as evidenced tions, record review, and hterviews the facility failed to anner to maintain dignity by ents (Resident #8, #89) wet o needed extensive to total and personal hygiene and resident's dignity by failing to during care for 1 of 6 residents erved to receive care. ed:		The statements included are admission and do not consti- agreement with the alleged of herein. The plan of correctio completed in the compliance federal regulations as outline in compliance with all federal regulations the center has ta take the actions set forth in t plan of correction. The follow correction constitutes the ce allegation of compliance. All	tute deficiencies n is e of state and ed. To remain l and state ken or will he following ving plan of nter¿s alleged	
	7/30/14. Diagnose prostatic hypertroph of urinary tract infer The comprehensive assessment dated was moderately co- incontinent of bowe extensive assistance assistance in perso According to the Ca dated 2/2/15 the Re bowel and bladder assist for toileting. The Resident was incontinence with in	e Minimum Data Set (MDS) 1/31/15 indicated the Resident gnitively impaired, was always and bladder, and needed be in toileting and limited		deficiencies cited have been completed by the dates indic 1. Interventions for affected Resident #8 was provided in care and clean linens were a bed by NA #1 on 08/30/15. Resident #89 was provided i care by NA #1 on 08/30/15 a Restorative NA #1 on 09/01/ linens were applied to Resid on 08/30/15 and 09/01/15. NA #6 was verbally in-servic Staff Development Coordina 8/31/15 on maintaining priva emphasis on ensuring reside covered appropriately while a	or will be cated. resident: continent applied to the incontinent and by 15. Clean ent #89 bed ed by the tor (SDC) cy with an ents are	
	-	Der/SUPPLIER REPRESENTATIVE'S SIG	NATURE		ລວວເວແບ່ນ	(X6) DATE

09/25/2015

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.

Electronically Signed

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED	
		345002			C 09/01/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/01/2013	
	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE COMPLÉTIO	
F 241	dated 6/25/15 indic moderately cognitiv incontinent of bladd of bowel, and need toileting and persor The Nursing Assist documented the Re needed to be check incontinence. The of protective or barrier incontinence episod Review of NA flow s documentation of ir 10:20 PM on 8/29/1 NA #1 was observe for Resident #8 on NA turned the resid brief, under pad, lin observed to be satu urine. NA #1 stated in an she had not been a incontinence care of on 8/29/15 until 6:1 stated she knew sh the incontinent resi had 25 residents ar constantly ringing a everyone. Resident #8 stated 9:05 AM that he ha	uarterly MDS assessment ated the Resident was vely impaired, was always der and frequently incontinent ed extensive assistance in hal hygiene. ant (NA) care guide esident used briefs and ked frequently for care guide documented r lotion should be used after des. sheets revealed no ncontinent episodes from 15 to 2:46 PM on 8/30/15. ed to provide incontinence care 8/30/15 at 6:12AM. When the lent over onto his side the uen and bed cover were urated with strong smelling interview on 8/30/15 at 7 AM able to do rounds and give on Resident #8 from 11:30 PM 2 AM on 8/30/15. The NA he was supposed to check on dents every 2 hours but she nd the call lights were and she could not get to in an interview on 8/30/15 at d not been changed all night	F 24	 with/providing activities of daily liv (ADL) care. 2. Interventions for residents idem having the potential to be affected Resident care observations were completed on 09/01/15 by the faci Director of Nursing (DON), Unit M (UM) and SDC on all residents residen facility to ensure incontinent care observations. After resident care observer completed, no other residen identified as having been affected deficient practice. 3. Systematic Change: Newly hired Licensed Nurses and nursing assistants (C.N.A.'s) will be educated by the SDC during their orientation period on Peri-care with emphasis on the performance of the incontinent care to dependent residential personal hygiene. Educated also include maintaining resident and dignity. Directed in-services for A) Incontin Care, B) Maintaining Dignity and F during ADL care were provided by clinical consulting company for all nurses, (C.N.A's) and restorative assistants by October 6th. 4. Monitoring of the change to sus system compliance ongoing: 	tified as it lity lanager siding in are had eds did ervations ts were by this certified be h imely idents to tion will privacy nent Respect a licensed nursing stain	
	and it bothered him The DON stated in	an interview on 9/1/15 at 5:10 ations were that the NA's		Resident care observation rounds performed (across all shifts: 1st, 2 3rd) by the facility DON, Unit Man RN Supervisor and/or SDC to ens	2nd and ager,	

Facility ID: 923267

CENTE	<u>RS FOR MEDICA</u> RE	AND HUMAN SERVICES			-	APPROVE 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G	Сом	E SURVEY PLETED		
		345002	B. WING			C 01/2015		
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
CYPRES	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE		
F 241	 241 Continued From page 2 would check incontinent residents every 2 hours to see if they needed incontinent care during all shifts. She further stated that a resident should not have to lay in a wet incontinent brief all night without being changed. 2. Resident #89 was admitted to the facility on 11/20/14 with diagnoses that included diabetes and cerebral vascular accident (CVA) with right sided paralysis. The comprehensive admission MDS assessment dated 11/27/14 indicated the Resident was cognitively intact, frequently incontinent of bladder and occasionally incontinent of bowel and needed extensive assistance with toileting and personal hygiene. The CAA dated 11/28/14 revealed the Resident required extensive assistance for toileting and was frequently incontinent of urine. The Resident was care planned 6/1/15 for 	F 24	1 residents are provided incontiner a timely manner and resident dignity/privacy is maintained duri care. These care observation rou be performed on 10 residents da weeks, three times weekly for (4 and then weekly for (4) weeks. Monthly for a minimum of three r the DON will report resident care observation round results to the Assurance and Performance Improvement Committee. The Q Assurance and Performance Improvement Committee will rev audits to make recommendation ensure compliance is sustained and determine the need for furth auditing beyond the three monthe	ng ADL unds will ily for (4)) weeks months, Quality uality uality iew the s to ongoing; er				
	incontinence with s frequent and when incontinence care. The Quarterly MDS Resident was cogn incontinent of bowe extensive assistant hygiene. The NA care guide have incontinence bed linen kept clea Review of NA flow documentation of in 10:20 PM on 8/29/ ²	taff interventions to include ever necessary (PRN) 6 dated 8/17/15 revealed the itively intact, frequently el and bladder and needed ce with toileting and personal revealed the resident was to care frequently and prn and his n and dry.						

If continuation sheet Page 3 of 26

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED	
		345002	B. WING		09	C 09/01/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
CYPRES	S POINTE REHABILI	TATION CENTER	2006 S 16TH STREET WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
F 241	When the NA turnerside the brief, incor- cover were observer smelling urine. On 9/1/15 at 7:25 A observed to provide Resident #89. Wh the Resident over of brief and incontinerside ³ / ₄ saturated with st NA #1 stated in an she had not been at incontinence care of PM on 8/29/15 unti- further stated that sc check on the incom- but she had 25 res- constantly ringing at Resident #89 state 7:20 AM it irritated he had to wait in a AM and not be cha Restorative NA #1 9/1/15 at 7:40 AM fi incontinent resident shift NA 's make the morning and she co #89 was so wet (with The DON stated in PM that her expect would check incom- to see if they need shifts. She further stated shifts. She further sta	ce care for Resident #89. ed the Resident over onto his ntinence pad, linen and bed ed to be saturated with strong AM, Restorative NA #1 was e incontinence care for en the Restorative NA turned onto his side the back of his nce pad were observed to be trong smelling urine. interview on 8/30/15 at 7 AM able to do rounds and give on Resident #89 from 11:30 il 6:15 AM on 8/30/15. She she knew she was supposed to tinent residents every 2 hours idents and the call lights were and could not get to everyone. d in an interview on 9/1/15 at him that the last three nights wet brief from 11 PM until 5 inged. stated in an interview on the NA ' s were to check its every 2 hours and the night heir last rounds at 6 AM in the ould not explain why Resident ith urine) on 9/1/15 at 5:10 tations were that the NA's tinent residents every 2 hours ed incontinent care during all stated that a resident should wet incontinent brief all night	F 24	41			

If continuation sheet Page 4 of 26

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES		IPLE CONSTRUCTION	(X3) DAT	. 0938-039	
NND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		MPLETED C	
		345002	B. WING		09/01/2015		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CYPRES	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 241	Continued From pa	ge 4	F 24	1			
	5/4/07 and had a di The Care Area Asse revealed the reside and was incontinen The most recent Mi Assessment (Quart the resident had se was rarely/never un the resident was inc and required extens and personal hygien The resident 's Can Living (ADLs) dated was totally depende for bowel and bladd resident wore incom On 8/31/15 at 2:36F was observed in the room removing line entering the room the observed to be pulle the bed closest to the foot of the bed lying with no clothing on spread was observed of the bed. NA#6 er she had to change the resident lying on the care, no visitors or a On 9/1/15 the Direct	re Plan for Activities of Daily 8 8/10/15 noted the resident ent for all ADLs. The Care Plan ler incontinence noted the tinent products for dignity. PM NA (Nursing Assistant) #6 e hall near the resident ' s n from the linen cart. Upon he privacy curtain was ed parallel to the left side of he door ending at the dent was observed from the g on her right side uncovered except for socks. The bed ed to be fan folded at the foot ntered the room and stated the resident ' s bed because e bed was soiled. The NA was not explain why she left the e bed uncovered. During the staff entered the room. ctor of Nursing stated in an ents should not be exposed for					

Facility ID: 923267

If continuation sheet Page 5 of 26

		AND HUMAN SERVICES			F	ORM	09/30/2015 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X:	COM	E SURVEY PLETED	
		345002	B. WING	;			C / 01/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CYPRES	S POINTE REHABILI	TATION CENTER			006 S 16TH STREET VILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From pa	ge 5	F:	312				
F 312 SS=D		ARE PROVIDED FOR		312			10/6/15	
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal						
	by: Based on observat resident and staff ir provide incontinence maintain personal h (Resident #89, #8, extensive assistance toileting/personal hy The findings include 1. Resident #89 wa 11/20/14 with diagn the knee amputatio vascular accident (The comprehensive Set (MDS) assess the resident was co incontinent of blade incontinent of blade incontinent of blade sistance with toile The Care Area Ass revealed Resident a assistance for toilet incontinent of urine	-			The statements included are not an admission and do not constitute agreement with the alleged deficiencie herein. The plan of correction is completed in the compliance of state federal regulations as outlined. To remin compliance with all federal and stat regulations the center has taken or wit take the actions set forth in the following plan of correction. The following plan correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #8 was provided incontinent care by NA #1 and clean linens placed the bed 08/30/15. Resident #89 was provided incontinent care and clean linens placed on the be 08/30/15 by NA #1. Resident #45 was provided incontinent care and clean linens placed on the bed on 9/1 by Restorative NA #1. Resident #45 was provided incontinent care and clean linens placed on the bed on 9/1 by Restorative NA #1.	and nain te ill ing of t d on nt wed and /15 nt		

Event ID: ZTFL11

Facility ID: 923267

If continuation sheet Page 6 of 26

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			PLETED
		345002	B WING			С	
	ROVIDER OR SUPPLIER	545002	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	09/0	1/2015
					DO6 S 16TH STREET		
CYPRES	S POINTE REHABILI	TATION CENTER	WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 312	Continued From pa	ae 6	E 3	312			
		nitor for any skin issues					
	related to incontine	nt episodes and would be at			2. Interventions for residents identif	ied as	
	risk for complication	n from immobility			having the potential to be affected:		
	Resident #89 had a	recently revised care plan on			Resident care observations were completed on 09/01/15 by the facilit	v	
		adder incontinence related to			Director of Nursing (DON), Unit Ma		
		f to do incontinence care			(UM) and SDC on all residents resid	ding in	
	frequently and as n	eeded.			the facility to ensure incontinent car		
	The quarterly MDS	dated 8/17/15 indicated			been provided timely and care need not exist. After resident care obser		
		cognitively intact, frequently			were completed, no other residents		
		and bladder and needed			identified as having been affected b	y this	
		e with toileting and personal			deficient practice.		
	hygiene.				3. Systematic Change:		
		ant (NA) care sheet list			Newly hired Licensed Nurses and c		
		esident #89 was to have			nursing assistants (C.N.A.'s) will be		
		ollowed by barrier cream to and as needed and his bed			educated during their orientation pe Incontinent Care with emphasis on		
	linen was to be kep				performance of timely incontinent c		
	Review of NA comp	outerized flow sheets revealed			dependent residents to maintain pe		
		of incontinent episodes from			hygiene, application of skin protecti		
		15 to 2:23 PM on 8/30/15. AM, urinary incontinence care			ointments and maintaining resident privacy and dignity during ADL care		
		e provided to Resident #89.			Directed in-services for A) Incontine		
		resident, washed her hands,			Care, application of skin protective		
		gloves and obtained supplies			ointments and B) Maintaining Dignit	-	
		he NA cleansed the perineal b back technique, assisted the			Respect during ADL care were prov by a clinical consulting company for		
		his side and cleansed the			licensed nurses, (C.N.A's) and rest		
		he brief, under pad, linen and			nursing assistants by October 6th.		
		served to be saturated with			4 Manitaving of the shore is to	. i.a	
		with clean linen and protective e odor was noted. The NA did			 Monitoring of the change to susta system compliance ongoing: 	ain	
		e lotion after incontinence care.			Resident care observation rounds v	vill be	
	Resident #89 was o	observed to have pink skin			performed (across all shifts: 1st, 2n	d and	
	around the perirect	al area with no skin			3rd) by the facility DON, Unit Manag		
	breakdown noted.		1		RN Supervisor and/or SDC to ensu	re	

Facility ID: 923267

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
			-			С
		345002				01/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 2006 S 16TH STREET	DDE	
CYPRES	S POINTE REHABILI	TATION CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 312	On 9/1/15 at 7:25 A observed to have in Restorative NA #1 of not having incom The NA greeted the applied disposable to provide care. Th area using a front to resident to turn on perirectal region. The pad were observed and replaced with of A strong urine odor area was noted on and the NA applied perineal/rectal area On 8/31/15 at 10 A #89 was alert and of the call bell for ass incontinence care. been given a urinal use with his right si she checked him en needed incontinent called. Resident #89 state 10:01 AM that he of staff on night shift of without having to w stated he called for several hours befor change him. Resident #89 state 7:20 AM it irritated	AM Resident #89 was noontinence care by after the resident complained tinence care done all night. e resident, washed her hands, gloves and obtained supplies ne NA cleansed the perineal to back technique, assisted the his side and cleansed the The back of his brief and under to be ³ / ₄ saturated with urine clean linen and protective brief. was noted. A small open red the skin on the right buttock protective cream to the	F 31		during ADL n rounds will sidents for (4) or (4) weeks (s. ree months, care the Quality e l review the ations to ned ongoing; further	

If continuation sheet Page 8 of 26

		& MEDICAID SERVICES	()(0)). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
			A. DOILDI			С
		345002	B. WING		09	/01/2015
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRES	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 312	Continued From pa	ige 8	F 3	12		
	she had not been a incontinence care of PM on 8/29/15 until further stated that s check on the incont and as needed but the call lights were her first night by he everyone. On 9/1/15 at 7:40 A in an interview the P residents every 2 h made their last rour and she could not e so wet (of urine). 2. Resident #8 was 7/30/14. Diagnoses prostatic hypertroph history of urinary tra The comprehensive assessment dated was moderately cog incontinent of bowe extensive assistance assistance in perso According to the Ca dated 2/2/15 Reside bowel and bladder, assistance for toiled BPH and UTI. The most recent qu dated 6/25/15 indic moderately cognitiv incontinent of blado	e Minimum Data Set (MDS) 1/31/15 indicated Resident #8 gnitively impaired, was always and bladder, and needed be in toileting and limited				

If continuation sheet Page 9 of 26

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	TE SURVEY	
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:) ´co	MPLETED	
		345002	B. WING		00	C 09/01/2015	
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP C		/01/2013	
CYPRES	S POINTE REHABILI	TATION CENTER		006 S 16TH STREET /ILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 312	toileting and persor Resident #8 ' s carr incontinence includ disposable briefs a and as needed. The nursing assista documented Resid to be checked frequincontinence. The of protective or barrie incontinence episor Review of NA comp no documentation of 10:20 PM on 8/29/7 On 8/30/15 at 6:12 was observed bein Nursing Assistant (washed her hands, obtained supplies to cleansed the perine technique, assisted side and cleansed brief, under pad, lin observed to be satu urine and replaced brief. No protective incontinence care. have an intact prote and a small open re right ischium bone. NA #1 stated in an she had not been a incontinence care of on 8/29/15 until 6:1	hal hygiene. e plan, dated 4/4/15, for led interventions to use nd to change them frequently ant (NA) care sheet list ent #8 used briefs that needed uently and as required for care sheet documented r lotion should be used after des. outerized flow sheets revealed of incontinent episodes from 15 to 2:46 PM on 8/30/15. AM, urinary incontinence care g provided to Resident #8. NA) #1 greeted the resident, applied disposable gloves and o provide care. The NA eal area using a front to back d the resident to turn on his the perirectal region. The nen and bed cover were urated with strong smelling with clean linen and protective e lotion was applied after Resident #8 was observed to ective dressing on his sacrum ed area on the skin over the	F 312				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/30/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		345002	B. WING				C 01/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRES	S POINTE REHABILI	TATION CENTER			006 S 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	night by herself and In an interview on 8 stated he did not fe any shift to get his r wait a long time. Th waited on several o day or month) at lead briefs changed by th used the call light a would come right bac come back for sever further stated that la from when he went came in and it both changed. In an interview on 8 Resident #8 was a of bowel and bladde was aware when he ring his call light for him every 2 hours to incontinence care a computerized flow s 3. Resident #45 wa 8/11/15. Diagnoses Non-Alzheimer 's of disease, abnormalif weakness. The comprehensive assessment dated a #45 was cognitively incontinent of urine of bowel, and need toileting and person The Care Area Asse	 could not get to everyone. /30/15 9:05 AM, Resident #8 el there was enough staff on heeds met without having to he Resident stated he had ccasions (could not recall the ast 3 hours before he had his he staff. He stated he had nd the staff would tell him they ack, turn off the light, and not eral hours. The Resident ast night he was not changed to bed until the Surveyor ered him to be wet and not /31/15 at 10 AM NA #3 stated heavy wetter and incontinent er. The NA stated Resident #8 e voided but will not always assistance so she checked to see if he needed nd documented such on the sheets. s admitted to the facility on a included diabetes, the mentia, chronic lung y of gait, and muscle Minimum Data Set (MDS) B/18/15 indicated Resident intact, was frequently and occasionally incontinent er assistance in the sheet is admitted to the facility on the she	F 3	312			

(EACH DEFICIENC)	TEMENT OF DEFICIENCIES		TPLE CONSTRUCTION NG STREET ADDRESS, CITY, STATE, ZIP CC	CO	TE SURVEY MPLETED C	
S POINTE REHABILI SUMMARY STA (EACH DEFICIENCY	TATION CENTER	B. WING _		09	С	
S POINTE REHABILI SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CC		C 09/01/2015	
SUMMARY STA (EACH DEFICIENC)	TEMENT OF DEFICIENCIES					
(EACH DEFICIENC)			2006 S 16TH STREET WILMINGTON, NC 28401			
	SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
toiletry and experie exertion. Resident #45 had a incontinence with ir checking the reside with toileting as nee after each incontine The nursing assista Resident #45 need hours, assisted with incontinence care a On 8/30/15 at 5:38 was observed being NA #1 greeted the applied disposable to provide care. Th area using a front to resident to turn on perirectal region. T bed cover were obs urine and replaced brief. Resident #45 intact skin. No prof incontinence care.	ed extensive assistance with need shortness of breath with a care plan dated 8/24/15 for neterventions to include ent every 2 hours, assisting eded and providing pericare ent episode. ant care sheet list documented ed to be checked every 2 in toileting and provided as needed. AM, urinary incontinence care g provided to Resident #45. resident, washed her hands, gloves and obtained supplies the NA cleansed the perineal to back technique, assisted the his side and cleansed the the brief, under pad, linen and served to be saturated with with clean linen and protective to was observed to have pink tective lotion was applied after	F 3'	12			
she had not been a incontinence care of PM on 8/29/15 until further stated that s check on the incom and as needed but the call lights were	ble to do rounds and give on Resident #45 from 11:30 I 5:38 AM on 8/30/15. She she knew she was supposed to tinent residents every 2 hours that she had 25 residents and constantly ringing and it was					
	checking the reside with toileting as new after each incontine The nursing assista Resident #45 need hours, assisted with incontinence care a On 8/30/15 at 5:38 was observed bein NA #1 greeted the applied disposable to provide care. The area using a front the resident to turn on perirectal region. The bed cover were observed brief. Resident #45 intact skin. No pro- incontinence care. NA #1 stated in an she had not been a incontinence care of PM on 8/29/15 untifurther stated that so check on the incon- and as needed but the call lights were her first night by he everyone. The Director of Nur	checking the resident every 2 hours, assisting with toileting as needed and providing pericare after each incontinent episode. The nursing assistant care sheet list documented Resident #45 needed to be checked every 2 hours, assisted with toileting and provided incontinence care as needed. On 8/30/15 at 5:38 AM, urinary incontinence care was observed being provided to Resident #45. NA #1 greeted the resident, washed her hands, applied disposable gloves and obtained supplies to provide care. The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The brief, under pad, linen and bed cover were observed to be saturated with urine and replaced with clean linen and protective brief. Resident #45 was observed to have pink intact skin. No protective lotion was applied after incontinence care. NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #45 from 11:30 PM on 8/29/15 until 5:38 AM on 8/30/15. She further stated that she knew she was supposed to check on the incontinent residents every 2 hours and as needed but that she had 25 residents and the call lights were constantly ringing and it was her first night by herself and could not get to	checking the resident every 2 hours, assisting with toileting as needed and providing pericare after each incontinent episode. The nursing assistant care sheet list documented Resident #45 needed to be checked every 2 hours, assisted with toileting and provided incontinence care as needed. On 8/30/15 at 5:38 AM, urinary incontinence care was observed being provided to Resident #45. NA #1 greeted the resident, washed her hands, applied disposable gloves and obtained supplies to provide care. The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. 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The nursing assistant care sheet list documented Resident #45 needed to be checked every 2 hours, assisted with toileting and provided incontinence care as needed. On 8/30/15 at 5:38 AM, urinary incontinence care was observed being provided to Resident #45. NA #1 greeted the resident, washed her hands, applied disposable gloves and obtained supplies to provide care. The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The brief, under pad, linen and bed cover were observed to be saturated with urine and replaced with clean linen and protective brief. Resident #45 was observed to have pink intact skin. No protective lotion was applied after incontinence care. NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #45 from 11:30 PM on 8/29/15 until 5:38 AM on 8/30/15. 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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		E SURVEY	
ND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		C	
		345002	B. WING			01/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		•	
CYPRES	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 312	expectations were t incontinent resident need incontinent ca	that the NAs would check ts every 2 hours to see if they are during all shifts.	F 3 [.]				
F 314 SS=D	· · ·		F 3	14		10/6/15	
	resident, the facility who enters the facil does not develop p individual's clinical they were unavoida pressure sores reco	prehensive assessment of a r must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that uble; and a resident having eives necessary treatment and e healing, prevent infection and from developing.					
	by: Based on observat resident and staff ir keep residents at ri use barrier cream f #89, # 8) at risk for The findings include 1. Resident #89 wa 11/20/14 with diagn the knee amputatio vascular accident (The most recent qu dated 8/17/15 indic cognitively intact ar behaviors or rejecti documented the Re			The statements included are admission and do not constit agreement with the alleged of herein. The plan of correction completed in the compliance federal regulations as outline in compliance with all federal regulations the center has ta take the actions set forth in t plan of correction. The follow correction constitutes the ce allegation of compliance. All deficiencies cited have been completed by the dates indic 1. Interventions for affected of Resident #8 was provided in care by NA #1 and clean line the bed 08/30/15.	tute deficiencies n is e of state and ed. To remain l and state ken or will he following ving plan of nter's alleged or will be rated. resident: continent		

Facility ID: 923267

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	E SURVEY PLETED
						(C
		345002	B. WING			09/0	01/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRES	S POINTE REHABILI	TATION CENTER			006 S 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 13	F 3	14			
	extensive assistant toileting and persor no weight loss of 5 10% or more in the was at risk for press The Resident was impaired skin integ with interventions to relieving device on incontinence care, after incontinent ep kept clean and dry. The NA care guide have incontinence frequently and prn and dry. Review of NA flow documentation of in 10:20 PM on 8/29/7 On 8/30/15 at 6:15 was observed to be NA #1 cleansed the back technique, as his side and cleans brief, under pad, lin observed to be satu urine and replaced brief. The NA did no incontinence care. to have pink skin a no skin breakdown On 9/1/15 at 7:25 A	ce with bed mobility, transfer, nal hygiene. The resident had % or more in the last month or e last 6 months. The Resident issure ulcers but had none. care planned (5/6/15) for rity and incontinence (6/1/15) o include use of pressure bed/chair, frequent and prn application of barrier cream bisodes, and bed linen to be revealed the Resident was to care and apply barrier cream and his bed linen kept clean sheet revealed no ncontinent episodes from 15 to 2:23 PM on 8/30/15. AM, urinary incontinence care e provided to Resident #89. e perineal area using a front to sisted the resident to turn on sed the perirectal region. The nen and bed cover were urated with strong smelling with clean linen and protective ot apply barrier cream after Resident #89 was observed round the perirectal area with			Resident #89 was provided incontic care and clean linens placed on the 08/30/15 by NA # 1. Incontinent care clean linens placed on the bed on 9 by Restorative NA #1. 2. Interventions for residents identification having the potential to be affected: Resident care observations were completed on 09/01/15 by the facil Director of Nursing (DON), Unit Mar (UM) and SDC on all residents resisthe facility to ensure incontinent care been provided timely and care nee not exist. After resident care observer were completed, no other residents identified as having been affected by deficient practice. DON and Unit Manager performed assessment on all residents residing the facility on 9/17/15 and 9/18/15. other residents were identified as h been affected by this deficient practor 3. Systematic Change: Newly hired C.N.A.'s will be educated during their education period on the responsibility in preventative skin of with emphasis on ensuring resident are dependent for personal hygien- toileting are kept clean, dry and ba cream is applied (as ordered). Directed in-services for A) Incontin Care, application of skin protective ointments and B) Maintaining Dign Respect during ADL care were pro by a clinical consulting company for licensed nurses, (C.N.A's) and resi- nursing assistants by October 6th.	e bed are and 9/1/15 fied as ity anager iding in re had ds did rvations s were by this a skin ng in No having ctice. red eir are ts who e and rrier ent ity and vided r all	
	Restorative NA #1	after the resident complained tinence care done all night.			4. Monitoring of the change to sust	ain	

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	-	AND HUMAN SERVICES				FORM	09/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345002	B. WING				C 01/2015
	PROVIDER OR SUPPLIER	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2006 S 16TH STREET WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	to back technique, a his side and cleans back of his brief an be ³ / ₄ saturated with linen and protective was noted. A small the skin on the righ protective cream to Resident #89 stated 10:01 AM that he d staff on night shift (without having to w stated when he call several hours befor NA #1 stated in an she had not been a incontinence care of PM on 8/29/15 until further stated that s check on the incont but she had 25 resi constantly ringing a Restorative NA #1 s 9/1/15 at 7:40 AM t incontinent resident shift NA ' s make th morning and she co #89 was so wet (wi The Treatment Nur 9/1/15 at 8:56 AM t notified her that mo the Resident ' s but pressure ulcer. The	inge 14 the perineal area using a front assisted the resident to turn on ed the perirectal region. The d under pad were observed to n urine and replaced with clean e brief. A strong urine odor l open red area was noted on t buttock and the NA applied the perineal/rectal area. d in an interview on 8/31/15 at id not think there was enough 11PM-7AM) to meet his needs ait a long time. Resident #89 ed for assistance it might take they changed him. interview on 8/30/15 at 7 AM ble to do rounds and give on Resident #89 from 11:30 I 6:15 AM on 8/30/15. She she knew she was supposed to tinent residents every 2 hours dents and the call lights were and could not get to everyone. stated in an interview on he NA's were to check ts every 2 hours and the night per last rounds at 6 AM in the build not explain why Resident th urine) on 9/1/15at 7:25 AM. se stated in an interview on hat the Restorative NA had orning (9/1/15) of an area on tock and it was a stage II e nurse stated the doctor and yould be notified and treatment	F 3	;14	system compliance ongoing: Licensed nursing staff on all resider completes weekly skin checks routi The DON and Unit Manager will con to monitor to assure the skin check completed as well as the results of skin checks at least weekly. DON, Unit Manager, Wound Care N and SDC will also complete skin ch on 4 incontinent residents weekly for weeks. Monthly for a minimum of three mo the DON will report observation car round audit results to the Quality Assurance and Performance Improvement Committee. The Qua Assurance and Performance Improvement Committee will review audits to make recommendations to ensure compliance is sustained on and determine the need for further auditing beyond the three months.	inely. ntinue s are the Nurse ecks or 4 nths, e lity v the	

If continuation sheet Page 15 of 26

	COF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		B		MPLETED
		345002	B. WING			C
	PROVIDER OR SUPPLIER	545002		STREET ADDRESS, CITY, STATE, ZIP COI		/01/2015
	S POINTE REHABILI			2006 S 16TH STREET		
				WILMINGTON, NC 28401		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 314	begun. The Nurse to favor lying on the that position on his She further stated ti if he was left in urin more prone to brea more that the area The DON stated in PM that her expect would check incont to see if they neede shifts. She further s not have to lay in a being changed. 2. Resident #8 was 7/30/14. Diagnose vascular disease, h pressure ulcer heel wasting and disuse According to the Ca dated 2/2/15 the Re pressure ulcers, ha needed extensive a was always incontin The most recent qu dated 6/25/15 indic moderately cognitiv incontinent of blado of bowel, and need mobility, transfer, to The assessment do no weight loss or ga month or 10% or m Resident did not ha coded as having m	stated that the Resident liked e right side and would slide into own even after being turned. that she could not rule out that he it might cause the area to be addown but believed it was was not open to air. an interview on 9/1/15 at 5:10 ations were that the NA's inent residents every 2 hours ed incontinent care during all stated that a resident should wet diaper all night without admitted to the facility on s included diabetes, peripheral hypertension, hip fracture, I, incontinence and muscular		4		

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		& MEDICAID SERVICES	0.00		OMB NC		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED	
			A. DOILDIN			С	
		345002	B. WING _		09	/01/2015	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CYPRES	S POINTE REHABILI	TATION CENTER	2006 S 16TH STREET WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 314	The Resident was of impairment, potenti incontinence with ir pressure relieving of disposable briefs to prn, application of the episodes, treatment and dry. On 8/30/15 at 6:12 was observed being Nursing Assistant (area using a front to resident to turn on perirectal region. T bed cover were obs strong smelling urin linen and protective applied after incont observed to have a his sacrum and a s over the right ischiu	care planned 4/4/15 for skin ial for pressure ulcers, and hterventions to include use of device on bed/chair, be changed frequently and barrier cream after incontinent its as ordered, bed linen clean AM, urinary incontinence care g provided to Resident #8. NA) #1 cleansed the perineal o back technique, assisted the his side and cleansed the The brief, under pad, linen and served to be saturated with he and replaced with clean e brief. No barrier cream inence care. Resident #8 was in intact protective dressing on mall open red area on the skin um bone.	F 31	4			
	AM of the Treatmen Resident #8. A sm the skin over the rig ointment applied. T buttocks was remo- almost totally heale Resident ' s brief no The Nursing Assist documented the Re relieving device on hours, used briefs a frequently for incon documented protect used after incontine	nt Nurse giving wound care to all pink open area noted on ght ischium and zinc oxide The dressing on the right ved and skin observed to be ed. New dressing applied. The oted to be dry. ant (NA) care guide esident required pressure bed/chair, turning every 2 and needed to be checked tinence. The care guide ctive or barrier lotion should be					

Facility ID: 923267

If continuation sheet Page 17 of 26

TATEMENT	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY MPLETED C
		345002	B. WING		09	0/01/2015
	PROVIDER OR SUPPLIER S POINTE REHABILI	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2006 S 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	I SHOULD BE	(X5) COMPLETIC DATE
F 314	II Pressure Ulcer to measuring 1.3 cm cm depth with no d Review of Pressure Care Tool dated 8/2 Pressure Ulcer to I cm by 1 cm by 0.1 documented as an ischium measuring by 0.1 cm depth wi serosanguinous dr Review of NA flow documentation of i 10:20 PM on 8/29/ NA #1 stated in an she had not been a incontinence care of on 8/29/15 until 6:1 stated she knew sh the incontinent resi had 25 residents a constantly ringing a everyone. The Treatment Nur 8/31/15 at 10:10 A the facility with mul assessed and treat Resident ' s pressu 8/23/15 when she the left buttocks. Ta and responsible pa begun. The Nurse ulcer on the left but with treatment. Th 8/30/15 the Reside notified her the fam	23/15 revealed an open Stage o left buttock was noted length by 1.1 cm width by 0.1 lrainage. e Wound Assessment and 30/15 revealed the Stage II eft buttock now measured 0.4 cm. A new area was excoriation from brief right 2 cm length by 1.5 cm width th a small amount of	F 3	14		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	`´CO№	E SURVEY
		345002	B. WING			C /01/2015
	PROVIDER OR SUPPLIER	TATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 2006 S 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 314 F 323 SS=D	checked the Reside area over the right diaper line. She sta wetter and the area incontinent and/or f The Nurse stated th were care planned after incontinence of special ointment (Z to the area as treat The DON stated in PM that her expect shifts. She further s not have to lay in a being changed. 483.25(h) FREE OI HAZARDS/SUPER The facility must er environment remain as is possible; and	ent and noted an open red ischium bone around the ated the Resident is a heavy a could have been from being from the brief rubbing the area. that all incontinent residents to have barrier cream applied care. The nurse stated that a inc Oxide) was to be applied ment. an interview on 9/1/15 at 5:10 ations were that the NA's all stated that a resident should wet diaper all night without F ACCIDENT	F 314			10/6/15
	by: Based on observative resident and staff in transfer a resident manner for 1 of 3 re transferred with a normal The findings include	NT is not met as evidenced tion, record review and nterviews, the facility failed to with a mechanical lift in a safe esidents observed to be nechanical lift (Resident #8). ed: dmitted to the facility on		The statements included are ner admission and do not constitute agreement with the alleged defi herein. The plan of correction is completed in the compliance of federal regulations as outlined. in compliance with all federal ar	ciencies state and To remain	

Facility ID: 923267

If continuation sheet Page 19 of 26

	-	AND HUMAN SERVICES			FC	TED: 09 DRM APF NO: 09	PROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SU COMPLET	
		345002	B. WING			C 09/01/2	2015
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRES	S POINTE REHABILI	TATION CENTER			006 S 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) MPLETIO DATE
F 323	poliomyelitis, musc wasting and disuse 1/25/15 revealed a femur with femoral The annual compre (MDS) dated 1/31/ ⁷ required extensive transfers and was r was moderately con understood and use others. The Care Area Ass dated 2/2/15 identif extensive to total as The quarterly MDS Resident #8 requires staff with transfers Resident #8 was m and usually unders others. The Care Plan date having a performar limited mobility. Th	le weakness, muscular e atrophy. A readmission on diagnosis of closed fracture of nail placement. ehensive Minimum Data Set 15 indicated Resident #8 assistance of two staff with non-ambulatory. Resident #8 gnitively impaired and usually ually able to understand essment (CAA) summary fied Resident #8 required ssistance for ADL ' s. dated 6/25/15 indicated ed extensive assistance of two and was non-ambulatory. oderately cognitively impaired tood and able to understand	F3	23	take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: No harm was caused to Resident #8 by the wheelchair being tilted back during mechanical lift transfer. 8/31/15 NA #2 was provided one-on-or re-education by the facility Regional Clinical Director on ensuring a safe resident transfer while utilizing a mechanical lift. A return demonstration while utilizing a mechanical lift for transfers was required by NA #2 to ens safe and competent mechanical lift transfers. 2. Interventions for residents identified having the potential to be affected: A list of residents transferred by a mechanical lift was developed by the D 9/23/15. All residents will be observed during transfer to determine if appropriate/safe technique is demonstrated by Regional Clinical	y the ne sure as	
	of Resident #8 beir lift to a wheelchair During the transfer position and locked placed in front of R wheelchair. Nursin observed to tilt bac degree angle as Re by the mechanical	s made on 8/30/15 at 9:43 AM ing transferred by mechanical with 2 person assistance. , the wheelchair was put into I. The mechanical lift was esident #8 ' s empty ing Assistant (NA) #2 was k the wheelchair at a 30 esident #8 was being lowered lift. The front wheels were in contact with the floor when			Consultant. 8/31/15 the Staff Development Coordinator educated the C.N.A staff to assure all 4 wheels of the wheelchair remain on the ground and the wheels locked during transfer of residents usin mechanical lift. 3. Systematic Change: Newly hired Nursing Staff (Licensed Nurses and CNAs) will be educated during their orientation period on safe		

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	OMB NO. (X3) DATI	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G	СОМ	PLETED
		345002				C
	PROVIDER OR SUPPLIER	345002		STREET ADDRESS, CITY, STATE, ZIP COD		01/2015
				2006 S 16TH STREET	-	
CYPRES	S POINTE REHABILI	TATION CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 323	Continued From pa	age 20	F 32	3		
	the transfer was co	-		transfers utilizing a mechanica	l lift.	
				Licensed Nurses and CNAs wi	ll be	
		interview on 8/30/15 at 11:23 was tilted back during the		required to provide a return de utilizing a mechanical lift to ens		
		position Resident #8 in a		competency of skill.	buie	
		on that would not hurt his back.		By October 6th, An in-service	will be	
	The Director of Nu	raing (DON) stated in an		provided to Nursing Staff - Lice		
		rsing (DON) stated in an 5 at 11:45 AM every new		Nurses (LN) and Certified Nurs Assistants (CNA) by the Staff	sing	
		ned and observed by a staff		Development Coordinator or D	irector of	
		per technique of mechanical lift		Nursing on safe transfers utiliz		
		ientation. The DON stated the positioned and lifted up by the		mechanical lift. A DVD provide manufacturer will be used as the second		
		vered into a locked wheelchair,		material for training regarding		
	checked for position	ning and moved away from the		safe transfers. Licensed Nurse		
		e DON stated for the resident '		CNAs will be required to provid		
		chair should never be tilted nould be on the floor during the		demonstration utilizing a mech ensure competency of skill.	anical lift to	
	transfer.			4. Monitoring of the change to	sustain	
				system compliance ongoing:		
				Mechanical lift observations wi		
				performed by the Staff Develop Coordinator, Director of Nursin		
				Nursing Supervisor. Staff Deve		
				Coordinator, Director of Nursin		
				Nursing Supervisor will observ perform a mechanical lift trans		
				ensure transfer is performed s		
				Observations will be performed		
				shifts and will occur weekly for	a minimum	
				of (3) months. Monthly for a minimum of three	monthe	
				the DON will report audit result		
				Quality Assurance and Perform	nance	
				Improvement Committee. The	Quality	
				Assurance and Performance Improvement Committee will re	view the	
				audits to make recommendation		
				ensure compliance is sustaine	d onaoina:	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (E SURVEY PLETED
		345002				(09/0	C 01/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CYPRES	S POINTE REHABILI	TATION CENTER			06 S 16TH STREET ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 323	Continued From pa	ge 21	F 32	23	and determine the need for further		
F 353 SS=D	483.30(a) SUFFICI PER CARE PLANS	ENT 24-HR NURSING STAFF	F 3	53	auditing beyond the three months.		10/6/15
	provide nursing and maintain the highes and psychosocial w	ve sufficient nursing staff to d related services to attain or at practicable physical, mental, rell-being of each resident, as dent assessments and care.					
	numbers of each of personnel on a 24-l	ovide services by sufficient the following types of nour basis to provide nursing in accordance with resident					
		d under paragraph (c) of this urses and other nursing					
	section, the facility	d under paragraph (c) of this must designate a licensed charge nurse on each tour of					
	by: Based on observat and staff interviews sufficient nursing st needs and failed to to keep 3 of 6 resid clean and dry (Res of 6 residents free f	NT is not met as evidenced ions, record review, resident , the facility failed to provide aff to meet the resident ' s provide sufficient nursing staff ents observed during care ident #89, #8 and #45) and 2 rom skin breakdown #8). The findings included:			The statements included are not an admission and do not constitute agreement with the alleged deficient herein. The plan of correction is completed in the compliance of state federal regulations as outlined. To re in compliance with all federal and sta regulations the center has taken or	cies e and emain ate	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345002	B. WING _		C 09/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE,		1/2010
CYPRES	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIC DATE
F 353	record review and r the facility failed to manner to maintain residents (Residen needed extensive a with toileting/persor 2. Cross refer F314 record review and r the facility failed to pressure ulcers dry 6 residents (Reside risk for pressure ulc On 8/30/15 at 8:151 interview they had I lately and sometime supposed to be wo nursing schedule h changed and there schedules floating a On 8/30/15 at 8:251 conducted with Res (RP). The RP state 8/24/15 around 5:3 totally soaked " up top of her was wet bowel movement a stated later one of t short staffed. On 8/31/15 at 12:3 conducted with Nur 8/27/15 there were day shift. The Nurs did not get changed get turned and report	 2. Based on observations, resident and staff interviews provide incontinence care in a n personal hygiene for 3 of 6 t #89, #8 and #45) who assistance to total assistance nal hygiene. 4. Based on observations, resident and staff interviews keep residents at risk for v and use barrier cream for 2 of ent #89 and Resident #8) at cers. PM Nurse #8 stated in an had trouble with the schedule es they were not sure who was rking. The Nurse stated a ad been posted but then was were several different 	F 35		th in the following following plan of he center's e. All alleged been or will be indicated. ected resident: led incontinent laced on the bed continent care and the bed on 9/1/15 ided incontinent laced on the bed continent care and the bed on 9/1/15 ided incontinent laced on the bed he remaining shifts 8/31/15) were equate staff .N.A¿s) was of Nursing. dents identified as ffected: DON reviewed the or developing the sed nurses and stematic approach and staff was ner of the days work.	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED	
					(C	
		345002	B. WING			01/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
CYPRES	S POINTE REHABILI	TATION CENTER		2006 S 16TH STREET WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 353	Continued From pa	ige 23	F 3	53			
	done. The Nurse st job because the NA ready in time for the they should have 8 stated the next day they only had 3 NAs Administrator state NAs were schedule On 8/31/15 at 8:30 conducted with the of Nursing (DON). the staff to round on every 2 hours and r wetters. The Admin as quickly as possil nurses and NAs in Administrator state extra and have offe come in to work ext the DON did the nu working closely with staffing. The Admin used temporary sta had issues with trai On 8/31/15 at 2:26f an interview that on day shift and the 2 to work on the floor day supervisor and out and assisted the cared for. On 8/31/15 at 2:36f interview she tried to residents twice duri sometimes only cha	ated therapy could not do their As could not get the residents eir therapy. The Nurse stated NAs on day shift. The Nurse she told the Administrator is scheduled to work and the d she was not aware only 3 ed to work. AM an interview was Administrator and the Director The DON stated she expected in incontinent residents at least more often for the heavy istrator stated she was hiring ble and had hired a total of 12 the past month. The d she has had people come in ered bonuses to people who tra. The Administrator stated insig schedule and was in her to ensure adequate istrator stated she had not off because in the past she has ning of temporary staff. PM the Administrator stated in a 8/27/15 there were 3 NAs on restorative aides were pulled the Director of Nursing went e staff so the residents were PM NA #4 stated in an to change incontinent ing the day shift but anged them once because she	Γ 3	 approving and denying F request, scheduling for of vacancies in the schedul minimal staffing coverag Administrator worked wit Nursing to schedule a N Meeting on 9/10/15 to re and scheduling procedur Nursing Staff Meeting w 9/24/15 and 9/25/15 to re processes and updates. were also in-serviced into needed. The Administrator will co budgeted hours for licen and C.N.A. to an employ determine vacant positio 3.) Systemic Change A 6-week schedule (beg date of September 3) wa the licensed nurses and DON on 8/17/15. The sc posted in a (glassed in) of the staff break-room for The Nursing Supervisor, Development Coordinato Resource Manager were any staff vacancies in the schedule. The DON will a daily basis with the Nu and or SDC to ensure st adequate. The Director of Nursing 	eensus, filling le, and required e. The th the Director of ursing Staff view the staffing res. Another vas held on eview scheduling Nursing Staff lividually as mpare the current sed nursing staff ree list to ns. inning with a start as developed for C.N.A's by the hedule was case located in easy viewing. Staff or, and Human e designated to fill e 6-week verify staffing on rsing Supervisor affing is held a staff		
	On 8/31/15 at 2:36 interview she tried to residents twice duri sometimes only cha was so busy bathin have time. The NA change incontinent	to change incontinent ing the day shift but		a daily basis with the Nu and or SDC to ensure st adequate.	rsing Supervisor affing is held a staff irses and C.N.A's or attended) to or requesting		

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345002		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY		
		A. BUILDING			COMPLETED		
		B. WING			09/01/2015		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI			
CYPRESS POINTE REHABILITATION CENTER				2006 S 16TH STREET WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 353	Continued From pa	ge 24	F 3	53			
	³ Continued From page 24 residents to bathe. The NA stated she usually had between 11 and 15 residents on day shift and most of them were incontinent. The NA stated she had not changed some residents since she gave them a bath between 9AM and 10AM that morning. On 9/1/15 at 7:40AM Nurse #3 stated in an interview they used to have 5 NAs on night shift then went down to 4 and then 3 and sometimes 2. The Nurse stated this was partly due to call ins, no shows and staff leaving. The Nurse stated the staff were fed up with working short of help and some had left. On 9/1/15 at 7:50AM Restorative Aide#1 stated in an interview when she was pulled to staff on the floor she could not do her restorative residents. The Restorative Aide stated they did range of motion, checked for skin issues and applied splints, assisted residents with exercises on the Nu Step machine, some would ambulate and some would do lower extremity exercises with weights, assisted residents with balancing exercises on the parallel bars, some residents would do bean bag toss and sit to stand exercises on the parallel bars. The Restorative Aide provided a list of 28 residents on restorative Aide provided a list of 28 residents on restorative and stated due to staffing on the floor these residents did not receive restorative services on 8/23/15, 8/24/15, 8/27/15 or 8/28/15. The Nurse in charge of the Restorative NAs stated in an interview on 9/1/15 at 9:49AM restorative services were provided 6 days a week and when the restorative aides were pulled to the floor the restorative duties did not get done for the day and were adjusted for another day. The Restorative NA's worksheet was reviewed with the nurse showing restorative was not done for 4			 and minimal staff coverage were also re-educated reprocedure for staying over arrives. The following strategies wimplemented to recruit lic and C.N.A's: 1) Contracts staffing agencies were init Vacancies will be posted and 3) Vacancies will be posted and 3) Vacancies will be plocal newspaper. 4.) Monitoring of the charr system compliance ongoin The Administrator will aud schedules weekly for 12 v appropriate staffing. The Quality Assurance Cord discuss and review the ree Nurse staffing and sched monthly for a minimum of Suggestions and recomm made as needed by the Committee to ensure consustained ongoing. 	garding the er until coverage ensed nurses s with Interim itiated, 2) on INDEED.com costed in the nge to sustain ing: dit staffing and weeks to verify committee will esults of the ule audits f three months. nendations will be Quality Assurance	e	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OME												
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED					
345002			B. WING				C 09/01/2015					
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE									
CYPRES	S POINTE REHABILI	TATION CENTER	2006 S 16TH STREET WILMINGTON, NC 28401									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE				
F 353	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 3	53								

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