DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	· /	SURVEY PLETED
		345002	B. WING				C / <b>25/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE		
0/000000				2	2006 SOUTH 16TH STREET		
CIPRESS		JN CENTER			WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)( §483.10(a) Resident I The resident has a rig self-determination, ar access to persons an outside the facility, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenance her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The face access to quality care severity of condition, must establish and m practices regarding tr provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The face	cise of Rights (2)(b)(1)(2) Rights. that to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. clility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her i the facility and as a citizen ted States. clility must ensure that the		550	DEFICIENCY)	IATE	6/13/18
		his or her rights without a, discrimination, or reprisal					
	free of interference, c reprisal from the facili	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed

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.

06/08/2018

						M APPROVE <u>     0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COM	E SURVEY PLETED C
		345002	B. WING			/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CVDDESS	POINTE REHABILITATI			2006 SOUTH 16TH STREET		
CIPRESS		ONCENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 550	Continued From page	<b>a</b> 1	F 55			
1 000			F 550			
		rights as required under this				
	subpart.	F is makened as and damaged				
		Γ is not met as evidenced				
	by:	n record review and			nlon of	
		on, record review and		Preparation and execution of this correction, does not constitute ad		
		erviews the facility failed to s assisted to the bathroom				
		the resident to experience		or agreement of the alleged facts fourth in this statement of deficier		
		ack of dignity for 1 of 1		plan of correction is prepared and	•	
		t 15). Findings included:		executed due to Federal and Stat		
		F 15). Findings included.			le	
	Review of the quarter	rly Minimum Data Set (MDS)		requirements.		
		aled Resident #15 was				
		y on 10/09/17 and had		F550		
	diagnoses of hyperte			1. Resident #15 was provided wit	h	
		at #15 was cognitively intact		incontinent care as well as a show		
		ed assistance of one person		5/21/2018. There were no negativ		
		et use. Resident #15 was		outcomes as a result of this defici		
	occasionally incontin			2. Root cause: The staff failed to	•	
				the resident to the restroom in tim		
	Review of the information	ation provided to the nursing		manner due to her transfer status		
		care of each resident (Care		being clear amongst staff member		
		on 05/21/18 Resident #15		time that elapsed during the valid		
	· ·	ssistance of one person for		transfer status caused the resider		
		eeded the limited assistance		have an episode of incontinence.	An	
	of one person for trar			audit was conducted on other res		
				residing in the facility on 5-22-201	18	
		05/21/18 at 8:40 AM the call		through 5-25-2018 and no reside	nts were	
		of Resident #15's room was		found to be soiled.		
	· ·	ember walked past the room		3. The DON/designee will conduc		
		ng the light. Two female staff		re-education with nursing staff by		
		e end of the hallway speaking		6/13/2018 on providing timely		
		ht was lit up on the panel at		incontinence care and accessing		
		nd the alarm was sounding.		resident transfer status. Audits wi		
		ere at the nurse's station.		conducted 3 times a week on pro	-	
		ting on the bed with her legs		timely incontinence care for 12 w		
		of the bed. The head of the		4. The QA team will review, analy	ze and	
		d she was leaning against		report the results at the monthly		
	the mattress in an aw	kward appearing position.		performance improvement comm	ittee	

Facility ID: 923267

	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	E SURVEY IPLETED
			A. BUILDING			С
		345002	B. WING		0	5/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		5/25/2010
				2006 SOUTH 16TH STREET		
CYPRESS	POINTE REHABILITATI	ON CENTER		WILMINGTON, NC 28401		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE
F 550	Continued From pag	e 2	F 55	50		
		earing a brief. She indicated		meetings to validate complia	nce is	
		he bathroom but could not get		achieved and sustained. Sub		
		own to get to the bathroom.		plans of correction will be imp		
		Nurse entered Resident		deemed necessary/appropria		
	#15's room and was	told by the resident that she		committee.		
		athroom. At 8:50 AM the				
		oom after informing Resident				
		ng to check on how the				
		rred. At 8:53 AM the MDS				
		the room with some linens.				
		Nurse left the room after				
		nt #15 that a resident from vas now in the adjoining				
		ne (Resident #15) would				
		he bathroom. The MDS				
		dent #15 the aide that was				
		next door had been told to let				
		bathroom was available for				
		At 9:06 AM the Speech				
	Therapist (ST) came	to Resident #15's room.				
	She indicated Reside	ent #15 had a mild stroke				
		ays prior but was recovering				
		the Rehabilitation Aide (RA)				
		5's room. She indicated she				
	•	Resident #15 that day but				
		taff member (she was unable				
		see if the resident needed				
		sferring to the bathroom. The allable for Resident #15 to				
		RA left Resident #15's room				
		d out how the resident				
	-	AM the Rehabilitation				
		esident #15's room. She				
	informed Resident #					
		5/16/18) had changed her				
		vo person mechanical lift				
		recent stroke and that the				
	lift could not be used	to take her into the				

Facility ID: 923267

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. (X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPL	
					с	
		345002	B. WING			5/2018
NAME OF PF	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CC	DE	
				2006 SOUTH 16TH STREET		
CIPRE33	POINTE REHABILITATI	ON CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION			(X5) COMPLETIO DATE
F 550	Continued From page	e 3	F 55	50		
		athroom. The Rehabilitation	F 50			
		at Resident #15 would				
		omfortable with the PT she				
		he was sent for. Resident				
	#15 indicated that sh	e had not been transferred				
	to the bathroom using	g the mechanical lift and did				
i t c k		cause she was afraid it would				
		0 AM Resident #15 indicated				
		wet herself because she				
	-	it. She stated at first it				
		he wet herself but now she				
		se it always took staff a long she was used to it. At 9:28				
		Resident #15's room with a				
		assisted to sit on the edge of				
	the bed in preparatio	<b>u</b>				
		indicated that the nursing				
	staff was supposed to	o use the mechanical lift for				
		e therapists could transfer				
	-	a walker. Resident #15 was				
		the bathroom so the PT				
		er into the wheelchair and				
		er room where she could be ver chair and placed over the				
		was assisted to stand in				
		fer to the wheelchair. The				
	· ·	s noted to be saturated with				
		Resident #15 wore appeared				
		urine. There was a fabric				
	lined, plastic backed,	incontinence pad over a				
	folded in quarters bar	th blanket on top of the				
		ath blanket and incontinence				
		ted with urine. The bottom				
		he shoulder area to the				
	-	Rehabilitation Director				
		ed linens and rivulets of urine				
		attress. A strong smell of				
1	LIRING WAS NOTED OF TO	e time the linens were				

Facility ID: 923267

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	
		345002	B. WING				_ 25/2018
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS		ON CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	acceptable that Resid condition. At 9:36 AM the shower room whe assistance of three st 9:39 AM the saturated Resident #15 was plat the toilet to use the ba was removed Resident to be red but there wa #15 stated her buttoch had laid in urine for so continuous observation offer of a bedpan or to to see if incontinence while her transfer stat In an interview on 05/ Assistant (NA) #1 ind Resident #15 at approf looking at the front of on the moisture indica change in color to ind been incontinent of un Resident #15 she won NA #1 stated Resident was wet when she se indicated she had use Resident #15 out of b In an interview on 05/ 10:35 AM the Director the care guides for ea computer. She stated access to the information	er and stated it was not lent #15 was found in that A Resident #15 was taken to aff members to stand. At d brief was removed and uced in a shower chair over athroom. When the brief nt #15's buttocks were noted as no breakdown. Resident ks were red because she o long. Throughout the on there had never been any o check Resident #15's brief care could be provided tus was being established. 21/18 at 10:28 AM Nursing icated she had checked oximately 7:30 AM by the brief for a color change ator line. There was no icate that Resident #15 had rine. She indicated she fed mate her breakfast and told uld be back to provide care. at #15 did not tell her she rved her breakfast. She ed the mechanical lift to get	F	550			

Facility ID: 923267

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345002	B. WING				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS	POINTE REHABILITATIO	ON CENTER			006 SOUTH 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	In an interview on 05/ Occupational Therapi staff was supposed to transfer Resident #15 In an interview on 05/ Nurse stated that a lo discussed about Resident meetings. She indicat discussion that Resident appropriate for therapi discussion about the was not aware Resident transfers. She indicat Coordinator were resident transfers. She indicat care guides but since was in process Resident care guide had not yee In an interview on 05/ stated the PT had infor Resident #15 needed transfers. She indicated the PT had informed Resident #15 needed transfers. She indicated the MDS N In an interview on 05/ stated he had informed Resident #15 required transfers by nursing stated In an interview on 05/ stated he had informed Resident #15 required transfers by nursing stated the fresident being saturation indicated the facility w best for Resident #15 stated Residen	<ul> <li>22/18 at 9:51 AM the st (OT) stated the nursing o use a mechanical lift to 5.</li> <li>224/18 at 5:18 PM the MDS to of things had been ident #15 in clinical ated she remembered a ent #15 may or may not be by but did not remember any use of a mechanical lift so ent #15 needed one for ted she and the MDS ponsible for updating the a significant change MDS ent #15's care plans and et been updated.</li> <li>25/18 at 10:05 AM Nurse #4 formed her on 05/16/18 that urse to do.</li> <li>25/18 at 11:45 AM the PT ed Nurse #4 on 05/16/18 that d a mechanical lift for</li> </ul>	F	550			

Facility ID: 923267

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/03/2018 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345002	B. WING		_		C 25/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CYPRESS	POINTE REHABILITATIO	DN CENTER		2006 SOUTH 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550 F 584 SS=D	readily available to the In an interview on 05/ stated she expected t information to be on th to know how to access stated she expected r dignity and that it sho to figure out how Ress could be taken to the resident's mental hea and no resident shoul were not being cared Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-( §483.10(i) Safe Envire The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, of homelike environmen use his or her persona possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall ex the protection of the ri- or theft.	transfer information to be e staff. 25/18 at 2:05 PM the DON he correct transfer he care guide and for staff s the information The DON esidents to be treated with uld not have taken so long ident #15 transferred so she bathroom. She indicated a lth should be maintained d be made to feel that they for. ble/Homelike Environment 7) onment. th to a safe, clean, elike environment, including iving treatment and g safely. ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can ices safely and that the facility maximizes resident us not pose a safety risk. kercise reasonable care for esident's property from loss	F 55	0			6/13/18
		eeping and maintenance maintain a sanitary, orderly,					

	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/03/2018 RM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED C
		345002	B. WING		o	5/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
CYPRESS	POINTE REHABILITATI	ON CENTER		2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 584	Continued From page and comfortable inter	ior;	F 5	84		
	§483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private	ed and bath linens that are				
	resident room, as spe	ecified in §483.90 (e)(2)(iv); ite and comfortable lighting				
	levels. Facilities initia	table and safe temperature Ily certified after October 1, a temperature range of 71 to				
	sound levels.	maintenance of comfortable				
Based on record revia clean living areas obse floor in a re in the bath Findings in	record review, the fac clean living environm areas observed that h floor in a resident's ro	n, staff interviews and cility failed to maintain a ent for 2 of 12 resident nad visible feces dried on the bom (#20B) and on the wall een rooms (#4 and #6).		F584 1. Room 20 and the barroom 4 and 6 were clear upon notification during were no negative outco this observation. 2. Root Cause: The st	aned appropriately g survey. There omes as a result of	
	Findings included: During the initial tour	of the facility on 05/20/18 at		any feces on the floor i the bathroom between housekeeping staff and	in room 20 and in in room 4 and 6. The	
	size areas of dried fe	latex gloves and two quarter ces were observed on the nt's bed in Room 20B.		aware of the cleaning t fluids. An audit was co facility housekeeping n notification, there were	nducted by the nanager following	
	11:15 AM she stated assigned to Room 20 had been employed a	lurse #7 on 05/20/18 at that she was the nurse IB. She reported that she at the facility for one week. ssed by herself and the		3. The Housekeeping I will conduct re-educati regarding maintaining environment by 6/11/20 be educated on checki	Manager/Designee on to staff a sanitary 018. Staff will also	

Event ID: LHZB11

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STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /	PLE CONSTRUCTION	(X3) DAT	IO. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED
		345002	B. WING		0	C 5/25/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 -	
CYPRESS	POINTE REHABILITATI	ON CENTER		2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 584	Housekeeping Direct she would use bleach feces and then ask he floor. The Housekee was the responsibility initial spillage and the responsibility was to that he would not hav on the floor of a resid said it should have be first rounds after brea follow up observation the dried stool had be and the trash remove An additional observa splattered on the wall resident rooms #4 an on initial tour. The fe the wall at 2:30 PM o was shown to the Ho 05/23/18 who stated up earlier either by nu summoned a housek feces off the wall. Record review of the company policy revea furniture that is conta quantities of blood or referred to nursing pe for decontamination a employees are only t	or. Nurse #7 reported that n wipes to clean up the dried ousekeeping to disinfect the ping Manager stated that it y of nursing to clean up the en housekeeping's disinfect the area. He stated ye expected feces to be dried lent's room at 11:00 AM. He een seen and cleaned on the akfast by housekeeping. A that 1:30 PM revealed that een cleaned from the floor ed. ation of dried feces I in the bathroom between of #6 was made on 05/20/18 ces was again observed on n 05/23/18 (3 days later). It usekeeping Director on it should have been cleaned ursing or housekeeping. He eeper who cleaned the contracted housekeeping aled: "Any equipment or minated with visibly large other bodily fluids will be ersonnel of the client facility and will not be handled by usekeeping company). o clean previously is or small areas requiring	F 5	bathroom areas for cleanliness 6/11/2018. Audits will be cond times a week for 12 weeks to e sanitary environment is mainta resident care areas to include I 4. The QA team will review, ar report the results at the monthil performance improvement com meetings to validate compliance achieved and sustained. Subse plans of correction will be imple deemed necessary/appropriate committee.	ucted 3 ensure a ined on pathroom. halyze and y mittee ere is equent emented as	
		ne Housekeeping Director on e stated that housekeeping				

Facility ID: 923267

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345002	B. WING				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS	POINTE REHABILITATIO	ON CENTER			006 SOUTH 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	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	cleaning the common trays were still on the came off the floor he rounds that included a and checking soaps a next step included go and wiping down hori behind furniture, clea mopping floors. He s after lunch for additio stated that this was th cleaning. He said the was also used when be deep cleaned. In an interview with C she stated that if she would have cleaned if and had called house area. She said the ai housekeeping would Interview with the Dirn at 3:15 PM she said if soon as feces was se cleaned up. She said clean the area first wi housekeeping closet to disinfect the area. housekeeping staff an supply room with disi	M each day and started areas because breakfast hallways. After the trays said staff began room sweeping, emptying trash, and paper towel needs. The ing back through the rooms zontal surfaces, sweeping ning bathrooms, and aid the rooms were revisited nal cleaning if needed. He to 5 step method of 2 7 step method of 2 7 step method of cleaning rooms where scheduled to 2 NA #12 on 05/23/18 at 3:05 saw feces on the floor she t up with a towel and water keeping to disinfect the des had to remove it before	F	584			
F 600 SS=D	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F6	600			6/13/18
	§483.12 Freedom fro	m Abuse, Neglect, and					

Facility ID: 923267

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	-	ND HUMAN SERVICES MEDICAID SERVICES			F	ITED: 07/03/2018 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		OATE SURVEY OMPLETED
		345002	B. WING			C 05/25/2018
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STA	TE, ZIP CODE	
CYPRESS	POINTE REHABILITATI	ON CENTER		2006 SOUTH 16TH STREET WILMINGTON, NC 28401	I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 600	neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(1) Not us physical abuse, corpo- involuntary seclusion This REQUIREMENT by: Based on observatio resident and staff inte- have the correct trans- to staff causing a 59 of 1 residents (Reside Review of the quarter dated 03/16/18 revea admitted to the facility diagnoses of hyperte depression. Residen and needed the limite for transfers and toile Review of the 05/01/ Therapy and Occupa revealed no mention mechanical lift to trans staff that directed the Guide) revealed that	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and nical restraint not required to edical symptoms. ty must- e verbal, mental, sexual, or oral punishment, or ; F is not met as evidenced on, record review and erviews the facility failed to sfer information accessible minute delay in toileting for 1 ent # 15). Findings included: rly Minimum Data Set (MDS) aled Resident #15 was y on 10/09/17 and had nsion, diabetes, and it #15 was cognitively intact ed assistance of one person et use. 18-05/20/18 Physical tional Therapy notes that nursing was to use a	F 6	F600 1. Resident #15 was incontinent care as y 5/21/2018. There we outcomes as a resul 2. Root cause: The communicate effective the resident's transfer plan of care could be that elapsed during residents transfer st resident to have an incontinence. The te updated while trying transfer resulted in a episode. An audit we other residents in the transfer status was a similar findings 3. The NHA/Designer re-education with nu 6/11/2018 regarding	well as a shower on ere no negative It of this deficiency facility staff did not ively on the change in er status so that her e updated. The time verification of atus caused the episode of ransfer status was to conversation to an incontinent vas conducted on all e facility to ensure correct, there were no	

Event ID: LHZB11

Facility ID: 923267

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S	. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPL	ETED
						)
		345002	B. WING		05/2	25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CVDDESS	POINTE REHABILITATI	ON CENTER		2006 SOUTH 16TH STREET		
OTFICEO		ONCENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From pag	e 11	F 60	00		
		eeded the limited assistance	1.00	educated on how to acces	s the kardex for	
	of one person for trai			transfer status by 6/11/20		
	In an observation on 05/21/18 at 8:40 AM the call			was educated also on upd		
				care for any changes. Auc		
	light above the door of Resident #15's room was			conducted 3 times a week	on providing	
	lit up. A male staff member walked past the room			timely incontinence care a		
		ng the light. Two female staff		transfer status in followed		
		e end of the hallway speaking		the plan of care for 12 wee		
		ht was lit up on the panel at nd the alarm was sounding.		4. The QA team will review report the results at the me		
		ere at the nurse's station.		performance improvement	-	
		ting on the bed with her legs		meetings to validate comp		
		of the bed. The head of the		achieved and sustained. S		
		d she was leaning against		plans of correction will be	-	
		vkward appearing position.		deemed necessary/approp	-	
		earing a brief. She indicated		committee.	-	
		e bathroom but could not get				
		own to get to the bathroom.				
		Nurse, who had been				
		iff member at the end of the				
		nt #15's room. She had a				
		ith Resident #15 and was nat she needed to use the				
	•	M the MDS Nurse left the				
		Resident #15 that she was				
	going to check on ho					
		AM the MDS Nurse came				
	back to the room with	n some linens and had				
		vith Resident #15. At 8:59				
		eft the room after explaining				
		a resident from the room				
		the adjoining bathroom				
	-	at she would need to wait to he MDS Nurse informed				
		e wanted to provide care at				
		as in the bathroom and that				
		Id to let staff know when the				
	Datili Uulli was avalla	ble for Resident #15's use.				

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	l` '	G	COMPLETED		
			A. DOILDING	5		С	
		345002	B. WING		0	5/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/20/2010	
				2006 SOUTH 16TH STREET			
CYPRESS	POINTE REHABILITATI	ON CENTER		WILMINGTON, NC 28401			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO		(X5) COMPLETIO	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	DATE	
F 600	Continued From page	e 12	F 60	00			
	Resident #15's room	She indicated Resident					
		e approximately five days					
		ing quickly. At 9:10 AM the					
	Rehabilitation Aide (F	RA) came to Resident #15's					
	room. She indicated	she was not assigned to					
		y but had been told by a staff					
		able to remember who) to					
	see if the resident ne						
	-	throom. The resident who					
		had been taken back to her					
	room and the bathroo						
		At 9:11 AM the RA left					
		stating she would find out					
		sferred. At 9:14 AM the					
		or came into Resident #15's					
		Resident #15 that the					
		PT) had changed her transfer					
		n mechanical lift transfer stroke and that the lift could					
	U U	er into the bathroom in her					
		The Rehabilitation Director					
		nt #15 would probably feel					
		h the PT she was familiar					
		for. At 9:20 AM Resident					
		e had already wet herself					
		o longer hold it. She stated					
		when she wet herself but					
		it because it always took					
		elp her and she was used to					
	-	came to Resident #15's					
	room with a walker a	nd she was assisted to sit on					
	the edge of the bed in	n preparation for transfer into					
	a wheelchair. The P	T indicated that the nursing					
		o use the mechanical lift for					
		e therapists could transfer					
		walker. Resident #15 was					
		the bathroom so the PT					
	decided to transfer he	er into the wheelchair and					
		er room where she could be					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FOR	D: 07/03/2018 MAPPROVEI D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE SURVEY COMPLETED	
		345002	B. WING			-		C / <b>25/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STA	ATE, ZIP CODE	•	
CYPRESS	POINTE REHABILITATI	ON CENTER			2006 SOUTH 16TH STREET			
					WILMINGTON, NC 2840			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD E ICED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 13	F	60	0			
		er chair and placed over the						
		was assisted to stand in						
		er to the wheelchair. The s noted to be saturated with						
	-	Resident #15 wore appeared						
		urine. There was a fabric						
	-	incontinence pad over a						
	•	h blanket on top of the ath blanket and incontinence						
		ited with urine. The bottom						
		he shoulder area to the						
	•	Rehabilitation Director						
		ed linens and rivulets of urine attress. A strong smell of						
		e time the linens were						
	exposed. The Rehat	pilitation Director offered						
		er and stated it was not						
		dent #15 was found in that A Resident #15 was taken to						
	the shower room whe							
		taff members to stand. At						
		d brief was removed and						
	-	aced in a shower chair over						
		athroom. When the brief nt #15's buttocks were noted						
		as no breakdown. Resident						
	#15 stated her buttoo	ks were red because she						
		o long. Throughout the						
		on there had never been any						
		o check Resident #15's brief care could be provided						
		tus was being established.						
		/21/18 at 10:28 AM Nursing						
		licated she had checked oximately 7:30 AM by						
		the brief for a color change						
	•	ator line. There was no						
	change in color to inc	licate that Resident #15 had						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345002	B. WING				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS		DN CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #15's room Resident #15 she wor NA #1 stated Resider was wet when she se In an interview on 05/ 10:35 AM the Director the care guides for ea computer. She indica copies in resident clos nurse's desks. She s had access to the info going into the comput residents. In an interview on 05/ Occupational Therapi therapists could trans using a walker. She i was supposed to use transfers. In an interview on 05/ Rehabilitation Directo ask the PT how to tra indicated the PT was resident so she came She indicated Reside stroke recently and th was underway. She se evaluation was done a mechanical lift should Rehabilitation Directo mechanical lift was di meeting which the MI	rine. She indicated she fed mate her breakfast and told uld be back to provide care. In #15 did not tell her she rved her breakfast. 21/18 at approximately r of Nursing (DON) stated ach resident were only in the ated there were no printed sets or in binders at the tated the nursing staff all ormation and should be ter to see how to care for the 22/18 at 9:51 AM the st (OT) stated only the fer Resident #15 out of bed indicated the nursing staff a mechanical lift for 22/18 at 10:43 AM the r stated the RA had come to nsfer Resident #15. She working with another to Resident #15's room. In #15 had experienced a lat a significant change MDS stated a physical therapy and it was decided a I be used for transfers. The r stated the change to a scussed in a clinical DS Nurse attended. She nge to a mechanical lift for ng staff had not been	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345002	B. WING				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
CYPRESS	POINTE REHABILITATIO	ON CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	BE ATE	(X5) COMPLETION DATE			
F 600	facility Nurse Consult Resident #15's transf clinical meeting that t She stated the MDS I the care guide to sho now needed for trans In an interview on 05/ stated the only way s a resident was if she could ask the nurse. care guides to look at recorded a resident's would put down how but there was nothing resident should be transformed to the transformed as the statement In an interview on 05/	<ul> <li>(22/18 at 10:53 AM the ant stated the change in er status was discussed in a he MDS Nurse attended.</li> <li>Nurse should have updated w that a mechanical lift was fers.</li> <li>(22/18 at 2:30 PM NA #2 he knew how to take care of already knew them or she She indicated there were no to the care of daily living she she transferred a resident of that told her how the ansferred.</li> <li>(22/18 at 3:03 PM NA #3 the information on how</li> </ul>	F	600	0		
	stated she was an ag third time at the facilit guides for residents h In an interview on 05/ stated she was an ag facility about three tin indicated there was a	book at the nurse's desk n how to care for each					
	stated she was a staf	23/18 at 6:20 AM NA #6 f aide and had worked in the hs. She indicated if she did					

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 07/03/2018 FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	) MULTIPLE CONSTRUCTION BUILDING			) DATE SURVEY COMPLETED
		345002	B. WING				C 05/25/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS	POINTE REHABILITATI	ON CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 600	Continued From page	e 16	E E	600			
1 000		e for a resident she would		000	0		
		stated that before she was					
		y she did not know the					
	the computer.	o care for residents was in					
	In an interview on 05	i/23/18 at 6:42 AM NA #7					
		ted in the computer and					
	could go there to find transfer a resident.	the information on how to					
		/24/18 at 12:50 PM the or stated when a therapist					
	documented a reside	•					
		something different to each					
		ated that in Resident #15's nat the nursing staff needed					
		lift for transfers. She					
	indicated the need for	or a mechanical lift was					
		al meeting and the MDS					
		eting. The Rehabilitation are guide should have been					
		nt #15's new transfer needs.					
		It there was a problem with					
	verbai communicatio	n between disciplines.					
	In an interview on 05	/24/18 at 3:14 PM Nurse #3					
		days ago she did not know					
		eded a mechanical lift for ing staff. She indicated that					
	-	d by an aide how to transfer					
	Resident #15 she wo	ould have told them that two					
	people were necessa lift was needed.	ary but not that a mechanical					
		24/18 at 5:18 PM the MDS					
	Nurse stated that a lo discussed about Res	-					
		ated she remembered a					
	-	coloto Event ID: LUZ	1				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/03/2018 / APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345002	B. WING					C 25/2018
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CO	DDE		
CYPRESS	POINTE REHABILITATIO	ON CENTER			006 SOUTH 16TH STREET VILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 600	appropriate for therap discussion about the was not aware Reside transfers. She indica Coordinator were resp care guides but since was in process Resid care guide had not yet In an interview on 05/ stated the PT had info Resident #15 needed transfers. She indicat aide who should have in report. She indicat have put the informat told the oncoming nur had done that. She in problem with commun #4 stated she did not that was up to the ME In an interview on 05/ stated he had informe Resident #15 required transfers by nursing s In an interview on 05/ Administrator stated t resident being saturat indicated the facility w best for Resident #15 s that long for transfer a current transfer inform to the staff.	ent #15 may or may not be by but did not remember any use of a mechanical lift so ent #15 needed one for ted she and the MDS bonsible for updating the a significant change MDS ent #15's care plans and t been updated. 25/18 at 10:05 AM Nurse #4 ormed her on 05/16/18 that a mechanical lift for ted she would have told the e passed the information on ed she thought she would ion on the shift report and se but was not sure if she ndicated there was a big nication in the facility. Nurse update the care guide as 05 Nurse to do. 25/18 at 11:45 AM the PT ed Nurse #4 on 05/16/18 that d a mechanical lift for taff. 25/18 at 12:15 PM the he delay in transfer and the red was not intentional. She vas trying to do what was to keep her safe. She should not have had to wait	F	600				

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/03/207 FORM APPROVE OMB NO: 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345002	B. WING		C 05/25/2018
NAME OF PF	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
CYPRESS	POINTE REHABILITATI	ON CENTER		006 SOUTH 16TH STREET	
			I	VILMINGTON, NC 28401 PROVIDER'S PLAN OF CORRECTION	(175)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 600	Continued From page	e 18	F 600		
	stated she had found	Resident #15 saturated			
		cover her assignment. She			
	indicated she had inf DON. NA #8 stated t communication in the				
	la en interview en OF	125/40 at 2:05 DM the DON			
	stated she expected	/25/18 at 2:05 PM the DON the correct transfer			
		the care guide and for staff			
		ss the information. She			
		ed the care guide to be y and for there to be better			
		een therapy and nursing.			
		expected residents to be			
		nd that it should not have			
		e out how Resident #15 cated a resident's mental			
		ntained and no resident			
		el that they were not being			
		d that no resident should nd that the facility was trying			
	to do what was safes				
F 658		eet Professional Standards	F 658		6/13/18
SS=D	CFR(s): 483.21(b)(3)	(i)			
	§483.21(b)(3) Compr	ehensive Care Plans			
	The services provide	d or arranged by the facility,			
		mprehensive care plan,			
	must- (i) Meet professional	standards of quality.			
		Γ is not met as evidenced			
	by:	and an interview of the form		5050	
		ons, record review and staff / failed to assess a resident		F658 1. Resident #56 was assessed by Nurse	<b>_</b>
		had a change in condition		#4 and findings were provided to the	-
	and was admitted to	-		mid-level provider a order was obtained	to
	residents observed.			transfer resident #56 to the emergency	
				room for further evaluation 5/22/2018.	

Event ID: LHZB11

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/03/2018 MAPPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345002	B. WING	B. WING			C <b>25/2018</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS	POINTE REHABILITATI			2	006 SOUTH 16TH STREET		
OTT REDU		on olivien		N	VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 658	Continued From page	e 19	F	658			
	Findings included:		•	000	2. Root Cause: Nurse #4 had provided	4	
					care to resident #56 during the mornin		
	Resident #56 was ad	mitted to the facility on			and was going to assess the resident		
		s included, in part, dementia,			her afternoon medication pass. The		
		ety, chronic cystitis without			nurse reports that she should have		
	and difficulty walking	he urine), muscle weakness			assessed the resident sooner. Assessment were completed by facili	t.,	
	and unifically waiking				RN's on 5/24/2018 on current residen		
	The Minimum Data S	set (MDS) 30-day quarterly			there was no similar findings noted.	,	
	assessment revealed	Resident #56 was			3. Nurse #4 was educated on 5/22/20	18	
		here were no moods or			on timely assessment and notification	the	
		Resident #56 required th one staff assist with bed			MD/RP on change of condition by the		
	mobility, transfers, ea				DON. The DON/Designee will conduct re-education on change in condition to		
		staff assist with locomotion			licensed nurses by 6/11/18. Audits wil		
	-	assist with one staff assist			conducted 3 times a week for 12 weel		
	÷ .	rsonal hygiene. Resident			ensure change in condition and timely		
	#56 was always cont	inent of bowel and bladder.			assessments are completed		
	An interview with Res	sident #56 on 05/20/18 at			appropriately. 4. The QA team will review, analyze a	nd	
		alert and pleasant resident.			report the results at the monthly	i i di	
	Resident #56 was pro	-			performance improvement committee		
	wheelchair.				meetings to validate compliance is		
					achieved and sustained. Subsequent		
		sident #56 on 05/21/18 at			plans of correction will be implemente		
		e resident was out of bed, ng herself in her wheelchair.			deemed necessary/appropriate by this committee.	5	
		ig horoch in her wheelendir.					
	An observation of Re	sident #56 on 05/21/18 at					
		ne resident was out of bed					
	and propelling her- se	elf in her wheelchair.					
	An interview with Res	sident #56 on 05/21/18 at					
		cted. Resident #56 stated					
	she was doing fine a	nd had breakfast and lunch.					
	An observation of Re	sident #56 on 05/22/18 at					
		e resident was lying in bed					
		sleeping. The resident was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF		
		345002	B. WING				25/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
CYPRESS	POINTE REHABILITATIO	ON CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD					
F 658	not dressed and there her room. An observation of Re 10:00 am revealed th and appeared to be s not dressed. An observation of Re 11:00 am revealed th and appeared to be s not dressed and did r An interview was con 05/22/18 at 11:07 AM resident stated she w was sleepy. Nurse # confused earlier this r of her room in her brid the hall to use a bath she did not take her w assessment, but she (NA) assisted her bac was a new behavior f A review of a nursing 05/22/18 indicted Res temperature of 102 do irregular heart rate of distended abdomen. #56 was sent out to th for further evaluation.	e was no meal tray noted in sident #56 on 05/22/18 at e resident was lying in bed leeping. The resident was sident #56 on 05/22/18 at e resident was lying in bed leeping. The resident was not respond to verbal stimuli. ducted with Nurse #4 on l. Nurse #4 revealed the asn ' t feeling well and she 4 stated the resident was morning when she came out ef and wanted to go down room. Nurse #4 reported vital signs or do an and the nursing assistant ck to bed. Nurse #4 stated it or the resident. progress note dated sident #56 had a egrees Fahrenheit with an 135 beats per minute and a The note indicated Resident the emergency department	F	658				
	05/22/18 at 2:15 PM. the resident this morr 8:30 or 8:45 AM and not feel well. Nurse #	Nurse #4 stated she asked ning if she was okay about the resident stated she did t4 reported the resident got er and took her morning						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 07/03/2018 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mult A. Buildi		(X3) DAT	E SURVEY IPLETED	
		345002	B. WING			0	C 5/25/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				20	06 SOUTH 16TH STREET		
CYPRESS		ON CENTER		w	ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 658	medications and was she was coming out of attempting to wander normal behavior. Nu to assess her when s medication pass at 1: she should have asse presented with the ne she did not feel well t stated she was sent to Department around 1 fever and increased f An interview was con 05/22/18 at 2:20 PM. did not eat breakfast She reported the resi room or her room and every morning and w when she went to ass resident cussed at her resident did not repor her lying in bed, not e cussing at her were m NA #2 stated she rep An interview with the 05/23/18 at 11:30 AM admitted to the hospi Infection (UTI). The p although he felt the d have changed the res history of chronic UTI nurse would have be when the resident ind and exhibited a change behavior. The physi	noted to be confused as of the room in her brief and . She stated this was not rse #4 stated she was going he did her afternoon 00 PM. Nurse #4 stated essed her when she ew behavior and reported his morning. Nurse #4 o the Emergency 2:00 pm on 05/22/18 with a heart rate. ducted with NA #2 on NA #2 reported the resident and that was not her norm. dent usually ate in the dining d would get up and about as talkative. NA #2 stated sist her in the morning, the er. NA #2 stated the t she did not feel well, but eating her breakfast and not typical behaviors for her. orted it to Nurse #4.	F	658			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/03/201 FORM APPROVE OMB NO. 0938-039		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345002	B. WING		C 05/25/2018		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CVDDESS	POINTE REHABILITATI			2006 SOUTH 16TH STREET			
OTTREOO				WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 658	Continued From page	22	F 6	58			
	05/23/18 at 12:45 PM	Nurse Practioner (NP) on I stated that she would have o assess the resident based					
F 677 SS=D	on 05/24/18 at 2:30 F of the nurse would have resident when she pro- condition with her bell feeling well.	Director of Nursing (DON) PM revealed her expectation ave been to assess the esented with a change of navior and complained of not or Dependent Residents	F 6	77	6/13/18		
33-0	§483.24(a)(2) A resid out activities of daily services to maintain of personal and oral hypersonal and ora	ent who is unable to carry living receives the necessary good nutrition, grooming, and giene; is not met as evidenced		F677			
	provide incontinence dependent on staff fo residents (Resident #	r transfer and care for 1 of 1 15). Findings included:		1. Resident #15 was provided with incontinent care as well as a showed 5/21/2018. There were no negative outcomes as a result of this deficient 2. Root Cause: The staff failed to the resident to the restream is time.	ncy assist		
	dated 03/16/18 revea admitted to the facility diagnoses of hyperte depression. Residen	Iy Minimum Data Set (MDS) led Resident #15 was y on 10/09/17 and had nsion, diabetes, and t #15 was cognitively intact ed assistance of one person		the resident to the restroom in time manner due to her transfer status n being clear amongst staff members time that elapsed during the validat transfer status caused the resident have an episode of incontinence. A	ot . The ion of to		
	for transfers and toile occasionally incontine	t use. Resident #15 was ent of bladder.		was conducted on other residents r in the facility on 5-22-2018 through 5-25-2018 and no residents were for	residing		
	Review of the information staff that directed the	ation provided to the nursing		be soiled. 3. The DON/designee will conduct			

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	S FOR MEDICARE &					NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		· · /	TE SURVEY MPLETED		
			A. BUILDING			С		
		345002	B. WING			5/25/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		5/25/2010		
				2006 SOUTH 16TH STREET				
CYPRESS	POINTE REHABILITAT	ION CENTER		WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
F 677	Continued From page	0.02	F 07	-				
1 0//	Continued From pag		F 67		fby			
	,	on 05/21/18 Resident #15 sistance of one person for		re-education with nursing stat 6/11/2018 on providing timely	•			
		needed the limited assistance		incontinence care and access				
	of one person for tra			resident transfer status. Audi	•			
				conducted 3 times a week on	providing			
	In an observation on	05/21/18 at 8:40 AM the call		timely incontinence care for 1	2 weeks.			
		of Resident #15's room was		4. The QA team will review, a				
		nember walked past the room		report the results at the month	•			
		ng the light. Two female staff		performance improvement co				
		e end of the hallway speaking		meetings to validate complian				
		ght was lit up on the panel at nd the alarm was sounding.		achieved and sustained. Sub plans of correction will be imp	•			
		ere at the nurse's station.		deemed necessary/appropria				
		tting on the bed with her legs		committee.				
		of the bed. The head of the						
		id she was leaning against						
	the mattress in an av	wkward appearing position.						
		earing a brief. She indicated						
		ne bathroom but could not get						
		r own to get to the bathroom.						
		Nurse entered Resident						
		told by the resident that she athroom. At 8:50 AM the						
		oom after informing Resident						
		ing to check on how the						
		rred. At 8:53 AM the MDS						
		the room with some linens.						
	At 8:59 AM the MDS	Nurse left the room after						
	explaining to Reside	nt #15 that a resident from						
		vas now in the adjoining						
		he (Resident #15) would						
		he bathroom. The MDS						
		ident #15 the aide that was						
		next door had been told to let bathroom was available for						
		At 9:06 AM the Speech						
		to Resident #15's room.						
	She indicated Resid	ent #15 had a mild stroke						

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	OF DEFICIENCIES					O. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	· · · ·	E SURVEY IPLETED
			A. BUILDIN	IG		<u>_</u>
		345002	B. WING			С
		545002				5/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
CYPRESS	POINTE REHABILITATI	ON CENTER		2006 SOUTH 16TH STREET		
	1			WILMINGTON, NC 28401		1
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIN	AN OF CORRECTION /E ACTION SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		D TO THE APPROPRIATE ICIENCY)	DATE
F 677	Continued From page	e 24	F 6	77		
	· · · · · · · · · · · · · · · · · · ·	the Rehabilitation Aide (RA)				
		5's room. She indicated she				
		Resident #15 that day but				
		taff member (she was unable				
		see if the resident needed				
		ferring to the bathroom. The				
		ailable for Resident #15 to				
		RA left Resident #15's room				
		d out how the resident				
	-	AM the Rehabilitation				
		esident #15's room. She				
	informed Resident #1					
		5/16/18) had changed her				
		vo person mechanical lift				
		recent stroke and that the				
	lift could not be used					
		n because the mechanical lift				
	would not fit in the ba	athroom. The Rehabilitation				
	Director indicated that	at Resident #15 would				
		omfortable with the PT she				
	was familiar with and	he was sent for. Resident				
	#15 indicated that sh	e had not been transferred				
		g the mechanical lift and did				
		cause she was afraid it would				
	injure her leg. At 9:2	0 AM Resident #15 indicated				
		wet herself because she				
	could no longer hold	it. She stated at first it				
	bothered her when sl	he wet herself but now she				
		se it always took staff a long				
	time to help her and	she was used to it. At 9:28				
		Resident #15's room with a				
	walker and she was a	assisted to sit on the edge of				
	the bed in preparatio					
		indicated that the nursing				
		o use the mechanical lift for				
		e therapists could transfer				
	-	a walker. Resident #15 was				
	still requesting to use	e the bathroom so the PT				
		er into the wheelchair and				

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		ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 07/03/2018 DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) D	ATE SURVEY OMPLETED	
		345002	B. WING				C 05/25/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CVDDESS				2006	SOUTH 16TH STREET		
CIPRESS		ON CENTER		WIL	MINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	transferred to a show toilet. Resident #15 v preparation for transfe back of her gown was urine. The brief that I to be saturated with u lined, plastic backed, folded in quarters bat bottom sheet. The ba pad were both satura sheet was wet from the mid-thigh area. The I removed the saturate were noted on the ma urine was noted at the exposed. The Rehat Resident #15 a show acceptable that Resid condition. At 9:36 AM the shower room whe assistance of three st 9:39 AM the saturate Resident #15 was plat the toilet to use the b was removed Reside to be red but there wa #15 stated her buttoc had laid in urine for si continuous observatio offer of a bedpan or to to see if incontinence while her transfer stat In an interview on 050 Assistant (NA) #1 ind Resident #15 at apprilooking at the front of	er room where she could be ver chair and placed over the was assisted to stand in er to the wheelchair. The s noted to be saturated with Resident #15 wore appeared urine. There was a fabric incontinence pad over a th blanket on top of the ath blanket and incontinence the with urine. The bottom he shoulder area to the Rehabilitation Director ed linens and rivulets of urine attress. A strong smell of e time the linens were bilitation Director offered er and stated it was not dent #15 was found in that M Resident #15 was taken to	F	677			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345002	B. WING				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CYPRESS		ON CENTER			006 SOUTH 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 677	change in color to ind been incontinent of ur Resident #15's roomr Resident #15 she wor NA #1 stated Resider was wet when she se indicated she had use Resident #15 out of b In an interview on 05/ 10:35 AM the Directo the care guides for ea computer. She stated access to the informa into the computer to s residents. In an interview on 05/ Occupational Therapi staff was supposed to transfer Resident #15 In an interview on 05/ Nurse stated that a lo discussed about Resi meetings. She indica discussion that Resid appropriate for therap discussion about the was not aware Resider transfers. She indica Coordinator were resi care guides but since was in process Resid care guide had not ye In an interview on 05/	<ul> <li>licate that Resident #15 had rine. She indicated she fed mate her breakfast and told uld be back to provide care. In #15 did not tell her she arved her breakfast. She ed the mechanical lift to get the on 05/19/18.</li> <li>(21/18 at approximately r of Nursing (DON) stated ach resident were only in the d the nursing staff all had tion and should be going see how to care for the</li> <li>(22/18 at 9:51 AM the state (OT) stated the nursing staff all had tion and should be going see how to care for the</li> <li>(22/18 at 5:18 PM the MDS to f things had been ident #15 in clinical ated she remembered a ent #15 may or may not be by but did not remember any use of a mechanical lift so ent #15 needed one for ted she and the MDS ponsible for updating the a significant change MDS ent #15's care plans and et been updated.</li> <li>(22/18 at 6:00 AM NA #4 punds were conducted every</li> </ul>	F	677			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345002	B. WING				25/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS		ON CENTER			006 SOUTH 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	27	F	677			
	indicated she went no providing care. She s residents more often In an interview on 05/ stated she had found before when she took	22/18 at 6:20 AM NA #6 on-stop during her shift stated she checked on her than every two hours. 25/18 at 1:10 PM NA #8 Resident #15 saturated s over her assignment. She ormed the hall nurse and the					
	two hours to check re In an interview on 05/ stated she expected i completed every two indicated she would r a resident's brief to ch stated that visualizing moisture line in the br was no odor. The DC have taken so long for	ands should be done every sidents for incontinence. 25/18 at 2:05 PM the DON ncontinence rounds to be hours and as needed. She not expect aides to pull back neck for incontinence. She a change in color to the rief was sufficient if there DN indicated it should not r Resident #15 to be taken					
F 684 SS=D	care. Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resident that residents received	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in	F	684			6/13/18
	care plan, and the res	ensive person-centered					

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. (X3) DATE SU	URVEY
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLE	ETED
		345002	B. WING			5/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
CYPRESS	POINTE REHABILITATI	ON CENTER		2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Based on observatio interviews, the facility centered care plans t of 3 residents (Reside range of motion and of Findings included: Example #1 Resident #19 was ad 10/10/06. Diagnosis neuromuscular dysfu hand contractures. The Minimum Data S 14-day assessment rr cognitively impaired. extensive assistance transfers, bed mobilit extensive assistance dressing, eating and #19 had impairments lower extremities. R for any splinting or ra A review of the physic order was written on protectors to be on at tolerance. A review of the care pr revealed the resident breakdown developm mobility with an interv	ens, record review and staff or failed to follow patient or apply palm protectors to 2 ent #19 and #9) observed for contractures. mitted to the facility on included hemiplegia, nction and right and left set (MDS) dated 03/26/18, evealed the resident was Resident #19 required with two staff assist with y, toileting and bathing, and with one staff assist with personal hygiene. Resident to both sides to upper and esident #19 was not coded nge of motion. cian orders revealed an 04/18/18 for bilateral palm t all times per patient	F 68	<ul> <li>F684 <ol> <li>Resident's #19 and #9 h as ordered. Neither Residen negative outcome as a rest observation.</li> <li>Root Cause: There was communication between the nurses and the certified nut as to who would apply the devices daily. The restoral staff will apply splinting devident forward. An audit was commension residents to ensure that det place on 6/4/2018</li> <li>The DON/Designee will re-education on ensuring at applied per directions by 60 will be conducted 3 times at weeks to ensure splints are ordered.</li> <li>The QA team will review report the results at the module performance improvement meetings to validate compliance achieved and sustained. Statistical sets and plans of correction will be i deemed necessary/appropic committee.</li> </ol> </li> </ul>	ent had a ult of this miss e licensed rsing assistants splinting tive nursing vices going tive nursing vices going tive nursing vices going tive nursing vices were in conduct Il devices are (11/18. Audits a week for 12 e applied as t, analyze and onthly committee iance is ubsequent mplemented as	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/03/2018 MAPPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		LETED
		345002	B. WING				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS	POINTE REHABILITATIO	DN CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	An observation of Res 1:42 PM revealed the on bilateral hands. Th noted to be contracted and trim and there we odor on her palms. An observation of Res 4:45 PM revealed the on bilateral hands. An observation of Res 8:50 AM revealed the on bilateral hands. An observation of Res 10:30 AM revealed the on bilateral hands. An observation of Res 12:30 PM revealed the on bilateral hands. An observation of Res 2:30 PM revealed the on bilateral hands. An observation of Res 4:30 PM revealed the on bilateral hands. An observation of Res 10:15 AM revealed the on bilateral hands.	e 29 sident #19 on 05/20/18 at re were no palm protectors ie resident ' s hands were d, fingernails were clean re no signs of indentation or sident #19 on 05/20/18 at re were no palm protectors sident #19 on 05/21/18 at re were no palm protectors sident #19 on 05/21/18 at ere were no palm protectors sident #19 on 05/21/18 at ere were no palm protectors sident #19 on 05/21/18 at re were no palm protectors	F	684			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345002	B. WING				C 25/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS	POINTE REHABILITATIO	ON CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	on bilateral hands. An interview with NA is revealed Resident #1 relied on staff assistan #2 stated Resident #1 bilateral feet, but she resident wore splints NA #2 stated she was could use her hands to reported the only way of a resident was if sh would ask the nurse. An observation of Res 6:00 AM revealed the on bilateral hands. An interview with Nurs AM revealed "She was on at all times." Th for the palm protector bureau draw and app Nurse #8 stated it was was up to the nurse to An interview was com Nursing (DON) on 05. DON reported her exp staff was to follow the palm protectors were physician.	re were no palm protectors #2 on 05/22/18 at 2:30 PM 9 was total care and she nce for all of her care. NA 19 wore bunny boots to her	F	684			
	Example 2						
	Resident #9 was adm 08/15/17 and re-enter	-					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345002	B. WING				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CYPRESS	POINTE REHABILITATIO	ON CENTER			006 SOUTH 16TH STREET VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	nondominant side her contracture. The May 2018 current the resident's palm proprotector on at all time resident, remove for her redness." A quarterly Minimum (MDS) dated 02/21/18 intact cognition, requi- all activities of daily lis- bilateral upper and low Review of the care pla Resident #9 stated the impaired skin integrity due to multiple sclero contracture. Interven protector to the right her hygiene and monitor to On 05/20/18 at 11:45 AM Resident #9 was protector on his right. In an interview with R 8:30 AM he stated that fallen on the floor best ago and he had not so he did wear it except wheelchair and when put on for a week. Her when he had it on. On 5/23/18 at 5:30 Pf had received a new p	ed multiple sclerosis, right miplegia and right hand at physician orders regarding rotector was: "Right palm es as tolerated by the hygiene and check for Data Set assessment 8 revealed the resident had ired extensive assistance for ving except eating, and had wer extremity impairments. an dated 03/05/18 for at he was at risk for y related to poor bed mobility sis and a right hand tions included: palm hand, remove for hand for redness. AM and on 05/23/18 at 8:30 observed without a palm hand. tesident #9 on 05/23/18 at at his palm protector had side his bed about a week een it since. He stated that	F	684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345002	B. WING				C 25/2018
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS	POINTE REHABILITATIO	DN CENTER			006 SOUTH 16TH STREET /ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	he was going to eat. In an interview condu Nursing on 05/24/18 a the nurse aides applie She said they docume electronic Point of Ca She said it was her ex protector was ordered applied by the nurse a planned In an interview with N 7:50 AM she stated th regarding specific pat or asking a nurse. Sh palm guard or a splint task to be done. She Resident #9. She sai he wore a palm guard sure" that she saw it a providing care but cou In an interview with N at 8:05 AM she stated #9 on her assignment the resident Kardex to each resident. She re #9 wore a palm guard stated that she could wearing the palm guard care of him. She said	se dinner was coming and cted with the Director of at 12:05 PM she stated that ed splints and palm guards.	F	584			
F 688 SS=D	on the resident.	rease in ROM/Mobility	F6	688			6/13/18

Facility ID: 923267

If continuation sheet Page 33 of 57

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/03/2018 // APPROVED ). 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345002	B. WING	_		C 05/25/2018		
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	03/	23/2010	
10 112 01 11					2006 SOUTH 16TH STREET			
CYPRESS	POINTE REHABILITATIO	ON CENTER			WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 688	resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoida §483.25(c)(2) A reside motion receives appro- services to increase re- prevent further decreas §483.25(c)(3) A reside receives appropriate as assistance to maintain the maximum practica reduction in mobility is This REQUIREMENT by: Based on observation interviews, the facility protectors to 2 of 3 re- #9) observed for rang contractures. Findings included: Example #1 Resident #19 was add 10/10/06. Diagnosis neuromuscular dysfur hand contractures. The Minimum Data S- 14-day assessment re- cognitively impaired.	cility must ensure that a ne facility without limited not experience reduction in is the resident's clinical es that a reduction in range ble; and ent with limited range of opriate treatment and ange of motion and/or to ase in range of motion. ent with limited mobility services, equipment, and n or improve mobility with able independence unless a is demonstrably unavoidable. is not met as evidenced ns, record review and staff failed to apply ordered palm sidents (Resident #19 and te of motion and mitted to the facility on included hemiplegia, notion and right and left et (MDS) dated 03/26/18, evealed the resident was Resident #19 required	F	688	<ul> <li>F688</li> <li>1. Resident's #19 &amp; #9 had splints applied as ordered and documentation accurately recorded. Neither Resident had a negative outcome as a result of tobservation.</li> <li>2. Root Cause: There was miss communication between the licensed nurses and the certified nursing assista as to who would apply the splinting devices daily. Nursing staff documente splint application without validating devices daily. Nursing staff documente splint application without validating devices daily apply splinting devices going forwa An audit was completed on like resider to ensure that devices were in place or 6/4/2018.</li> <li>3. The DON/Designee will conduct</li> </ul>	this ants ed vice taff rd. nts n		
	14-day assessment re cognitively impaired.	evealed the resident was			6/4/2018.			

Facility ID: 923267

If continuation sheet Page 34 of 57

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	: 07/03/2018 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	345002	B. WING		05/2	; 25/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CYPRESS POINTE REHABILITATI			2006 SOUTH 16TH STREET			
CTFRESS FOINTE REHABILITATI	ONCENTER		WILMINGTON, NC 28401			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
<ul> <li>extensive assistance dressing, eating and #19 had impairments lower extremities. R for any splinting or rate of a review of the physic order written on 04/12 protectors to be on all tolerance.</li> <li>A review of the care prevealed the resident breakdown developm mobility with an intervipalm protectors to be removed for hand hysic redness.</li> <li>An observation of Re 1:42 PM revealed there will noted to be contracted and trim and there will odor on her palms. An observation of Re 4:45 PM revealed the eated the on bilateral hands. The noted to be contracted and trim and there will odor on her palms. An observation of Re 4:45 PM revealed the on bilateral hands.</li> <li>An observation of Re 8:50 AM revealed the on bilateral hands.</li> <li>An observation of Re 10:30 AM revealed the on bilateral hands.</li> </ul>	y, toileting and bathing, and with one staff assist with personal hygiene. Resident to both sides to upper and esident #19 was not coded nge of motion. cian orders revealed an 8/18 for bilateral palm	F 64	88 applied per directions and that the r validates the device is in place befo documentation can be completed th be completed by 6/11/18. Audits wi conducted 3 times a week for 12 we ensure splints are applied as ordere 4. The QA team will review, analyze report the results at the monthly performance improvement committe meetings to validate compliance is achieved and sustained. Subsequen plans of correction will be implement deemed necessary/appropriate by t committee.	re his will II be eeks to ed and ee nt ted as		

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345002	B. WING				C 25/2018	
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
CYPRESS	POINTE REHABILITATIO	ON CENTER			2006 SOUTH 16TH STREET WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 688	12:30 PM revealed th on bilateral hands. An observation of Re 2:30 PM revealed the on bilateral hands. A review of the Treatr (TAR) revealed Nurse apply palm protectors 05/21/18 for the day s	ere were no palm protectors sident #19 on 05/21/18 at the were no palm protectors ment Administration Record e #5 initialed the task to to bilateral hands on shift.	F	688	3			
	4:30 PM revealed the on bilateral hands. An observation of Re	sident #19 on 05/21/18 at are were no palm protectors sident #19 on 5/22/18 at are were no palm protectors						
	10:15 AM revealed th on bilateral hands. An observation of the Nurse #5 initialed the protectors to bilateral day shift. An observation on Re	sident #19 on 05/22/18 at ere were no palm protectors TAR at 11:00 AM revealed task to apply palm hands on 05/22/18 for the esident #19 on 05/22/18 at re were no palm protectors						
	revealed Resident #1 relied on staff assista #2 stated Resident # bilateral feet, but she	#2 on 05/22/18 at 2:30 PM 9 was total care and she nce for all of her care. NA 19 wore bunny boots to her was not aware if the or anything to her hands.						

Facility ID: 923267

If continuation sheet Page 36 of 57

		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 07/03/2018 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		STRUCTION	(X3)	DATE SURVEY COMPLETED
		345002	B. WING _				C 05/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
CVDDESS		ON CENTER		2006 S	OUTH 16TH STREET		
CIFRES		ONCENTER		WILMI	NGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 688	NA #2 stated she was could use her hands reported the only way of a resident was if sh would ask the nurse. An observation on Re 5:30 PM revealed the on bilateral hands. An observation of Re 6:00 AM revealed the on bilateral hands. An observation of the Nurse #8 initialed the protectors to bilateral night shift. An interview with Nur AM revealed the proc medication to confirm to check it off in the of check mark would sh #8 explained that if th number would appea enter a reason for the as ordered. Nurse #8 (applying bilateral pal that was why there w observed the residen palm protectors were stated "Oh, did they t them bilateral? I thou And then stated, "She them on at all times." room for the palm pro- in a bureau draw and resident. Nurse #8 st	s fed with assistance and to hold a special cup. NA #2 y she knew how to take care he already knew them or she esident #19 on 05/22/18 at ere were no palm protectors sident #19 on 05/23/18 at ere were no palm protectors a TAR at 6:10 AM revealed task to apply palm hands on 05/23/18 for the that it was completed was computer. Nurse #8 stated a ow up if it was done. Nurse task was not done, a code r to prompt the nurse to a task not being completed B reported this particular task im protectors) was done and tas a check mark. Nurse #8 t at this time and noted the e not on the resident and ake them off?" "She wears ught it was just one hand." e was supposed to have The nurse searched the otectors which were located a applied them to the	F	588			

Facility ID: 923267

If continuation sheet Page 37 of 57

	-	D HUMAN SERVICES				FORM	1 APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345002	B. WING			05/	C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
CYPRESS		ON CENTER					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	WILMINGTON, NC 28401 PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 688	Continued From page	37	E C	588			
1 000	them.			500			
		se #4 on 05/23/18 at 10:50					
		assigned to Resident #19					
	on 05/22/18. Nurse # the palm protectors d	4 stated she did not apply					
	Resident #19 because	e it was Nurse #5 ' s					
	responsibility because	e it was considered a stated it was a nursing					
	measure to apply the	•					
	AM revealed she sign completed on 05/21/1 palm protectors were she did not apply ther Nurse #5 could not re	se #5 on 05/23/18 at 11:00 ted the task off as being 8 and 05/22/18 because the on her. Nurse #5 stated n, but saw them on her. call the time that she otectors on the resident.					
	An interview was con Nursing (DON) on 05 DON reported her exp	ducted with Director of /24/18 at 2:30 PM. The pectations of the nursing palm protectors as ordered					
	-	-					
	the resident's palm pr protector on at all time	t physician orders regarding otector was: "Right palm es as tolerated by the hygiene and check for					
	A quarterly Minimum	Data Set assessment					

	-	ID HUMAN SERVICES				FORM	APPROVED			
		MEDICAID SERVICES					0. 0938-0391			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY			
			A. BUILD	ING.	<u></u>					
		345002	B. WING				C 25/2018			
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2010			
					2006 SOUTH 16TH STREET					
CYPRESS		ON CENTER		WILMINGTON, NC 28401						
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX TAG			PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE			
IAG	G REGULATORY OR LSC IDENTIFYING INFORMATION)		IAG		DEFICIENCY)					
F 688	Continued From page	38	F	688	3					
			1	000						
		8 revealed the resident had red extensive assistance for								
		ving except eating, and had								
		wer extremity impairments.								
		wer extremity impairments.								
	Review of the care pla	an dated 03/05/18 for								
	Resident #9 stated th									
	impaired skin integrity	related to poor bed mobility								
	due to multiple sclero	sis and a right hand								
	contracture. Interven	tions included: palm								
	protector to the right I	nand, remove for hand								
	hygiene and monitor	for redness.								
		AM and on 05/23/18 at 8:30								
		observed without a palm								
	protector on his right	esident #9 on 05/23/18 at								
		at his palm protector had								
		side his bed about a week								
		een it since. He stated that								
	he did wear it except									
		eating but had not had it to								
		e said his hand felt better								
	when he had it on.									
	On 5/23/18 at 5:30 PI	V the resident stated that he								
	had received a new p	alm protector for his hand								
		surveyor. He said he had								
	•	se dinner was coming and								
	he was going to eat.									
		cted with the Director of								
		at 12:05 PM she stated that								
		ed splints and palm guards.								
	She said they docume	re (POC) system Kardex.								
		xpectation that if a palm								
		by the physician that it be								
	-	aides as ordered. She								
		gone into Resident #9's								
		d had found his old palm								

Facility ID: 923267

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/03/20 RM APPROVE IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			TE SURVEY MPLETED
		345002	B. WING		0	C 5/25/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	Ē	
CYPRESS		ON CENTER		SOUTH 16TH STREET MINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 688 F 732 SS=C	issued a new one tha In an interview with N 7:50 AM she stated th regarding specific pai or asking a nurse. She palm guard or a splin task to be done. She Resident #9. She sa he wore a palm guard sure" that she saw it providing care but co In an interview with N at 8:05 AM she stated #9 on her assignmen the resident Kardex th each resident. She re #9 wore a palm guard stated that she could wearing the palm guard care of him. She said on his dresser. Posted Nurse Staffing CFR(s): 483.35(g)(1) §483.35(g) Nurse Sta §483.35(g)(1) Data re must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following catego unlicensed nursing st resident care per shif (A) Registered nurses (B) Licensed practical	tt that he had also been tt day to wear. Iurse Aide #9 on 05/25/18 at hat she obtained information tient care by looking in POC he said if a resident had a t it would show in POC as a reported that she cared for id that she remembered that d and that she was "pretty and put it on his hand while uld not say for certain. Iurse Aide #10 on 05/25/18 d that she cared for Resident t. She said she looked at o determine the needs of emembered that Resident d on his right hand. She not remember if he was ard the last time she took d she did remember seeing it g Information -(4) affing Information. equirements. The facility ng information on a daily and the actual hours worked gories of licensed and aff directly responsible for t: s.	F 688			6/13/18

Event ID: LHZB11

Facility ID: 923267

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/03/2018 APPROVED
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			LETED
		345002	B. WING				C 25/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS				2	006 SOUTH 16TH STREET		
				V	VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	Continued From page	<b>≥</b> 40	F	732			
	(C) Certified nurse aid (iv) Resident census.	les.					
	§483.35(g)(2) Posting (i) The facility must pospecified in paragraph daily basis at the begi (ii) Data must be post (A) Clear and readabl (B) In a prominent pla residents and visitors §483.35(g)(3) Public a staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on observation	best the nurse staffing data (g)(1) of this section on a inning of each shift. teed as follows: le format. acce readily accessible to access to posted nurse cility must, upon oral or a nurse staffing data c for review at a cost not to ty standard.			F732 1. Upon identification that the staffing sheet was not posted as per		
	Findings included:				requirements, the staffing sheet was posted.		
	on 05/20/18 at 11:00	on entrance to the facility AM revealed that the nurse ed in the main hallway was			2. Root cause: The facility failed to ass the duty of posting nursing staffing. The weekend manager will now be respons for ensuring staffing sheets are posted There were no residents affected by thi	ible	
	#8, who was working adjacent to the postin				observation. 3. Re education was provided to the Administrative staff by the NHA regardi the daily staffing sheets that need to be	ng	

Facility ID: 923267

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					с	
		345002	B. WING		05/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VPRESS				2006 SOUTH 16TH STREET		
		en center		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC	
F 732	Continued From page	e 41	F 73	2		
	said she was not the	charge nurse and did not		posted. Education will be completed	by	
		sed change the staffing		6/11/2018. Audits will be conducted 3		
	sheet each day.			times a week for 12 weeks to ensure		
	In an interview with th	ne Director of Nursing (DON)		staffing sheets are posted per requirements		
		PM she stated that during the		4. The QA team will review, analyze	and	
		gh Friday), she changed the		report the results at the monthly		
	nurse staffing sheet the	•		performance improvement committee		
	hallway. She said sh			meetings to validate compliance is		
		ot assigned the duty to ng forward the DON said		achieved and sustained. Subsequent plans of correction will be implemented		
		s duty to a specific nurse to		deemed necessary/appropriate by thi		
	-	ct posting was displayed		committee.	0	
	every day including w					
F 759	Free of Medication E	rror Rts 5 Prcnt or More	F 75	9	6/13/18	
SS=D	CFR(s): 483.45(f)(1)					
	§483.45(f) Medicatior	Frrors				
	The facility must ensu					
	\$483 45(f)(1) Medicat	tion error rates are not 5				
	percent or greater;					
	This REQUIREMENT	is not met as evidenced				
	by:	, . , . <i></i>		5750		
		n, record review and staff		F759		
		ews the facility failed to medication error rates		1. Notification was provided to the ME regarding the administration of the		
		videnced by 2 medication		Clonidine to Resident #65. Clarification	n	
	-	rtunities, resulting in a		was obtained from the MD and the		
		of 7.69% for 1 of 5 sampled		parameters for the blood pressure		
	residents (Resident #			medications were discontinued. There		
	medication administra	ation. Findings included:		were no negative outcomes as a resu this		
	During a medication a	administration observation		2. Root Cause: There was a transcription	otion	
		M Nurse #1 was observed		error that lead to the medication error		
	passing medications	to Resident #65. Prior to the		Labetalol. Nurse #1 failed to read the		
		lications Nurse #1 obtained		special instructions attached to the		
		pressure. Nurse #1		medication orders prior to administeri		

Event ID: LHZB11

Facility ID: 923267

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED
			5 14/11/2			С
		345002	B. WING			)5/25/2018
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CYPRESS	POINTE REHABILITATIO	ON CENTER		2006 SOUTH 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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 759	Continued From page	e 42	F 7	59		
	(systolic/diastolic). Si labetalol 200mg (milli the pharmacy. She v for Resident #65 and dosage according to the Administration Record sticker on the bubble with special instruction hold the medication if reading was less than diastolic blood pressu the medication in a sr Resident #65. Nurse 0.3mg in the cup to giverifying it was the co the MAR. There were listed on the pharmace clonidine. Nurse #1 se provide medications to point Nurse #1 was re medication administra bubble pack containing asked to read the spet the pharmacy. After in pharmacy instructions seen the label and re She verified the elect instructions to hold the blood pressure was les she would hold the la Resident #65's physic	tated she was ready to o Resident #65. At this equested to stop the ation and to pull out the og the labetalol. She was icial instructions supplied by reading the special is she stated she had not viewed the electronic MAR. ronic MAR contained e labetalol if the diastolic ess than 100. She indicated betalol and speak with cian for clarification on the istering the medication. vith the medication		<ul> <li>medications. There were residents observed with sin Nurse #1 received disciplit 5/30/2018.</li> <li>3. Education was provided following MD orders and were medication package instructions in eMA be provided re education administration and review instruction in the eMAR by Education will be completed Medication administration conducted 3 times a week ensure medication are administration are followed.</li> <li>4. The QA team will review report the results at the metings to validate compachings to validate compachieved and sustained. Splans of correction will be deemed necessary/appropricements.</li> </ul>	imilar findings. nary action on d to Nurse #1 on validating uction with AR. Nurses will on medication ing special / the DON. ed by 6/11/18. audits will be a for 12 weeks to ministered per y listed w, analyze and onthly t committee bliance is Subsequent implemented as	
		conciliation (medications o what was ordered) on				

		ID HUMAN SERVICES MEDICAID SERVICES			FO	PRINTED: 07/03/2018 FORM APPROVED OMB NO. 0938-0391		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED		
		345002	B. WING		n	C 5/25/2018		
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD				
CYPRESS	POINTE REHABILITATI	ON CENTER		2006 SOUTH 16TH STREET				
				WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 759	special blood pressur order showed the clo if the diastolic blood p Nurse #1 was approa checking the MAR for order included blood that she should have In an interview on 05, #65's physician state be followed. He indic that the diastolic and Resident #65's blood transposed, someone verify the parameters In an interview on 05, stated she should have in the electronic MAR pressure parameters medications. In an interview on 05, Director of Nursing (I the facility medication 5%. She indicated sh be given as ordered a followed. The DON in questions regarding r	ately 9:15 AM it was dent #65's clonidine also had re parameter orders. The nidine 0.3mg should be held pressure was less than 100. Ached and verified by r special instructions that the pressure parameters and also held the clonidine. /24/18 at 9:32 AM Resident d he expected his orders to cated that although he felt systolic parameters for pressure had just been e should have called him to	F 75					
F 812 SS=F	from the physician. Food Procurement,S CFR(s): 483.60(i)(1)(	tore/Prepare/Serve-Sanitary 2)	F 81	12		6/13/18		
	§483.60(i) Food safe The facility must -	ty requirements.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/03/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345002	B. WING		C 05/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •
CYPRESS			:	2006 SOUTH 16TH STREET	
		SH OLHTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 812	Continued From page	2 44	F 812	2	
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming food \$483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observatio facility failed to keep a mayonnaise at or beld during operation of th failed to air dry kitche storage, and failed to repackaged food item Findings included: 1. Upon entering the PM a deep tray pan co a well of the steam ta melting ice and next to and five preplated dis Cole slaw were sitting table waiting to be pla At 5:25 PM on 05/22/ used to check the tray	ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ince with professional rvice safety. ' is not met as evidenced n and staff interview the a cold salad made with bw 41 degrees Fahrenheit e trayline. The facility also nware before stacking it in label and date opened and is in storage areas. kitchen on 05/22/18 at 5:22 of Cole slaw was observed in ble above a shallow pan of o a well housing hot foods, hes which included bowls of g on the edge of the steam aced on resident trays.		<ul> <li>F812</li> <li>1. Following identification of the undat food items, dry stock items and improp dried trays appropriate corrective actio took place. Upon identification that the slaw exceeded temperature it was disposed of. No residents were affect by this deficient practice.</li> <li>2. Root Cause: Dietary employees fail to follow outlined guidance on food storage and preparation as well as pro- drying of dishes. The employees were able to explain proper procedures to the administrator. Disciplinary actions will provided.</li> <li>3. Dietary staff was provided with re- education on: dating food items, proper food handling (including cold foods) and proper drying procedures on 5/20/20 and 5/291/2018. Audits will be conduct</li> </ul>	perly on ted ed oper e he be be r nd 18

Facility ID: 923267

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	E SURVEY
	OUNTEDHON	IDENTIFICATION NOMBER.	A. BUILDING		С	
		345002	B. WING		05/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
CYPRESS	POINTE REHABILITATIO	ON CENTER		2006 SOUTH 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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 812	thermometer registered when used to check t Cole slaw to be place At 5:28 PM on 05/22/ dietary staff still had 1 for residents. He rep assembling the slaw a 05/22/18, and placed to chill. He commenter utilized in the prepara assembly. The Cook contained diced cabb vinegar, and sugar. recorded the temperat degrees Fahrenheit w initially began operati At 5:34 PM on 05/22/ (DM) stated when he Cole slaw prior to the operation the calibrate registered 37 degrees At 2:35 PM on 05/23/ staff was trained to us preparing cold salads	ed 68.2 degrees Fahrenheit he last bowl of preplated d on a resident tray. 18 the PM Cook stated the 1 1/2 meal carts to send out orted that he finished at about 1:00 PM on it in the walk-in refrigerator ed that all the ingredients he tion were chilled prior to stated that the Cole slaw age, carrots, mayonnaise, The Cook reported that he ture of the slaw at 40 when the supper trayline on at 5:00 PM. 18 the Dietary Manager took the temperature of the supper trayline beginning ed thermometer actually	F 81	<ul> <li>3 times a week for 12 weeks to kitchen policies are followed to storage of food, labeling of foor preparations of hot and cold it proper drying of dishes.</li> <li>4. The QA team will review, ar report the results at the month performance improvement cor meetings to validate complian achieved and sustained. Subs plans of correction will be impledeemed necessary/appropriat committee.</li> </ul>	o include od, ems and halyze and ly mmittee ce is equent emented as	
	residents. He report salads over ice in a si began operation. He temperature control s best not to place all t tray pan. According t salads made with ma	ed staff usually placed cold team well once the trayline e commented that from a tandpoint it was probably he chilled salad in one big o the DM, allowing cold yonnaise to rise above 41 or long periods of time could				

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/03/2018 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345002	B. WING				C / <b>25/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS		ON CENTER			006 SOUTH 16TH STREET		
				V	VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	stated cold salads shibefore they were services should be assembled day they were due to assembled, he report supposed to be store meal trayline began of were to be kept in or process began. The allowing cold salads the Fahrenheit for long period bacteria and fungus the service of the store of the service	ould be prepared the day yed, or at the latest they in the early morning on the be served. Once ed the salads were d in refrigeration until the operation, and then they above ice once the trayline employee commented to rise above 41 degrees eriods of time could cause o grow in the food. of the kitchen, beginning at 8, 6 of 12 tray pans stacked on a shelving unit had de of them. At this time the ese tray pans were stacked f 05/19/18, and retained em overnight. 18 the Dietary Manager mployees were trained to air efore stacking it in storage. kitchenware wet overnight formation and result in	F	812			
	stated there should b present when kitchen storage. He reported to use drying racks and drying of kitchenware the dish machine and process. He comme kitchenware wet could	d the dietary staff was taught nd fans to promote the which had been run through I three-compartment sink					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		345002	B. WING				C 25/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CVDDESS			2006 SOUTH 16TH STREET					
CIFRESS		JN CENTER		V	WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 812	Continued From page	2 47	F	312				
	11:23 AM on 05/20/18 chips which were oper food preparation table open dates. In the re containers of pink lerr and dates on them. three bags of ziti past pasta, one bag of elbe container of dry/powd did not have labels or them. In the walk-in r mayonnaise, one gall one gallon of lite Italia sweet pickle relish, or dressing, and one gal dressing were opened documenting the date initially opened up. In bag of waffle fries had without a label and da During a follow-up tou on 05/23/18, one gallon of Cole slaw dressing dressing, one gallon of gallon of thousand isl- walk-in refrigerator, w have labels on them of were initially opened. At 2:35 PM on 05/23/ (DM) stated he and hi storage areas daily w that all opened food it items, and leftovers w	llon of thousand island d, but were without labels es on which they were n the walk-in freezer a brown d been opened, but was						

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 07/03/2018 FORM APPROVED 1B NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		345002	B. WING _				C 05/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CYPRESS		ON CENTER			06 SOUTH 16TH STREET LMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 812 F 842 SS=D	stock person monitor weekly for labeling ar were trained to place in storage bags with I affixed to these bags dating and labeling w first out" (FIFO) conce the freshest food pos At 2:57 PM on 05/23/ stated all employees storage areas for labe in and out of the dry s coolers, and walk-in r He reported labeling a keep stock rotated pr Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re resident-identifiable to accordance with a co agrees not to use or of except to the extent the to do so. §483.70(i) Medical re §483.70(i) 1 In accord	ed storage areas once ad dating, and the cooks food from opened packages abels and dates to be . According to the DM, as important in the "first in, ept which promoted serving sible. 18 a dietary employee were supposed to monitor eling and dating as they went storage room, reach-in refrigerators and freezers. and dating was important to operly. dentifiable Information 483.70(i)(1)-(5) nt-identifiable information. elease information that is to the public. elease information that is to an agent only in ntract under which the agent disclose the information he facility itself is permitted cords. rdance with accepted Is and practices, the facility al records on each resident ented; e; and		312			6/13/18

Facility ID: 923267

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345002	B. WING			C 05/25/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
CYPRESS	POINTE REHABILITATIO	ON CENTER			006 SOUTH 16TH STREET VILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	<del>)</del> 49	F {	842				
	all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to hea by and in compliance §483.70(i)(3) The faci record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The mer (i) Sufficient information (ii) A record of the ress (iii) The comprehensiv provided;	r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches e law. dical record must contain- on to identify the resident;						

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/03/ FORM APPRC OMB NO. 0938-(
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345002	B. WING		C 05/25/2018
NAME OF P	ROVIDER OR SUPPLIER		- ·	STREET ADDRESS, CITY, STATE, ZIP CODE	·
				2006 SOUTH 16TH STREET	
CIPRESS		ON CENTER		WILMINGTON, NC 28401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE
F 842	Continued From page	e 50	F 842	2	
	and resident review e		1 0 12		
	determinations condu				
		s, and other licensed			
	professional's progre				
		logy and other diagnostic			
		equired under §483.50.			
	This REQUIREMENT	Γ is not met as evidenced			
	by:				
		ons, record review and staff		F842	
	-	inaccurately documented a		1. Resident's #19 & #9 had spl	• •
	task as completed on			as ordered and documentation	-
	Administration Recor			accurately recorded. Neither F	
	(Resident #19 and #9	rotectors to be applied to		had a negative outcome as a re observation.	esuit of this
	bilateral hands at all t			2. Root Cause: There was mi	ee
				communication between the lic	
	Findings included:			nurses and the certified nursing	
	Example #1			as to who would apply the splir devices daily. Nursing staff do	cumented
	Pesident #10 was ad	mitted to the facility on		splint application without valida was in place. The restorative n	-
	10/10/06. Diagnosis			will apply splinting devices goir	•
	-	nction and right and left		An audit was completed on like	-
	hand contractures.			to ensure that devices were in 6/4/2018.	
	The Minimum Data S	set (MDS) dated 03/26/18,		3. The DON/Designee will cond	duct
		evealed the resident was		re-education on ensuring all de	
		Resident #19 required		applied per directions and that	the nurse
		with two staff assist with		validates the device is in place	
		y, toileting and bathing, and		documentation can be complet	
		with one staff assist with		be completed by 6/11/18. Aud	
		personal hygiene. Resident		conducted 3 times a week for 1	
		to both sides to upper and		ensure splints are applied as o	
	liower extremities. R	esident #19 was not coded		4. The QA team will review, an	-
	for any enlipting or re	ngo of motion at the time of			
		nge of motion at the time of		report the results at the monthl	-
	for any splinting or ra this look back period.	-		performance improvement com	mittee
	this look back period.	-			mittee e is

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/03/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345002	B. WING				C 25/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CYPRESS	POINTE REHABILITATIO			20	006 SOUTH 16TH STREET		
				W	VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From page	<u>9</u> 51	F	842			
	protectors to be on at tolerance.			0.12	deemed necessary/appropriate by th committee.	is	
	revealed the resident breakdown developm mobility with an interv palm protectors to be removed for hand hys redness. An observation of Re 1:42 PM revealed the on bilateral hands. Th noted to be contracte and trim and there we odor on her palms. An observation of Re 8:50 AM revealed the on bilateral hands. An observation of Re 10:30 AM revealed the on bilateral hands. An observation of Re 12:30 PM revealed th on bilateral hands. An observation of Re 2:30 PM revealed the on bilateral hands.						
	(TAR) revealed Nurse	e #5 initialed the task to s to bilateral hands on					

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	-					FORM	): 07/03/2018 1 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		345002	B. WING		_	05/2	C 25/2018
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				2006 SOUTH 16TH STREE	т		
CYPRESS	POINTE REHABILITATIO	ON CENTER	,	WILMINGTON, NC 2840	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	An observation of Res 8:30 AM revealed the on bilateral hands. An observation of Res 10:15 AM revealed th on bilateral hands. A review of the TAR a #5 initialed the task to bilateral hands on 05/ An observation on Re 1:20 PM revealed the on bilateral hands. An observation of Res 6:00 AM revealed the on bilateral hands. A review of the TAR a #8 initialed the task to bilateral hands on 05/ An interview with Nurs AM revealed the proc medication to confirm to check it off in the co check mark would sho #8 explained that if th number would appear enter a reason for the as ordered. Nurse #8 (applying bilateral pain that was why there wa observed the resident palm protectors were stated "Oh, did they ta	sident #19 on 5/22/18 at ere were no palm protectors sident #19 on 05/22/18 at here were no palm protectors at 11:00 AM revealed Nurse o apply palm protectors to /22/18 for the day shift. esident #19 on 05/22/18 at ere were no palm protectors sident #19 on 05/23/18 at ere were no palm protectors at 6:10 AM revealed Nurse o apply palm protectors to /23/18 for the night shift. ese #8 on 05/23/18 at 6:10 cess of signing off a task or n that it was completed was omputer. Nurse #8 stated a ow up if it was done. Nurse the task was not done, a code r to prompt the nurse to e task not being completed B reported this particular task im protectors) was done and as a check mark. Nurse #8 t at this time and noted the not on the resident and ake them off?" "She wears	F 842		DEFICIENCY)		
	that was why there was observed the resident palm protectors were stated "Oh, did they ta	as a check mark. Nurse #8 t at this time and noted the not on the resident and					

Facility ID: 923267

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/03 FORM APPR OMB NO. 0938-	OVED
STATEMENT OF DEFICIENCIES (> AND PLAN OF CORRECTION				IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345002	B. WING _		C 05/25/2018	8
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI		
CVDDESS	POINTE REHABILITATI			2006 SOUTH 16TH STREET		
OTFICESS		ONCENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT	ETION
F 842	And then stated, "She on at all times." The the palm protectors w bureau draw and app Nurse #8 stated it wa was up to the nurse to reported she should r without applying the p An interview with Nur AM reported she was on 05/22/18 and 05/2 did not apply the palm on Resident #19 beca responsibility because treatment. Nurse #4 measure to apply the stated if there were in mark on the TAR, the was completed. Nurse are not supposed to s treatment until they h An interview with Nur 05/23/18 at 11:00 AW task off as being com 05/22/18 because the her. Nurse #5 stated saw them on her. Nu were in the box on the there were initials and the task was completed recall the time that sh protectors on the resi	e is supposed to have them nurse searched the room for which were located in a blied them to the resident. Is a nursing measure and it o apply them. The nurse not have signed the task off palm protectors. The mass of the task off palm protectors. The #4 on 05/23/18 at 10:50 assigned to Resident #19 23/18. Nurse #4 stated she in protectors on the day shift ause it was Nurse #5 ' s e it was considered a stated it was a nursing palm protectors. Nurse #4 nitials in the box with a check en that would mean the task se #4 reported that nurses sign off a medication or ave completed it. The #5 (treatment nurse) on the revealed she signed the upleted on 05/21/18 and e palm protectors were on she did not apply them, but urse #5 confirmed her initials e TAR. Nurse #5 stated if d a check mark it indicated red. Nurse #5 could not	F 8	342		
		ducted with the Director of /24/18 at 2:30 PM. The				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/03/2018 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345002	B. WING		0	C 5/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
CYPRESS		ON CENTER		2006 SOUTH 16TH STREET		
				WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 842	ROVIDER OR SUPPLIER         S POINTE REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 842			

Facility ID: 923267

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		MEDICAID SERVICES				D. 0938-03
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	· · /	E SURVEY PLETED
			A. BUILDING			С
		345002	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
CYPRESS POINTE REHABILITATION CENTER			2006 SOUTH 16TH STREET			
CTPRESS		ON CENTER		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From page	- FF				
F 042			F 84	2		
		M the resident stated that he				
		palm protector for his hand				
		surveyor. He said he had				
	he was going to eat.	just taken it off because dinner was coming and be was going to eat				
	In an interview conducted with the Director of					
	Nursing on 05/24/18 at 12:05 PM she stated that					
	-	ed splints and palm guards.				
	She said they docum					
	electronic Point of Care (POC) system Kardex.					
	She said it was her e	xpectation that if a palm				
	-	d by the physician that it be				
		aides as ordered. She				
	-	cted the documentation in				
		tual care delivered to a				
		t expect documentation to				
		ard was on a resident if it				
	was not.	Jurse Aide #9 on 05/25/18 at				
		hat she obtained information				
		tient care by looking in POC				
		he said if a resident had a				
	palm guard or a splint it would show in POC as a					
		e reported that she cared for				
		id that she remembered that				
	he wore a palm guar	d and that she was "pretty				
		and put it on his hand while				
		uld not say for certain and				
		d that the device was in				
		t's hand) on 05/21/18 at				
	00:56.	lurgo Aido #10 05/05/40				
		Iurse Aide #10 on 05/25/18				
		d that she cared for Resident				
		t. She said she looked at o determine the needs of				
		emembered that Resident				
		d on his right hand. She not remember if he was				

Facility ID: 923267

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/03/2018 1 APPROVED 2: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345002	B. WING		_	( 05/2	C 25/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CYPRESS		ON CENTER		2006 SOUTH 16TH STREET VILMINGTON, NC 2840			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	care of him. She said on his dresser and the 05/21/18 at 12:33 as place). She said she the palm guard on Re In an interview with th Nursing on 05/25/18 a the nurse aide replied POC that it meant tha was on the resident a Review of the electron that both Nurse Aide	e 56 I she did remember seeing it at is why she signed it off on on his hand (device in did not remember putting seident #9 on 05/21/18. The Assistant Director of at 9:25 AM he stated that if 1 "yes" to device in place in the device (palm guard) t the time it was signed off. hic Kardex in POC revealed #9 and #10 replied "yes" to //21/18 for Resident #9's	F 842				

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